

Sex, lives and commissioning II

A report by the Advisory Group on Contraception on the commissioning of contraceptive and abortion services in England

May 2014



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About the Advisory Group on Contraception

The Advisory Group on Contraception (AGC) is an expert advisory group made up of leading clinicians and advocacy groups who have come together to discuss and make policy recommendations concerning the contraceptive needs of women of all ages. The AGC came together in November 2010 with a focus on ensuring that the contraceptive needs of all women in England, whatever their age, are met. A full list of members is available in Appendix 1.

Comprehensive, open access sexual and reproductive health services play an important part in delivering improved public health outcomes by preventing ill health, improving wellbeing and addressing inequalities. We believe that all women should have ready access to high quality services which offer them information about, and a choice from, the full range of contraceptive options.

We are keen to work with individuals and organisations with an interest in sexual and reproductive health to ensure that the policy environment appropriately addresses the contraceptive needs of all women of reproductive age.

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Executive summary

- All 152 upper tier and unitary councils in England were sent Freedom of Information requests. Of these, 134 (88 per cent) were able to provide a response in full and the below findings reflect these responses. We believe the high response rate gives us a detailed picture of how local authorities are commissioning contraceptive services in England today

Commissioning of contraceptive services in today's health system

- This is the first year that local authorities are responsible for the commissioning of the majority of contraceptive services since the passing of the 2012 Health and Social Care Act, with other elements split between clinical commissioning groups and NHS England
- The Department of Health has published its ambitions for sexual health services in England in its policy document *A framework for sexual health improvement in England*. The framework sets out eight ambitions including reducing unintended pregnancies amongst women of all ages and the continued reduction in the rate of under 16 and under 18 conceptions
- Findings from the audit revealed that over one third (35 per cent) of local authorities that responded to the AGC's audit did not issue a service specification as part of their procurement of potential sexual health providers in 2013/14. The decision not to issue a specification raises concerns about how some commissioners will hold providers to account on the quality of care being delivered by those services

Delivering comprehensive, open access contraceptive services

- Our audit found evidence of commissioners applying restrictions in access to contraceptive services that would appear to be against national policy and clinical guidance
- The restrictions reported or identified did not necessarily reflect a city or borough-wide policy, but, in some instances, a policy for a specific service. Examples of the restrictions identified include services not being available to women over a certain age or because of their place of residence

Assessing contraceptive need and service provision

- 40 per cent of commissioners confirmed that an assessment of contraceptive services in their area had been carried out in the past three years, with a quarter (26 per cent) reporting that an assessment was currently underway
- However, nearly a third (31 per cent) of local authorities said no assessment was planned or had been carried out. Based on population figures for women of reproductive age (15 to 44) by local authority, that means contraceptive services are being commissioned for 2.9 million women without a proper assessment of services, outcomes and experience^{1, 2}

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- 64 per cent of local authorities reported that no assessment had been completed into the local need for additional contraceptive training to provide subdermal implants and intrauterine methods
- Poor awareness of the number of professionals able to fit these methods can create a further barrier to women accessing more effective forms of contraception. It can also impact on how services are planned and commissioned by local authorities

Commissioning and funding arrangements

- Figures from our audit have revealed that 60 per cent confirmed the existence of an arrangement to jointly commission and/or contract sexual and reproductive health services with other local authorities. For instance, six councils in Berkshire said that they are “working in a shared arrangement for the commissioning of some sexual health and contraceptive services”³
- Joint arrangements allow councils to share responsibilities and promote more integrated commissioning across council boundaries. However, when joint arrangements are in place, individual councils should ensure they are able to report back on the services being provided in their area
- Figures published by the Department for Communities and Local Government (DCLG) illustrate variation in the level of spend being reported by councils on contraceptive services
- When the same information was requested by the AGC, 42 per cent of councils that responded to the audit were unable to provide us with information on the amount of money being spent on contraceptive services, with 25 per cent of councils providing information that was not clear or possible to interpret. The figures also revealed considerable issues surrounding the reporting of money being spent with all councils that could provide information on spend reporting different figures to the AGC’s audit than to the DCLG

Reducing unintended pregnancies and improving access to all methods of contraception

- 20 per cent of commissioners confirmed that they currently had a plan in place to reduce unintended pregnancies in their area, with 43 per cent of councils stating that a plan was currently being developed. One third (34 per cent) of councils said no plan was in place
- The AGC is concerned about those councils that have yet to make any progress in putting formal plans in place to tackle unintended pregnancies and the potential impact this could have on service delivery and the care women receive
- Over a quarter of councils (28 per cent) confirmed a plan was in place to increase uptake and improve access to contraception, with a third having a plan in development. 57 per cent of the local authorities with a plan in place to increase access to contraception also had a formal plan to reduce unintended pregnancy

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Summary of recommendations

Commissioning of contraceptive services in today's health system

1. To promote accountability of service provision, local authorities should publish on their websites tender documents and service specifications for the commissioning of contraceptive services in their area at the beginning and end of the procurement process. Commercially sensitive information should be redacted
2. When tendering for contraceptive services, local authorities should use the Department of Health's *Integrated Sexual Health Services: National Service Specification* as a basis for their own specification
3. NHS England should set out a plan for the way in which it intends to work with local authorities and CCGs to ensure that a holistic approach is taken to the commissioning of comprehensive sexual and reproductive health services nationally and locally. This should include the provision of high quality contraceptive care within pre and post-natal services
4. The Department of Health should publish annual reports, setting out progress towards delivering each ambition within *A framework for sexual health improvement in England*. As part of these reports, the Department of Health should invite Public Health England and NHS England to report back against their own progress towards delivering the ambitions
5. As part of any review of the sexual health improvement framework and Public Health Outcomes Framework, the Department of Health should use indicators that measure and map outcomes across an individual's life course. This will allow national and local decision-makers to identify age groups that are achieving the best and worst outcomes
6. NICE should consider the interim quality standards for contraceptive services published by the AGC and Faculty of Sexual and Reproductive Healthcare as part of the development of its own standard. Development of the quality standard for contraceptive services should be prioritised by NICE, particularly in light of the Government's sexual health policy and new responsibilities that have been passed to councils
7. Health and wellbeing boards should be encouraged to monitor the implementation of the sexual health improvement framework in their area in order to ensure coordinated and integrated commissioning decisions

Delivering comprehensive, open access contraceptive services

8. Commissioners should ensure contraceptive services are truly open access. These services should be based on national standards, policy and clinical guidelines
9. Commissioners should urgently reconsider any restrictions on the prescribing of contraceptive methods and make sure methods are prescribed on the basis of clinical quality and individual

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choice. Appropriate funding arrangements should also be put in place for services that prescribe all effective contraceptive methods

10. Commissioners should ensure that, when specific services are restricted, robust referral pathways are in place that allow all women to access the full range of contraceptive methods at a time and location that suits them
11. As part of their annual reports, local Healthwatch should include a review of how the local authority and local NHS commissioners have performed against the Department of Health's sexual health improvement framework

Assessing contraceptive need and service provision

12. Commissioners and providers should ensure robust referral pathways are in place across the sexual health service to promote an integrated and seamless experience of care
13. One year on from taking charge of commissioning sexual and reproductive health services, local authorities should consider requesting their health and wellbeing boards undertake a review of contraceptive services in their area. These reviews should assess how local areas can deliver on the ambitions of the sexual health improvement framework
14. Any review or assessment of contraceptive services should include consultation with service users and women in the local area who may have access to these services. Outputs from these consultations should be used to inform future planning and provider decisions
15. Working with local providers, all commissioners should have arrangements in place to assess the training requirements of their local workforce to ensure that there is an appropriate number of healthcare professionals qualified to fit and remove subdermal implants and intrauterine contraceptive methods

Commissioning and funding arrangements

16. Commissioners should consider introducing key markers and tests to ensure providers are commissioned and funded not just on the basis of cost but because they are also able to deliver against the principles of high quality and open access contraceptive services
17. There are significant and unexplained variations in how councils are reporting spend on sexual and reproductive health services. Local authorities should, as a matter of urgency, review the reporting and coding mechanisms for the funding of areas within the public health budget, including the amount spent on contraceptive services
18. The Department for Communities and Local Government should, with the Department of Health, provide clarity to local authorities about what constitutes spend on contraceptive services to aid them with internal and external reporting on spending of the ring-fenced budget

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19. The Department of Health should ensure that local authorities are aware that, as part of a public health service or intervention, the cost of any contraceptive prescription should be met by local authorities' ring-fenced public health allocation

Reducing unintended pregnancies and improving access to all methods of contraception

20. We would strongly urge councils to continue funding primary care contracts for LARCs. Removal of these agreements could have significant impact on women's access to the full range of contraceptives and be a significant barrier towards the Government's achieving its ambition of reducing the number of unintended pregnancies in England
21. Commissioners should have plans in place to reduce unintended pregnancy. These plans should seek to address the number of repeat abortions and improve outcomes for women of all ages
22. In the absence of a relevant indicator, the AGC recommends Patient Reported Experience Measures (PREMs) should be used as a proxy for contraceptive outcomes about how supported service users aged over 20 feel in managing their sexual and reproductive health. Many contraception providers are already required to collect such information for service users but this information is not collated, published, or used to measure outcomes
23. Health and wellbeing boards should ask commissioners to report back annually on their plans to reduce the rate and number of unintended pregnancies in their area. Health and wellbeing boards should consider requesting this information after the annual dataset on abortion statistics is published by the Department of Health
24. Local authority health scrutiny committees should consider holding reviews about progress towards improving access to contraception and reducing the rate of unintended pregnancy



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Introduction

The Advisory Group on Contraception (AGC) is made up of leading clinicians and advocacy groups who have come together to discuss and make policy recommendations concerning the sexual and reproductive health needs of women of all ages. The focus of this has previously been skewed towards addressing the needs of teenagers, therefore the AGC came together in November 2010 to ensure that the contraceptive needs of all women, whatever their age, are met.

Over the past three years the AGC has welcomed the opportunity to work with politicians, policy-makers, commissioners and advocacy groups to ensure that the reforms to the NHS and public health systems in England deliver real, long lasting improvements in contraceptive services for women of all ages. The AGC believes that comprehensive, open access sexual and reproductive health services play an important part in delivering improved public health outcomes by preventing ill health, improving wellbeing and addressing inequalities.

The AGC believes that it should be mandatory (as a minimum) for the following elements of a comprehensive, integrated sexual and reproductive health service for all ages to be commissioned:

- Sexual health and contraceptive services in general practice
- Comprehensive community contraceptive services
- Termination of pregnancy (fully integrated services offering the full range of contraception, STI testing and treatment)
- Provision of contraception as an integral part of other specialist services, for example maternity, and medical specialties where drug treatment or medical problems specifically affect conception or foetal wellbeing
- Testing and treatment of STIs (including opportunistic chlamydia testing)
- STI partner notification activity
- HIV testing and treatment
- Sexual health outreach (eg provision of sexual health advice and contraception in community settings, crisis centres etc)
- Workforce training on sexual health and contraception
- Specialist health promotion

However, in 2012, we were concerned about anecdotal evidence of women being refused access to contraceptive services on the basis of age, place of residence or choice of method, and the potential impact of the reforms to the health system in leading to a greater fragmentation of care for women. That is why, in April 2012, we published the first audit looking at the current commissioning arrangements for contraceptive services and the outcomes they were delivering⁴.

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The report of the audit's findings, *Sex, lives, and commissioning: An audit of the commissioning of contraceptive and abortion services in England*, found stark variations in the arrangements commissioners had in place for contraceptive services and demonstrated that:

- As many as **3.2 million women of reproductive age (15-44)** were living in areas where fully comprehensive contraceptive services, through community and/or primary care services, were not provided
- Those commissioners restricting access to contraceptives or contraceptive services had a **higher abortion rate than the national average**
- Over a quarter (28 per cent) of commissioners responding to the audit **did not have a strategy in place** to tackle rates of unintended pregnancy in their area⁵

Sex, lives and commissioning made a number of recommendations to inform the Government's new sexual health policy and its findings led to two parliamentary inquiries into the issue, including one by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK^{6,7}.

Ensuring women have access to a suitable and reliable method of contraception is a crucial part of delivering good health outcomes for women. Failure to meet people's contraceptive needs also comes at a cost. A report commissioned by leading sexual health charities, Brook and the Family Planning Association (FPA), estimates that if current levels of access to services continue, unintended pregnancies and sexually transmitted infections will cost the NHS £11.4 billion between 2013 and 2020⁸. It goes on to demonstrate that further restrictions in access could potentially increase NHS and wider public sector costs by a further £10 billion over the same period⁹.

In 2012, there were 176,480 abortions carried out in England by the NHS and NHS agencies¹⁰. It has been estimated that £1 invested in contraception saves £11.09 in averted outcomes¹¹. Reducing the number of unintended pregnancies could therefore deliver a significant cost saving to the public purse and commissioners of sexual health, maternity and social care services, as well as having a positive impact for women.



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Following the publication of its audit, the AGC was pleased that the Department of Health chose to adopt a number of our recommendations in its new sexual health policy document, *A framework for sexual health improvement in England*, particularly the Government's ambition to reduce the number of unintended pregnancies amongst women of all ages¹².

This emphasis within national policy is an important step in addressing the unintended consequences that have resulted from the previous focus on tackling of teenage pregnancy. For instance, over the past ten years, sexual and reproductive health services, education programmes and information have often been designed around the needs of teenagers. This has had the perverse effects of deterring older women from engaging with services to seek advice and disincentivising health services from seeking a contraceptive solution most appropriate to the woman in question. It also reflects disinvestment from services for post-teen women. The impact of this can be seen in the continuing high levels of abortions and repeat abortions in women aged 20 and over. For example, in England over four in five (83 per cent) abortions in 2012 occurred in women aged 20 and over¹³.

Two years on from its first audit, the AGC has undertaken a repeat audit of local authorities in England to assess what progress has been made in implementing the Department of Health's sexual health framework and our initial recommendations to commissioners. The audit also sought to understand the decisions being made by councils, with their new responsibilities, to commission comprehensive, open access sexual and reproductive health services.

The vast majority (approximately 80%) of contraceptive care continues to be provided in general practice¹⁴ and is not assessed, in full, by this report. We believe further work should be undertaken to explore the quality and provision of these services, and to identify where improvements can be made including through improved training of healthcare professionals.

This report presents the findings from the audit and marks the first comprehensive review of what the new commissioning environment looks like for contraceptive services. The AGC is keen to work with the Department of Health, Public Health England, commissioners and others to deliver the ambitions of the sexual health framework and to make constructive recommendations for how services can continue to be improved to meet the needs of women of all ages.

The Department of Health chose to adopt a number of our recommendations in its new sexual health policy document.

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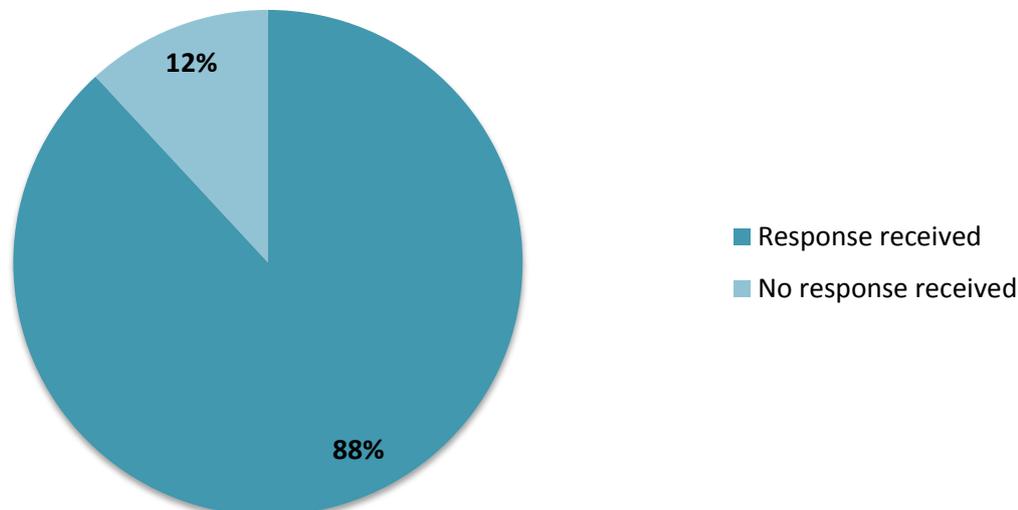
Methodology

The findings from this report are largely based on responses to a series of Freedom of Information requests submitted by the AGC to every upper tier and unitary authority in England in August 2013. The information requested included:

- Any policies to restrict access to specialist contraceptive services on the basis of age, place of residence, or contraceptive
- Details of a formal plan in place to reduce unintended pregnancies among all women of fertile age in its area and to increase access to all methods of contraception, including long-acting reversible contraception, for women of all ages in its area
- Information on how local authorities allocated the proportion of their ring-fenced public health budget for 2013/14 to commission sexual health services (including contraception and emergency contraception)
- Plans to conduct an assessment of the local need for additional contraceptive training to provide subdermal implants and intrauterine methods over the next two financial years
- Details of plans to jointly commission and/or contract sexual health services and/or contraceptive services with other local authority commissioners

A full list of the requests sent to local authorities is available in Appendix 2.

Figure 1: Percentage of local authorities that responded to the Freedom of Information requests



All 152 local authorities with responsibility for commissioning public health services were sent requests and 134 of these were able to provide responses within 30 working days, more time allowed than under statutory requirements. The AGC is grateful to all those local authorities that responded and a list of those councils is available in Appendix 3. All further analyses in this report are based on the responses of those councils that responded in full to the Freedom of Information requests.

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We are disappointed that 18 councils were unable to provide details on these issues meaning we are unable to assess their ability to effectively commission contraceptive services. As public authorities, these organisations are required by law to respond to Freedom of Information requests in a timely manner.

Local authorities are not required to respond to Freedom of Information requests in any particular format and the data were not always directly comparable. The analysis set out in this paper has been carried out by the AGC's secretariat, MHP Communications. Analysis has also been carried out of national abortion statistics, which are included in this report.

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Commissioning of contraceptive services in today’s health system

In evaluating the commissioning arrangements for contraceptive services in England, it is necessary to understand the new policy context and the background to the Government’s reforms to the public health system in England.

Commissioning arrangements for sexual and reproductive health services

Since 1 April 2013, local authorities have been responsible for the commissioning of the majority of contraceptive services, with new clinical commissioning groups and NHS England overseeing the commissioning of all remaining services. This change in commissioning responsibility followed the passing of the 2012 Health and Social Care Act and the publication of the Government’s new sexual health policy, *A framework for sexual health improvement in England*.

Figure 2 sets out the Department of Health’s breakdown of the commissioning arrangements for all sexual health services since 1 April 2013. Those areas marked in **bold** are directly relevant to contraceptive services.

Figure 2: Commissioning and governance responsibilities for contraception and abortion services¹⁵

Local authorities	Clinical commissioning groups	NHS England
<p>Comprehensive sexual health services. These include:</p> <p>Contraception, including implants and intra-uterine contraception and all prescribing costs, but excluding contraception provided as an additional service under the GP contract</p> <p>Sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing</p> <p>Sexual health aspects of psychosexual counselling</p> <p>Any sexual health specialist services, including young people’s sexual health, outreach, HIV prevention and sexual health promotion, services in schools, colleagues and pharmacies</p>	<p>Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term)</p> <p>Sterilisation</p> <p>Vasectomy</p> <p>Non-sexual health elements of psychosexual health services</p> <p>Gynaecology, including any use of contraception for non-contraceptive purposes</p>	<p>Contraception provided as an additional service under the GP contract</p> <p>HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure)</p> <p>Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs</p> <p>Sexual health element of prison health services</p> <p>Sexual Assault Referral Centres</p> <p>Cervical screening</p> <p>Specialist fetal medicine services</p>

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The AGC welcomes the Department of Health's decision to use the sexual health framework to set out the roles and responsibilities of each commissioning body within the new system to take forward this area of care. However, under this model, commissioning responsibilities for contraceptive services are incredibly complex and divided across a number of bodies within the new framework.

Ensuring any fragmentation of services is addressed or prevented will be a key measure of success for the Government's public health reforms. It will also require all commissioning bodies – including NHS England that will oversee the majority of contraceptive provision through the GP contract – to work collaboratively to oversee provision of a comprehensive service.

Local authorities are also now being expected to commission clinical services in relation to sexual health and contraception, in particular through the enhanced service agreements for certain LARC methods. Although it is likely that many directors of public health will have moved from old primary care trusts into local authorities, some personnel could be new to the area or unclear about what is meant to be included within the arrangements for these services. Given the complexity of clinical care for contraception, local authorities should be given the tools and support to understand this area of care.

As we set out in our first report, *Sex, lives and commissioning*, one of the key levers for improving clinical standards in contraceptive services will be the forthcoming quality standard for contraceptive services (including emergency contraception) to be published by the National Institute for Health and Care Excellence (NICE)¹⁶.

The AGC has already submitted a recommended set of quality statements on contraception to NICE for consideration. These are included in Appendix 4. In April 2014, the Faculty of Sexual and Reproductive Healthcare published its *Quality Standard for Contraceptive Services* (see Appendix 5), which "sets out a range of key quality measures and required outcomes for new local authority and NHS commissioners to achieve". NICE should consider how they can incorporate both of these documents into the standard it is expected to develop in due course.

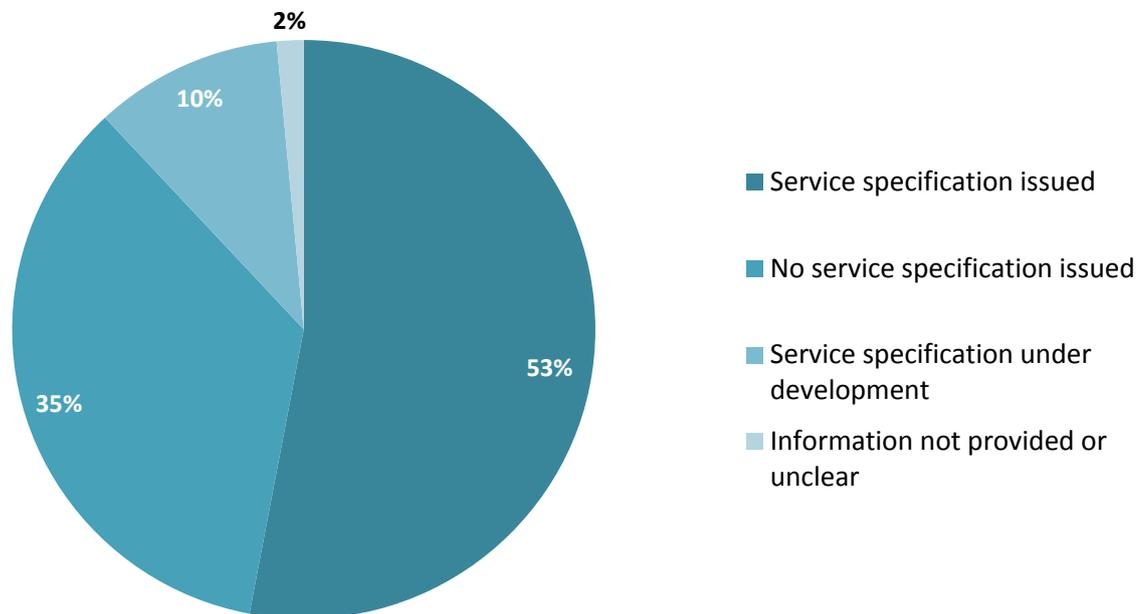
To support local authorities in carrying out their new responsibilities, the Department of Health published a model sexual health service specification and best practice guidance on the commissioning of sexual health services and interventions^{17, 18}.

We have welcomed the publication of these two documents as playing a vital role in shaping the planning, commissioning and delivery of sexual health services in England based on the latest up to date evidence. However, the AGC has previously raised concerns about the time taken to publish these documents and the potential impact this could have on the quality of contraceptive services available to women in England¹⁹.

As evidence of this, our updated audit of contraceptive services has revealed that over one third (35 per cent) of local authorities did not issue a service specification as part of their procurement of potential sexual health providers in 2013/14. The absence of any such specification raises questions about the extent to which these providers are being expected to deliver against the most up to date clinical and policy guidance.

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Figure 3: Percentage of local authorities that confirmed issuing a service specification as part of the procurement process to potential sexual health providers in 2013/14



In response to this information request, a number of commissioners said they had not undertaken a procurement process for 2013/14. Ten per cent of local authorities said a procurement process was currently underway and the service specification was under review. For instance, Kirklees Council said that it had “started a procurement process for an integrated sexual health service. The service specification has not yet been produced but it will be based largely on the national specification”²⁰.

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Ambitions for sexual health in England today

In March 2013, the Department of Health published its ambition to improve the sexual health and wellbeing of people living in England. *A framework for sexual health improvement in England*, first announced in the Department of Health’s public health white paper, set out eight objectives for how their ambition could be reached²¹.

Figure 4: Key objectives of the Department of Health’s sexual health framework for England²²



The AGC has welcomed the Department of Health’s decision to prioritise a reduction in the number of unintended pregnancies amongst women of all ages. We have long argued that the policy focus has, to date, been skewed towards addressing the needs of teenagers. This could possibly have had inadvertently led to a rise in the number of unintended pregnancies amongst older women.

Success in achieving the Government ambition for improvements in contraceptive care will require all organisations with an interest in sexual health, including local authorities, CCGs, NHS England area teams and providers, to come together and ensure that women have access to services that are truly open access. They should be available at times which are convenient for users, including late-nights and weekends. Moreover, contraceptive services should offer access to the full range of contraceptives so as to allow full and informed patient choice.

Based on conversations with officials in the Department of Health, the AGC is aware that plans are in place for the Department, with Public Health England, to develop a dashboard containing indicators

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against each of the objectives²³. This will then be used to measure the progress being made to achieve the overarching ambition.

Recommendation 1: To promote accountability of service provision, local authorities should publish on their websites tender documents and service specifications for the commissioning of contraceptive services in their area at the beginning and end of the procurement process. Commercially sensitive information should be redacted.

Recommendation 2: When tendering for contraceptive services, local authorities should use the Department of Health's *Integrated Sexual Health Services: National Service Specification* as a basis for their own specification.

Recommendation 3: NHS England should set out a plan for the way in which it intends to work with local authorities and CCGs to ensure that a holistic approach is taken to the commissioning of comprehensive sexual and reproductive health services nationally and locally. This should include the provision of high quality contraceptive care within pre and post-natal services.

Recommendation 4: The Department of Health should publish annual reports, setting out progress towards delivering each ambition within *A framework for sexual health improvement in England*. As part of these reports, the Department of Health should invite Public Health England and NHS England to report back against their own progress towards delivering the ambitions.

Recommendation 5: As part of any review of the sexual health improvement framework and Public Health Outcomes Framework, the Department of Health should use indicators that measure and map outcomes across an individual's life course. This will allow national and local decision-makers to identify age groups that are achieving the best and worst outcomes.

Recommendation 6: NICE should consider the interim quality standards for contraceptive services published by the AGC and Faculty of Sexual and Reproductive Healthcare as part of the development of its own standard. Development of the quality standard for contraceptive services should be prioritised by NICE, particularly in light of the Government's sexual health policy and new responsibilities that have been passed to councils.

Recommendation 7: Health and wellbeing boards should be encouraged to monitor the implementation of the sexual health improvement framework in their area in order to ensure coordinated and integrated commissioning decisions.

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Delivering comprehensive open access contraceptive services

Our first report in April 2012 found extensive evidence of commissioners restricting access to contraceptive services on the basis of age, residence or the type of method being prescribed²⁴. We were deeply concerned about the extent to which these restrictions were in place and the potential impact on women’s wellbeing and experience of accessing services.

Placing unfair restrictions on access to contraceptive services can have a significant impact on whether women are given a choice in the type of care or contraceptive method they receive (and hence on the continuing and careful use of contraception). For instance, the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK’s inquiry exploring restrictions in access heard evidence from eight women from Walthamstow who struggled to access contraception in their area²⁵. These women spoke about the amount of time they had to wait to be seen by a healthcare professional, or the need for them to travel long distances to access the method of their choice²⁶.

In our first report and submission to two parliamentary inquiries, the AGC called on commissioners to remove any policies or contracts that would restrict a woman’s access to contraceptive services, particularly those on the basis of age, and ensure they were truly open access. We also stressed the importance of councils, which were being charged with taking on responsibility for commissioning contraceptive services, understanding the importance of addressing such policies. The Department of Health addressed this issue within its sexual health framework, which stated:

“Abortion statistics show that rates for those aged over 25 have increased over the past ten years and indicate that significant numbers of women aged over 25 have unwanted pregnancies. Restricting access to services by age can therefore be counterproductive and ultimately can increase costs... This is why provision of high-quality, effective and accessible contraception for women of all ages is crucial to support people to plan and space their families”.²⁷

Policies restricting access to contraceptive services

To assess the extent to which such restrictions had been removed, the AGC asked local authorities to confirm whether they had a policy or contract in place which restricted access to specialist and/or community contraceptive services (not supplied by general practice) to women on the basis of age, place of residence or type of contraceptive method.

It is important to stress that how local areas responded to this query varied considerably and, in many cases, those areas that did report a restriction were highlighting a policy that applied to a specific specialised service rather than one that is city or borough-wide.

However, our audit did uncover evidence of restrictions that appeared to contradict national guidance and policy. For example Merton Council reported that its specialist clinics (for example, for the fitting of long-acting reversible contraceptives) are “only open to patients registered with a Sutton or Merton GP”.²⁸

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Many of the restrictions reported were based on a women’s age, in particular access to free emergency hormonal contraception from pharmacies through enhanced service arrangements. For instance, community pharmacists in York are able to prescribe emergency hormonal contraception “free of charge to women aged 14 – 24 years via a service specification [although it should be noted that women over the age of 24 would be able to access emergency hormonal contraception free of charge at CASH clinics or their GP]”²⁹, while in Oxfordshire this only applies to women under the age of 18³⁰.

The AGC recognises the importance of reducing the barriers for women wishing to access emergency hormonal contraception and that cost can sometimes be considered one of those barriers. However, focusing the policies of these agreements solely on young people wrongly assumes greater wealth amongst older women or that they would be able to access the prescription easily from their general practitioner.

The Department of Health’s policy is clear:

“Highly visible, accessible contraception services that supply the full range of contraceptive methods can reduce unwanted pregnancy and better support people of all ages to have children when they are ready, and these will play a key role in improving outcomes”³¹

Yet, nearly two years on from our first audit, it is clear that some of the restrictions in access put in place by primary care trusts have also been enacted by local authorities.

Recommendation 8: Commissioners should ensure contraceptive services are truly open access. These services should be based on national standards, policy and clinical guidelines.

Recommendation 9: Commissioners should urgently reconsider any restrictions on the prescribing of contraceptive methods and make sure methods are prescribed on the basis of clinical quality and individual choice. Appropriate funding arrangements should also be put in place for services that prescribe all effective contraceptive methods.

Recommendation 10: Commissioners should ensure that, when specific services are restricted, robust referral pathways are in place that allow all women to access the full range of contraceptive methods at a time and location that suits them.

Recommendation 11: As part of their annual reports, local Healthwatch should include a review of how the local authority and local NHS commissioners have performed against the Department of Health’s sexual health improvement framework.

Recommendation 12: Commissioners and providers should ensure robust referral pathways are in place across the sexual health service to promote an integrated and seamless experience of care.

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Assessing contraceptive need and service provision

There are core steps and processes that every commissioner should work towards when planning and commissioning high quality contraceptive services. This includes undertaking a thorough needs assessment of local contraceptive needs and provision of services, including any additional training requirements amongst healthcare professionals. The Department of Health's sexual health improvement framework states that "services should be commissioned against a robust assessment of local need"³².

The AGC believes that a comprehensive joint strategic needs assessment should include:

- Local data on the numbers of people of reproductive age
- The unintended pregnancy rate, and abortion and repeat abortion rates (compared to national averages)
- Provision of services (locations, staffing, opening hours and running costs)
- Workforce information (numbers of qualified fitters for LARC methods)
- Availability of methods of contraception at each site
- User feedback on their experience of the service

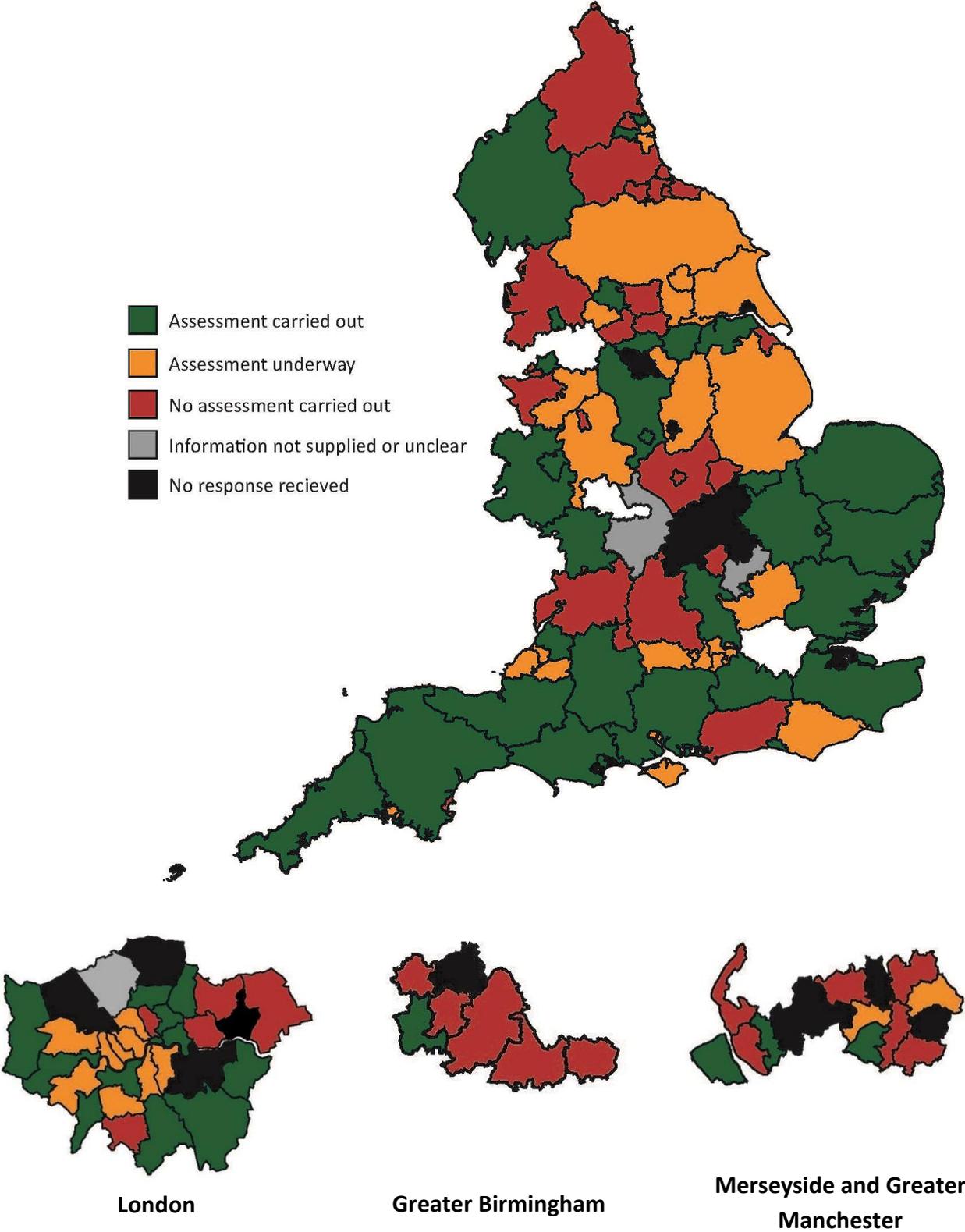
Commissioners in local authorities should also ensure they maintain close links with those commissioning other parts of the sexual and reproductive health service, since contraception is not commissioned in isolation but plays an important role in other health pathways (for example, treating heavy menstrual bleeding).

Without an assessment in place there is a real concern that funding and commissioning decisions will not be made on the basis of the needs of women in those areas. The AGC therefore requested information about whether, in the past three years, a needs assessment for local contraceptive provision has been carried out in the local authority area.



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Map 1: Map showing whether local authorities have carried out a needs assessment for local contraceptive provision in the last three years



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In Map 1, Greater Manchester and Merseyside, Greater Birmingham and London are not shown on the main map of England, and are therefore displayed as white. These areas have been pulled out separately for ease of interpretation.

40 per cent of councils that responded to our audit confirmed that a needs assessment for contraceptive services had been carried out in the past three years, with another 27 per cent reporting that an assessment was underway. However, 31 per cent of commissioners said no assessment was planned or had been carried out. Based on population figures for women of reproductive age (15 to 44) by local authority, this means that contraceptive services are being commissioned for 2.9 million women without a proper assessment of their needs, outcomes and experience^{33, 34}.

The AGC would urge all local authorities in England to ensure they have a detailed needs assessment in place before final commissioning decisions are made. This is particularly important for those areas of the country with high numbers of unintended pregnancy and repeat abortion rates.

The needs of women should be at the heart of all decisions about local contraceptive services. Capturing user feedback and experience can play a crucial role in helping commissioners understand how women in their area access services and the barriers they may face in being prescribed their choice of contraception. The AGC was pleased, therefore, to identify examples from the audit where councils were taking steps to gather such information and use it to inform how they carried out their responsibilities.

Buckinghamshire County Council³⁵

Access to contraception was a key priority for the sexual health strategy and commissioning intentions in Buckinghamshire. Commissioners in the county, therefore, wished to gain a greater understanding of the views of women aged 15-54 regarding contraceptive services focusing on the particular question: 'What information or services would increase their awareness of options (in particular LARC)?'.

Commissioners in Buckinghamshire prepared a questionnaire asking women about their experiences and advice they have received regarding contraception. Providers of contraceptive services distributed the questionnaire to approximately 500 women that attended a local clinic. The questionnaire was also available online for women that did not access contraceptive services directly.

To obtain further feedback from service users, four focus groups were held where participants were invited to discuss their experiences of using contraceptive services, in particular their sources of information, and the forms of contraception they were being offered. There was a fifth discussion with healthcare professionals in the area about the key issues around improving women's awareness of contraception.

The main themes to emerge from the study were:

- There is general satisfaction in the contraceptive services provided
- Access to LARCs is problematic due to clinical, personal and personnel constraints
- The contraceptive advice provided by GPs is frequently limited to the contraceptive pill

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- Dissatisfaction with the lack of referral or signposting to additional contraceptive services and availability of these services at the required times

Based on these findings, the team involved in the study made the following recommendations to commissioners and providers in Buckinghamshire:

- More written information is required, especially within GP surgeries, to allow women to access and understand what other contraceptive services are available locally
- Education and training of GPs, practice nurses and receptionists regarding contraceptive options other than the contraceptive pill
- Additional opening hours and personnel for outreach and specialist contraceptive services, to ensure contraceptive services are utilised to their fullest, accessible when women need them and provide an array of contraceptive options
- Further integration of sexual health services, to incorporate contraceptive and prevention of sexually transmitted disease advice, eg Chlamydia testing offered as standard

The results of the study were also published online and in GP surgeries across the county.

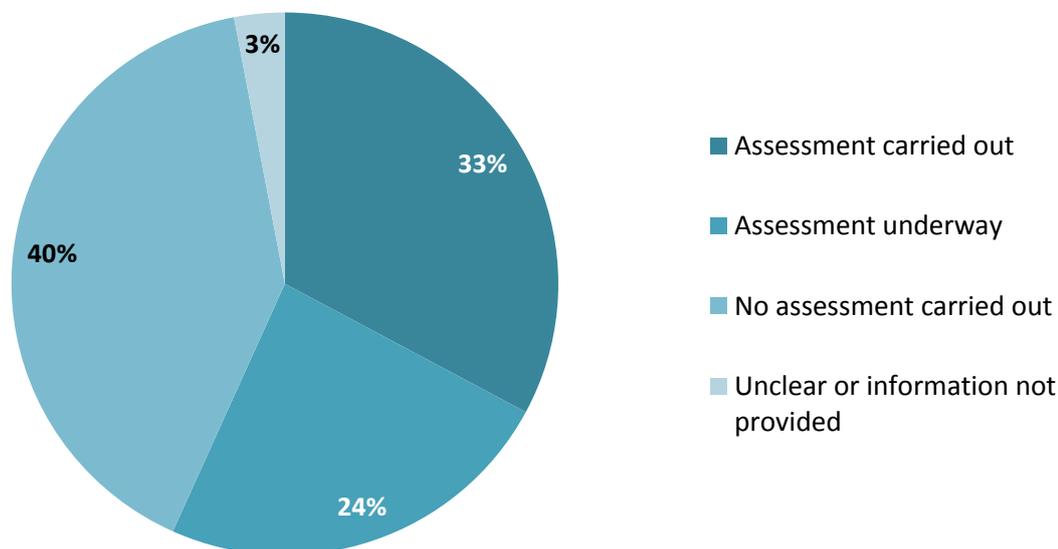
Ensuring there are sufficient healthcare professionals trained to fit and remove LARCs in general practice and community services

The fitting of LARC methods, especially intra-uterine contraceptive methods, is a clinical procedure which requires additional medical equipment and training. The AGC has long argued that having a well-trained workforce to fit and remove LARCs is an essential element in ensuring that women are able to access the contraceptive method of their choice.

As we have previously highlighted, anecdotal evidence suggests that there is currently a shortage of trained professionals able to fit and remove LARC methods and that this is acting as a barrier to women being able to access these effective method of contraception. The AGC, therefore, asked local authorities whether they had conducted an assessment of the local need for additional contraceptive training to provide subdermal implants and intrauterine methods.

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Figure 5: Percentage of local authorities that had conducted an assessment of the local need for additional contraceptive training to provide subdermal implants and intrauterine methods



Nearly two thirds (64 per cent) of councils reported that no assessment had been carried out or that one was currently underway. One third of councils did confirm that an assessment had been carried out and our audit identified a number of examples of good practice being taken forward across the country, for instance:

- Dudley Council said that it’s Office of Public Health “has a database of all accredited [LARC] fitters in the Borough and this is updated annually. It covers nurses and doctors in mainstream sexual health services and primary care”³⁶
- Trafford Council confirmed that it “monitors training for GPs who are signed up to the locally commissioned service”³⁷
- Norfolk Council reported that “local need for contraception training was identified through the needs assessment” and that the sexual health network will be devising an action plan to address this. It added that training “will be considered as a priority when redesigning/re-procuring services in future”³⁸

Unfortunately, there is currently no register held by Health Education England or NHS England on the number of qualified fitters of each type of LARC. The absence of this information can impact on the extent to which commissioners are able to appropriately plan and commission contraceptive services for the local population.

Recommendation 13: One year on from taking charge of commissioning sexual and reproductive health services, local authorities should consider requesting their health and wellbeing boards undertake a review of contraceptive services in their area. These reviews should assess how local areas can deliver on the ambitions of the sexual health improvement framework.

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Recommendation 14: Any review or assessment of contraceptive services should include consultation with service users and women in the local area who may have access to these services. Outputs from these consultations should be used to inform future planning and provider decisions.

Recommendation 15: Working with local providers, all commissioners should have arrangements in place to assess the training requirements of their local workforce to ensure that there is an appropriate number of healthcare professionals qualified to fit and remove subdermal implants and intrauterine contraceptive methods.

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Commissioning and funding arrangements

The Coalition Government's health reforms have led to the most radical transformation of public health commissioning in a generation. Local authorities in England are now responsible for commissioning public health services – including the majority of sexual and reproductive health services – based on local need and through a dedicated ring-fenced budget. Councils have also been given the freedom to work together to improve the health and wellbeing of their local populations through the commissioning of pan-borough or regional public health services.

The AGC has welcomed the principles behind the Government's reforms of the public health system in England and the opportunities they present to improve the quality of contraceptive services available to women in England. However, it is important to be aware that councils have not had public health responsibilities for over a generation and there are risks that the opportunities to improve services could be hampered by confusions over accountability, a lack of clinical expertise or short-term funding decisions. This is particularly the case given that, to date, the ring-fenced grant has only been guaranteed for two financial years (until March 2015).

It is likely that the transfer of funding and commissioning responsibility to councils will also lead to a politicisation of the public health agenda, and increased public scrutiny of how this money is being spent.

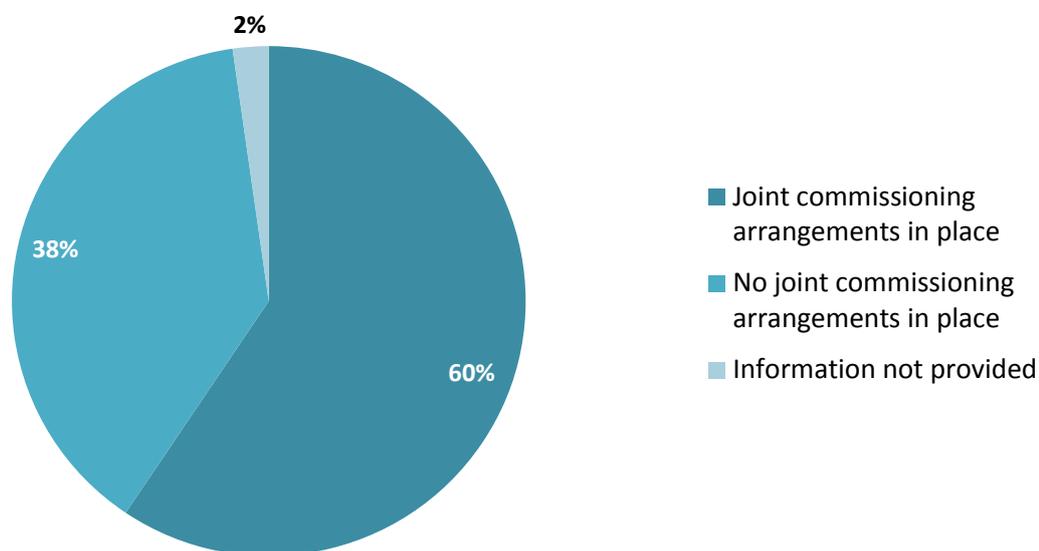
Assessing the existence of joint commissioning or contracting arrangements

Under the Government's health reforms, local authorities are able, following an appropriate assessment, to agree joint commissioning arrangements with other local authorities. This can be particularly important for 'open access' sexual and reproductive health services where men and women may choose to access services, for instance, nearer to their work rather than near where they live. The AGC was keen to establish, therefore, the extent to which these arrangements are in place and asked councils to provide such details.

The AGC has welcomed the principles behind the Government's reforms of the public health system in England and the opportunities they present to improve the quality of contraceptive services available to women in England.

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Figure 6: Percentage of local authorities that confirmed an arrangement is in place to jointly commission or contract sexual and reproductive health services (including contraceptive services)



The majority of councils that responded to the audit (60 per cent) confirmed the existence of an arrangement to jointly commission and/or contract sexual and reproductive health services with other local authorities. For instance, six councils in Berkshire said that they are “working in a shared arrangement for the commissioning of some sexual health and contraceptive services”³⁹.

Kensington and Chelsea Council also confirmed the existence of a tri-borough arrangement, saying:

“Sexual health is commissioned from the tri-borough public health service. As such, some services which were received by the local authorities from the NHS are already tri-borough services. As far as the local situation is concerned, Westminster City Council is the host local authority for tri-borough public health, however, there is no lead commissioning local authority and any procurement will need to pass through the governance of each local authority separately.”⁴⁰

The AGC recognises the importance of such arrangements and the role they can play in promoting a truly open-access service and avoiding access being on the basis of an individual’s postcode. However, it is important that commissioners are still able to report back on the services being commissioned in their area. For example, in response to our initial Freedom of Information request Barnet Council said: “the information you requested is not held by London Borough of Barnet but is held by Harrow Council. Harrow Council is the host borough for the newly formed joint Public Health team for Harrow and Barnet”⁴¹. After being contacted by the AGC’s secretariat for clarification on this response, it was confirmed that “the London Borough of Harrow and London Borough of Barnet operate a joint shared service which is hosted by Harrow Council. This means that operationally, whilst [the organisation] collect service information for individual Borough’s, this is held by Harrow”⁴². Officials within Harrow Council did offer to provide the requested information but, unfortunately, it was not possible to incorporate at the time of writing this report.

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The AGC is also concerned about the potential impact of joint commissioning on smaller providers. There is currently no cross-charging or tariff arrangement in place for contraceptive care, meaning most services are provided through block contracts. It could be the case that small providers would not necessarily be able to compete for these contracts when commissioned on a pan-borough or regional basis. This could risk the closure of smaller clinics and potentially require women to travel longer distances to access the contraceptive method of their choice.

The Local Government Association's guidance on sexual health commissioning, endorsed by Public Health England and the Association of Directors of Public Health, notes that the "introduction of tariffs for sexual health was part of a range of measures to improve access to, and improve and modernise, sexual health services"⁴³. The use of block contracts, it warns, could be a barrier to these service improvements.

Auditing funding arrangements for contraceptive services

In January 2013, the Health Secretary Jeremy Hunt, and Chief Executive of Public Health England, Duncan Selbie, announced details of the 2013/14 and 2014/15 grants to local authorities for their public health responsibilities⁴⁴. In its first year the total amount allocated to councils for public health spending was £2.66 billion⁴⁵. This will then rise to £2.79 billion in 2014/15⁴⁶. On announcing the funding allocations, the Department of Health confirmed plans to require local authorities to report back on how the funding was being spent⁴⁷. Guidance published on the funding said:

"In giving funding for public health to local authorities, it remains important that funds are only spent on activities whose main or primary purpose is to improve the health and wellbeing of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities"⁴⁸

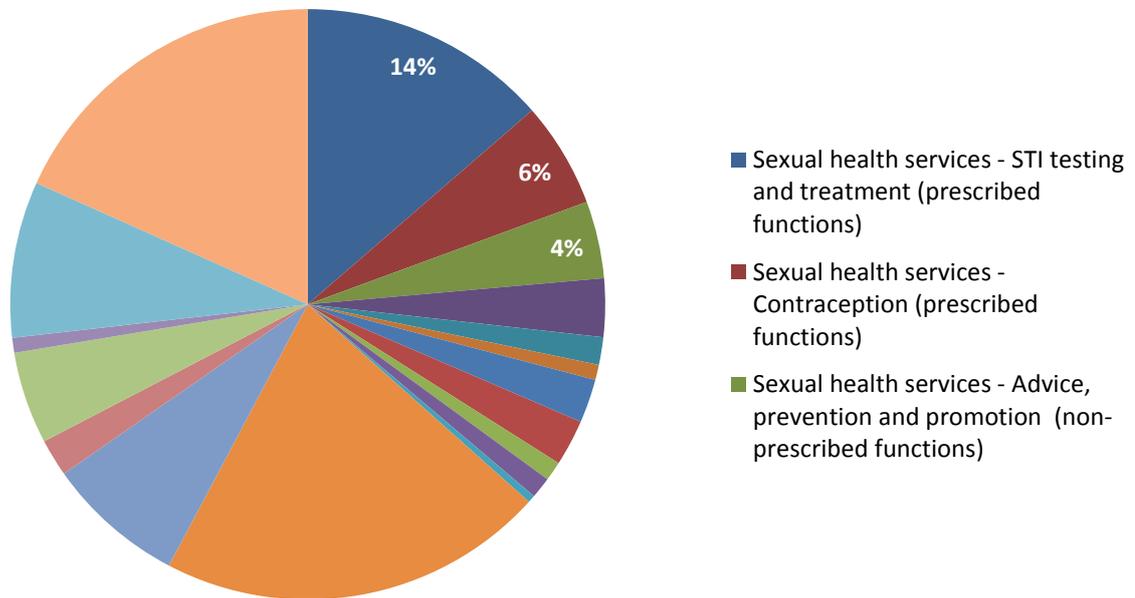
For sexual and reproductive health services, councils were asked to report back against three categories:

- **Sexual health services – STI testing and treatment** – prescribed functions
- **Sexual health services – Contraception** – prescribed functions
- **Sexual health services – Advice, prevention and promotion** – non-prescribed functions⁴⁹

Following this, on 31 July 2013, the Department for Communities and Local Government published the first budget estimates from local authorities on how they intended to spend their public health budgets in 2013/14⁵⁰. Nationally, the figures found that nearly one quarter of the total public health budget given to local authorities was expected to be spent on sexual and reproductive health services⁵¹.

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Figure 7: Reported spend of the total public health budget in England in 2013/14⁵²



The figures show that, across all of England, expenditure on contraception in 2013/14, which local authorities are required to commission by law, is expected to be six per cent of the total public health budget⁵³. The figures also provide information on the reported spend by local authorities on contraceptive services at a local level⁵⁴.

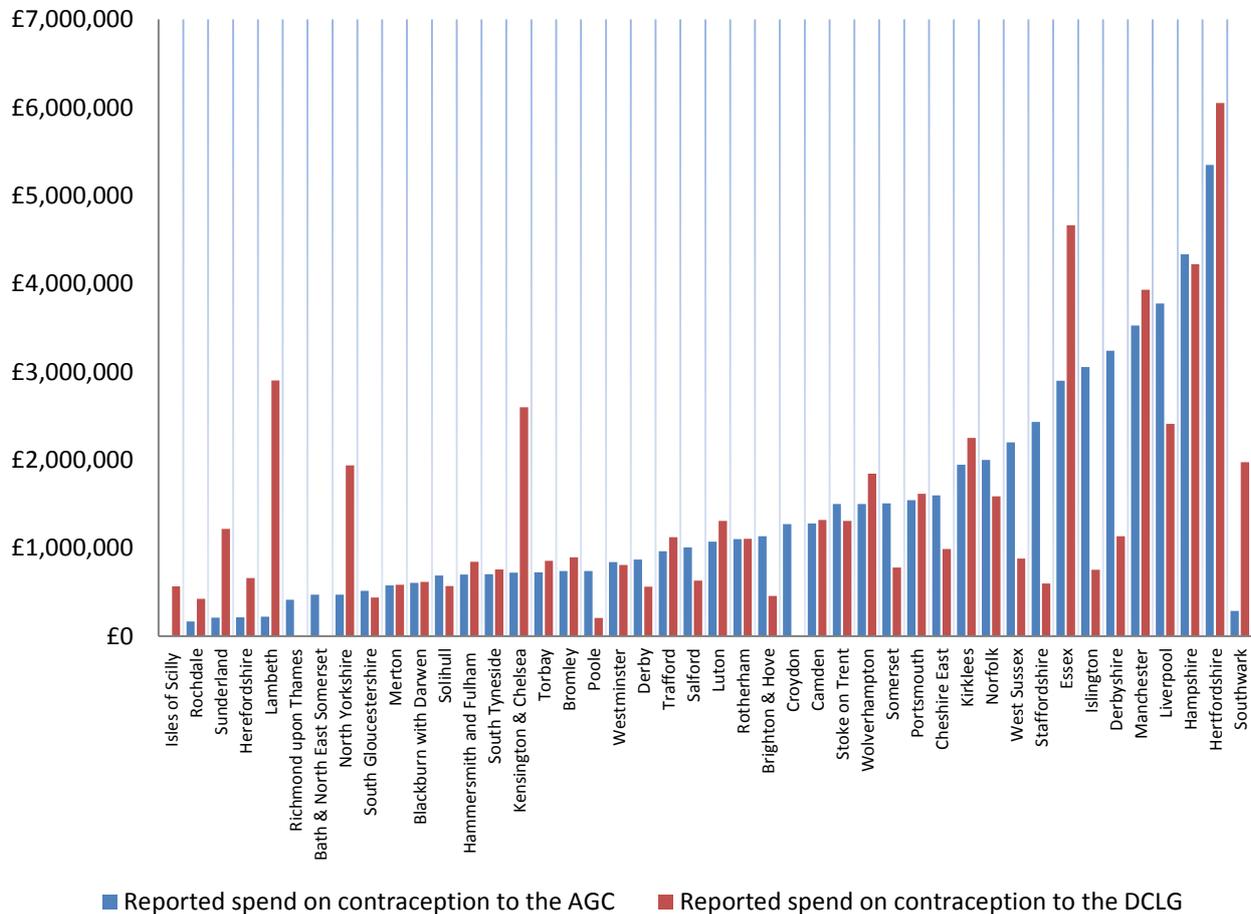
Given the extent of the variation in place, we do not believe the figures provided to the Department for Communities and Local Government provide a wholly accurate picture of how much councils are planning to spend on contraceptive services. Instead, and as we set out in our recommendations below, it reiterates the importance of accurate reporting and accountability in these scenarios.

Due to our concerns over the quality of the data reported to the Department for Communities and Local Government, the AGC requested the same information from local authorities, specifically on how much funding had been allocated to commission sexual health services (including contraception and emergency contraception) and contraceptive and emergency contraceptive services in 2013/14.

Worryingly, 42 per cent of councils that responded to our audit were unable to provide us with information on the amount of money they planned to spend on contraceptive services, with 33 councils providing information that was not clear or possible to interpret. Ten local authorities could not provide information on the amount being spent to commission sexual health services this year, while one provided information that was unclear.

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Figure 8: Planned spend on contraceptive services by 44 local authorities versus reported planned spend on contraceptive services to the Department for Communities and Local Government in 2013/14, by local authority, as requested to the AGC^{55, 56}



Even more surprising, as set out in

Figure 8, are the vast and unexplained inconsistencies in the level of reported spend on contraceptive services provided to councils in response to our audit versus the spend they reported to the Department for Communities and Local Government. This raises significant concerns about the reporting mechanisms councils have in place and how they are ensuring the public health funding is appropriately spent.

Recommendation 16: Commissioners should consider introducing key markers and tests to ensure providers are commissioned and funded not just on the basis of cost but because they are also able to deliver against the principles of high quality and open access contraceptive services.

Recommendation 17: There are significant and unexplained variations in how councils are reporting spend on sexual and reproductive health services. Local authorities should, as a matter of urgency,

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review the reporting and coding mechanisms for the funding of areas within the public health budget, including the amount spent on contraceptive services.

Recommendation 18: The Department for Communities and Local Government should, with the Department of Health, provide clarity to local authorities about what constitutes spend on contraceptive services to aid them with internal and external reporting on spending of the ring-fenced budget.

Recommendation 19: The Department of Health should ensure that local authorities are aware that, as part of a public health service or intervention, the cost of any contraceptive prescription should be met by local authorities' ring-fenced public health allocation.

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Reducing unintended pregnancies and improving access to all methods of contraception

The personal, social and economic costs of unintended pregnancies are well documented. Despite a small decline in the number of abortions in the past year, there were approximately 434,680 unintended pregnancies in England in 2012, costing the NHS £677 million⁵⁷. Reducing the number of unintended pregnancies amongst women of all ages is a key priority for the Government's sexual health framework, and in its first report, the AGC recommended commissioners have plans in place to deliver these improvements^{58, 59}.

To achieve this ambition, the Department of Health identified two key actions for local commissioners:

- Increase knowledge and awareness of all methods of contraception among all groups in the local population
- Increase access to all methods of contraception, including LARC methods and emergency hormonal contraception, for women of all ages and their partners⁶⁰

The AGC has welcomed these actions and is keen to work alongside local authorities and clinical commissioning groups to implement them.

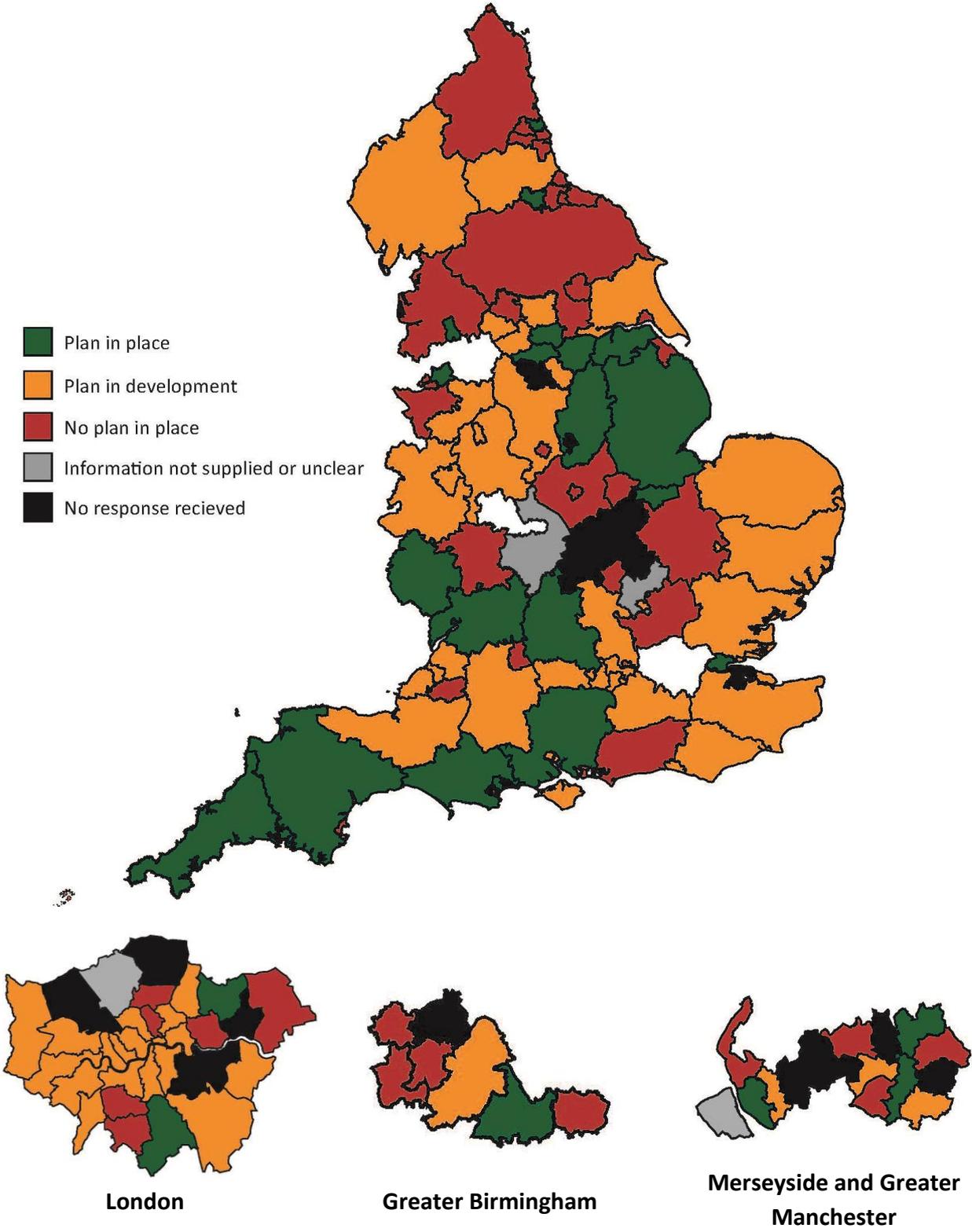
Plans in place to reduce unintended pregnancy amongst women of all ages

As part of its audit, the AGC wanted to assess the extent to which councils had plans in place to reduce unintended pregnancies and the extent to which improvements had been seen in this area since April 2013. Worryingly, out of those local authorities that responded to the AGC's audit, just 20 per cent of councils confirmed that they did have a plan in place to reduce unintended pregnancies in their area – examples of which we explore later on in this report. 43 per cent of local authorities that responded stated that a plan was currently under development while a third (34 per cent) said no plan was in place nor was one being developed. In other words, over three quarters of local authorities in England currently have no plan in place to tackle unintended pregnancies.

Worryingly, out of those local authorities that responded to the AGC's audit, just 20 per cent of councils confirmed that they did have a plan in place to reduce unintended pregnancies in their area

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Map 2: Local authorities with a plan in place to reduce intended pregnancies among all women of fertile age in their area



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In Map 2, Greater Manchester and Merseyside, Greater Birmingham and London are not shown on the main map of England, and are therefore displayed as white. These areas have been pulled out separately for ease of interpretation.

The AGC is concerned about the lack of progress that some local authorities have made in putting formal plans in place to tackle unintended pregnancies and the potential impact this could have on service delivery and the care women receive. We are also conscious about whether this lack of progress has been partly due to the Government's own sexual health policy document being delayed by 22 months, and the fact it was published just three weeks before councils were due to start commissioning public health services.

However, the audit did identify a number of areas across the country that are working with providers and other commissioners to develop robust plans aimed at reducing the rate of unintended pregnancy. We appreciate the significant challenges local authorities are facing as they continue to get to grips with their new public health responsibilities. Achieving better public health outcomes and delivering on the Government's national ambitions will require the sharing of good practice and for national organisations to help provide clear guidance and support. We recognise this as being part of our own role as a group of leading experts in contraceptive care.

Doncaster Borough Council, for example, confirmed that a key element of its plan to reduce unintended pregnancy was for all women requiring contraception to "be given information on and the choice of a full range of LARC methods"⁶¹. It added that those "services unable to provide LARC methods should have an agreed mechanism for referring women to services that do"⁶².

The AGC welcomes this local emphasis on ensuring robust referral pathways are in place. This is particularly important for GP practices that are not signed up to a primary care contract.

In its response, Peterborough City Council said:

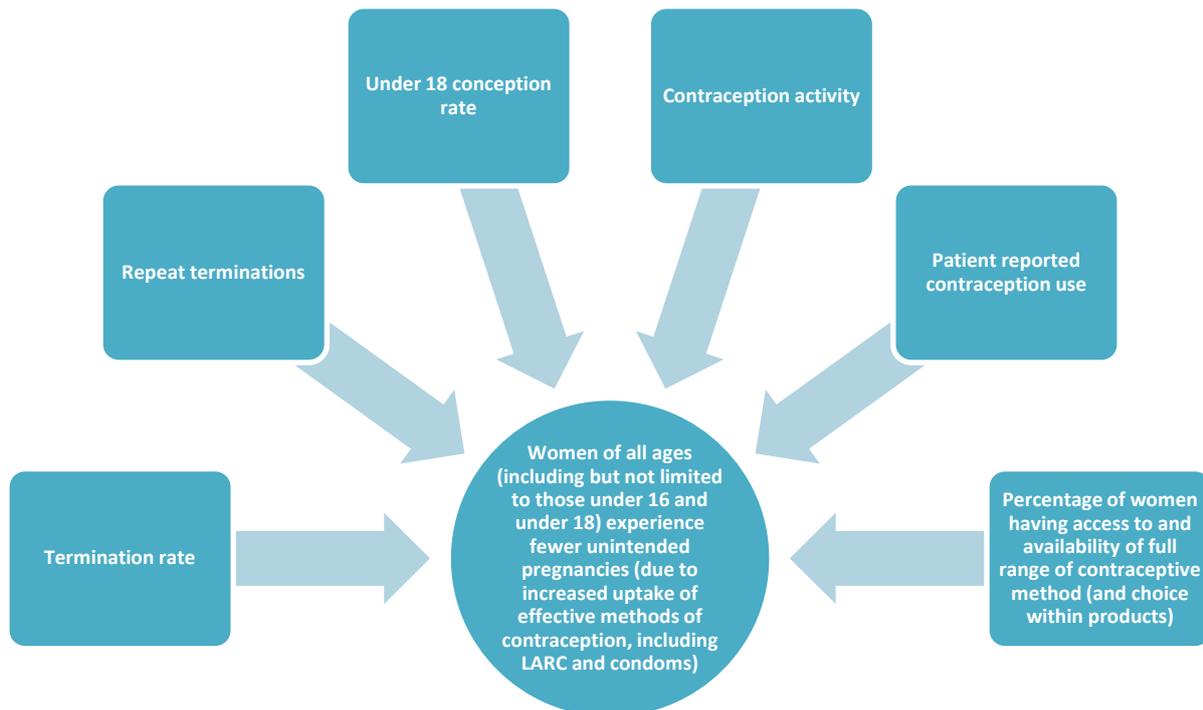
"[The Council] recognises this as a key priority within the Framework for Sexual Health Improvement in England. We plan to reduce unintended pregnancies among women of fertile age by including it as a key theme in our commissioning approach for 2014/15 and associated performance monitoring regime".⁶³

After receiving its response, the AGC contacted Peterborough City Council about their internal monitoring regime and the indicators being used to report back against the sexual health improvement framework. The Council helpfully provided a copy of their service specification which had the performance indicators embedded within it. The metrics contained against the outcome of reducing unintended pregnancies are outlined in

Figure 9.

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Figure 9: Performance indicators used by Peterborough City Council to measure performance against reductions in unintended pregnancies



In 2014, the AGC hopes to work with Peterborough City Council to develop its patient reported experience measure so as to record and monitor the outcomes of service users of all ages accessing those services. This, we hope, will provide a useful case study to illustrate how such measures can be used to record the performance of services against the Department of Health’s national framework.

The Department of Health’s sexual health framework recommends health and wellbeing boards should play an active role in the planning – through joint strategic needs assessments (JSNA) – and commissioning – through joint health and wellbeing strategies (JHWS) – of integrated sexual health services⁶⁴. The AGC welcomes this approach, particularly given the fragmentation of sexual health commissioning and the need for joined-up thinking.

In its response to our audit, Redbridge Council confirmed that improving sexual health outcomes, including through a reduction in unintended pregnancies, had been identified as a strategic priority by the Health and Wellbeing Board⁶⁵. One of the key actions to emerge from the JHWS was for commissioners and providers to work together to “actively promote long acting reversible contraceptives to high risk women aged 20-35 years” and to improve the provision of fitting of such methods⁶⁶.

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Although a number of councils were able to provide details of how they intended to address the rate and number of unintended pregnancies amongst women of all ages, local strategies continue to focus on the needs of teenagers. For example, Wakefield Metropolitan District Council has a strategy to reduce unintended pregnancies among all women of fertile age. However, the main priority is to reduce the conception rate amongst women under the age of 18⁶⁷. Wakefield adds that the rate is “significantly higher than the national average for England” but also that it is a measure within the Public Health Outcomes Framework⁶⁸.

The AGC has long argued that while the indicator for under-18 conception within the Public Health Outcomes Framework is welcome it does not address the contraceptive needs of women of all ages nor does it correspond with the Department of Health’s commitment to adopt a life stage approach to improving public health.

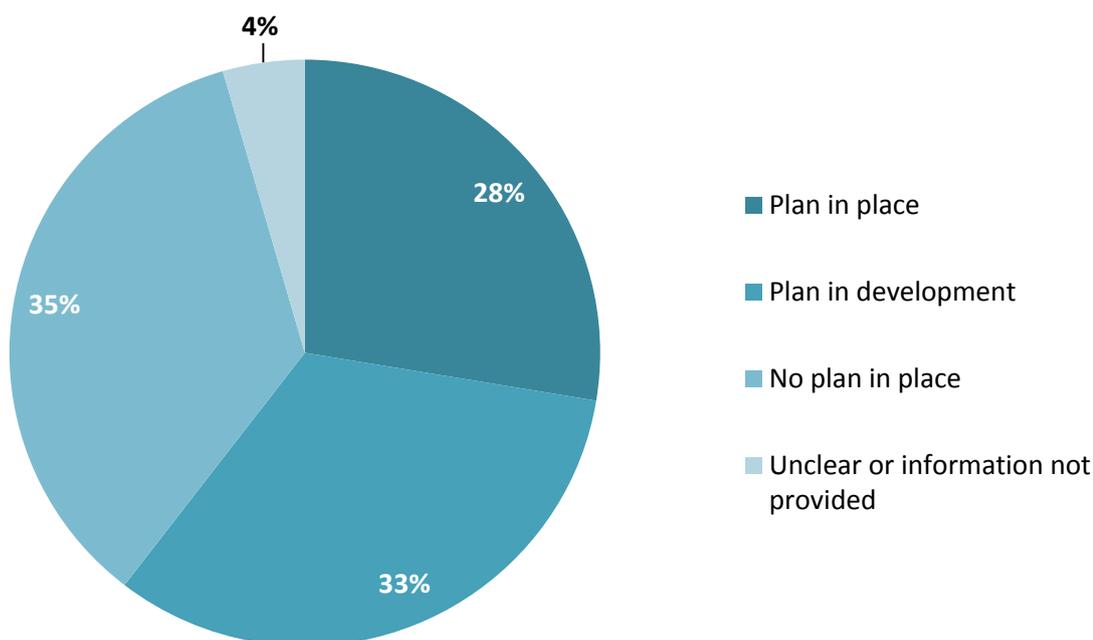


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Plans in place to increase access to all methods of contraception for women of all ages

Based on the actions identified within the Department of Health’s sexual health framework, the AGC asked local authorities whether they had a formal plan in place to increase access to all methods of contraception for women of all ages in their area. One third (35 per cent) confirmed that they had no plan in place nor was a plan being developed.

Figure 10: Percentage of local authorities with a plan in place to increase access to all methods of contraception for women of all ages in their area



28 per cent of local authorities did confirm a plan was in place, while a third said they currently had a plan in development. 57 per cent of the local authorities with a plan in place to increase access to contraception also had a formal plan to reduce unintended pregnancy. However, it is surprising that four local authorities – Havering, Newcastle upon Tyne, Trafford and West Sussex – have a plan to increase access to contraception but no plan to reduce unintended pregnancy^{69, 70, 71, 72}.

The AGC’s secretariat contacted the four local authorities to offer them the opportunity to clarify the situation. Officials at West Sussex County Council said they were working “with the NHS and other partners to carry out a comprehensive sexual health needs assessment which will include specific recommendations on both increasing access to contraception and reducing unintended pregnancies”⁷³. The outputs from this assessment will be published in July 2014 and inform plans for 2015/16 onwards.

Newcastle upon Tyne added that it is currently updating its guidance document for sexual health services, and this will include a section on access to contraception⁷⁴.

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Amongst the local authorities with a plan in place to improve access to contraception, there was variation in the approaches being adopted. Southampton City Council said that “providers have commissioning targets to increase LARCs”⁷⁵, while Plymouth Council “is currently delivering a LARC training and accreditation programme to further increase provision”⁷⁶.

The AGC has received representation about the future of enhanced service agreements for the fitting of LARC methods since responsibility for these has moved to local authorities in April 2013⁷⁷. We are aware that a number of councils are currently reviewing these agreements and concerns have been raised about whether they will be cut or scaled back⁷⁸.

In addition, AGC members have received anecdotal evidence of councils being unaware of their responsibility to fund both the prescribing and service delivery costs of these services⁷⁹. This has the potential to have a detrimental impact on access to contraceptives or services, and it is therefore important that commissioners are aware that the cost of any prescriptions should be reimbursed from local authorities’ ring-fenced public health allocations⁸⁰.

Recommendation 20: We would strongly urge councils to continue funding primary care contracts for LARCs. Removal of these agreements could have significant impact on women’s access to the full range of contraceptives and be a significant barrier towards the Government’s achieving its ambition of reducing the number of unintended pregnancies in England.

Recommendation 21: Commissioners should have plans in place to reduce unintended pregnancy. These plans should seek to address the number of repeat abortions and improve outcomes for women of all ages.

Recommendation 22: In the absence of a relevant indicator, the AGC recommends Patient Reported Experience Measures (PREMs) should be used as a proxy for contraceptive outcomes about how supported service users aged over 20 feel in managing their sexual and reproductive health. Many contraception providers are already required to collect such information for service users but this information is not collated, published, or used to measure outcomes.

Recommendation 23: Health and wellbeing boards should ask commissioners to report back annually on their plans to reduce the rate and number of unintended pregnancies in their area. Health and wellbeing boards should consider requesting this information after the annual dataset on abortion statistics is published by the Department of Health.

Recommendation 24: Local authority health scrutiny committees should consider holding reviews about progress towards improving access to contraception and reducing the rate of unintended pregnancy.

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Conclusion

Access to contraception and contraceptive services is a fundamental right. Ensuring women have access to a comprehensive set of contraceptive services, including the full range of contraceptive methods, is good for an individual's wellbeing but also for the public health outcomes of communities and society as a whole.

This is the first full financial year that local authorities have taken charge of commissioning the majority of contraceptive services since the passing of the 2012 Health and Social Care Act. This shift of responsibility from the old primary care trusts marked the most significant transformation to how these vital services are commissioned in a generation. While the AGC welcomed the principles and opportunities surrounding these changes, we were also acutely aware of some of the challenges it presented to women's access to contraception.

Two years ago, our first report illustrated some of the major progress that had been made over the previous decade in improving the quality of contraceptive services, people's access to contraception and in tackling levels of unintended pregnancy amongst some groups of women. However, the report also identified areas where urgent action needed to be taken to address unfair restrictions in access but also to ensure women of all ages received the care and support they deserved.

Today we are pleased to say that many of our recommendations have been adopted nationally. The Department of Health's *A framework for sexual health improvement in England* has set a clear ambition for the NHS and public health system to reduce the number of unintended pregnancies amongst women of all ages. Success, it says, can only come from addressing unwarranted restrictions in access and improving uptake of contraception.

At a local level our report has identified that many areas are responding to this national ambition and putting in place robust plans based on the principles of a high quality service. There is also clear evidence of councils working in partnership to ensure the legacy of a 'postcode lottery' in access to contraception is addressed.

And yet, despite many examples of good practice, there is still much more to be done. Many councils have yet to put a plan in place to reduce unintended pregnancy in their area; some restrictions in access to services continue to persist; and there are grave concerns over how councils are reporting the amount spent on contraceptive services through their ring-fenced budget.

These issues are not insurmountable and this report is designed to provide a constructive contribution to how we can deliver on the ambitions of the national sexual health framework. The AGC looks forward to continuing to work with the Department of Health, Public Health England, NHS England and others to improve the quality of these services and ensure they deliver the best possible outcomes for women of all ages.

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Appendix 1 – Members of the Advisory Group on Contraception

Dr Anne Connolly, Clinical Specialty Lead for Maternity, Women's and Sexual Health; Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups

Genevieve Edwards, Director of Policy, Partnerships and Communications, Marie Stopes UK

Ann Furedi, Chief Executive, British Pregnancy Advisory Service (bpas)

Baroness Gould of Potternewton, Chair of the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, and Co-Chair of the Sexual Health Forum

Natika H Halil, Director of Communications, Health and Wellbeing, Family Planning Association (FPA)

Jane Hatfield, Chief Executive, Faculty of Sexual and Reproductive Healthcare

Ruth Lowbury, Chief Executive, MEDFASH (Medical Foundation for HIV & Sexual Health)

Dr Jill Shawe, Specialist sexual and reproductive health research nurse, National Association of Nurses for Contraception and Sexual Health

Dr Connie Smith, Consultant in Sexual and Reproductive Healthcare

Harry Walker, Policy and Parliamentary Manager, Family Planning Association (FPA)

Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre and President of the Faculty of Sexual & Reproductive Healthcare

The AGC would like to pay tribute to the contributions of the late Dr Anne Szarewski, Clinical Senior Lecturer, Centre for Cancer Prevention, Wolfson Institute of Preventive Medicine and Associate Specialist, Margaret Pyke Centre. Anne was a valued member and friend of the AGC since it was established in 2010. Her extraordinary passion, insight and knowledge will be greatly missed.

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Appendix 2 – Freedom of Information requests sent to local authorities

Request 1: Please confirm or deny whether the local authority has any policy or contract in place that restricts access to specialist and/or community contraceptive services (not supplied by general practice) to women on the basis of i) age, ii) place of residence, or iii) of type of contraceptive method

- a) If confirmed please supply the local authority's policy or contract on restricting access to contraceptive services

Request 2: Please confirm or deny whether the local authority has, or plans to, put any restrictions in place on the prescribing or availability (across general practitioners and community settings) of any i) methods of emergency contraception, ii) long-acting reversible contraceptive methods or iii) other contraceptive methods during the financial year in (a) 2013/14 and (b) 2014/15

- a) If confirmed please supply details, including restrictions in provision, prescribing or availability of formulations for individual methods

Request 3: Please confirm or deny whether contraceptive methods including, but not limited to, all methods of emergency contraception are currently included on the local authority's list of items restricted for prescribing (across general practitioners and community settings)

- a) If confirmed please supply details of which products are listed

Request 4: Please confirm or deny whether the local authority has a formal plan in place to reduce unintended pregnancies among all women of fertile age in its area

- a) If confirmed please supply the local authority's plan/plans

Request 5: Please confirm or deny whether the local authority has a formal plan in place to increase access to all methods of contraception, including long-acting reversible contraception, for women of all ages in its area

- a) If confirmed please supply details

Request 6: Please confirm or deny whether, in the past three years, a needs assessment for local contraceptive provision has been carried out in the local authority area

- a) If confirmed please supply details of assessment

Request 7: Please confirm or deny whether the local authority issued a service specification as part of its procurement process to potential sexual health (including contraception) providers in 2013/14

- a) If confirmed please supply copies of the service specification(s)

Request 8: Please provide details of how much funding has been allocated by the local authority to commission (a) sexual health services (including contraception and emergency contraception) and (b)

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contraceptive and emergency contraceptive services from the ring-fenced public health budget during the financial years (a) 2013/14 and (b) 2014/15

Request 9: Please confirm or deny whether the local authority has plans in place to conduct an assessment of the local need for additional contraceptive training to provide subdermal implants and intrauterine methods in (a) 2013/14 and/or (b) 2014/15

- a) If confirmed please supply details of planned assessment(s)

Request 10: Please confirm or deny whether the local authority has undertaken an assessment of the range and diversity of (a) sexual health (including contraception) and (b) contraceptive providers in its area

- a) If confirmed please supply details of assessment

Request 11: Please confirm or deny whether the local authority is jointly commissioning and/or contracting (a) sexual health services and /or (b) contraceptive services with other local authority commissioners

- b) If confirmed please supply details of commissioning arrangements

Appendix 3 – Local authorities which responded to the Freedom of Information requests

Barnet	Hampshire	Reading	Windsor and Maidenhead
Barnsley	Haringey	Redbridge	Wirral
Bath & North East Somerset	Hartlepool	Redcar & Cleveland	Wokingham
Bexley	Havering	Richmond upon Thames	Wolverhampton
Birmingham City	Herefordshire	Rochdale	Worcestershire
Blackburn with Darwen	Hertfordshire	Rotherham	York
Bolton	Hillingdon	Rutland	
Bracknell Forest	Hounslow	Salford	
Bradford	Hull	Sandwell	
Brighton & Hove	Isle of Wight	Sefton	
Bristol	Isles of Scilly	Shropshire	
Bromley	Islington	Slough	
Buckinghamshire	Kensington & Chelsea	Solihull	
Calderdale	Kent	Somerset	
Cambridgeshire	Kingston upon Thames	South Gloucestershire	
Camden	Kirklees	South Tyneside	
Central Bedfordshire	Knowsley	Southampton	
Cheshire East	Lambeth	Southend on Sea	
Cheshire West & Chester	Lancashire	Southwark	
City of London	Leeds	Staffordshire	
Cornwall	Lincolnshire	Stockport	
Coventry	Liverpool	Stockton on Tees	
Croydon	Luton	Stoke on Trent	
Cumbria	Manchester	Suffolk	
Darlington	Merton	Sunderland	
Derby	Middlesbrough	Surrey	
Derbyshire	Milton Keynes	Sutton	
Devon	Newcastle upon Tyne	Swindon	
Doncaster	Newham	Telford & Wrekin	
Dorset	Norfolk	Thurrock	
Dudley	North East Lincolnshire	Torbay	
Durham	North Lincolnshire	Tower Hamlets	
Ealing	North Somerset	Trafford	
East Riding of Yorkshire	North Tyneside	Wakefield	
East Sussex	North Yorkshire	Waltham Forest	
Essex	Northumberland	Wandsworth	
Gateshead	Nottinghamshire	Warrington	
Gloucestershire	Oldham	Warwickshire	
Hackney	Oxfordshire	West Berkshire	
Halton	Peterborough	West Sussex	
Hammersmith and Fulham	Plymouth	Westminster	
	Poole	Wiltshire	
	Portsmouth		

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Appendix 4 – Statements for inclusion in the NICE quality standard on contraception

The AGC would recommend the following 10 statements for a quality standard on contraceptive services (including emergency contraception):

- **Statement 1:** People using contraceptive services should be treated with dignity and respect, and their privacy maintained at all times
- **Statement 2:** Commissioners should ensure contraceptive services are provided in a variety of locations, including in both primary and community settings
- **Statement 3:** People accessing contraceptive services should receive coordinated and integrated care, with clear information and advice which meets their individual contraceptive needs
- **Statement 4:** People using contraceptive services should have access to the provision of up-to-date, accessible, accurate and understandable information on, and supply of, the full range of emergency, reversible and permanent contraceptive methods
- **Statement 5:** Commissioners should ensure that the contraceptive needs of the local population can be served by an appropriate number of trained and qualified healthcare professionals
- **Statement 6:** People using contraceptive services should be informed of and able to access the full range of other sexual and reproductive health services, including access to testing for sexually transmitted infection, pregnancy testing, psychosexual counselling, and direct and timely referral to abortion services
- **Statement 7:** Commissioners should capture and make available high quality data on clinical outcomes and user experience of contraceptive services across care settings in order to measure the quality of services and help to facilitate patient choice
- **Statement 8:** People accessing contraceptive services should leave with a positive experience of care
- **Statement 9:** Providers that offer only some contraceptive services (as opposed to a comprehensive service encompassing information about and access to the full range of emergency, reversible and permanent contraceptive methods) should ensure that people who wish to choose a service that they do not offer are informed of how to access additional services to address their needs, and that there are clear referral pathways for this
- **Statement 10:** People accessing abortion services should receive comprehensive, accurate, unbiased information on and supply of the reversible contraceptive of their choice

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Appendix 5 – Faculty of Sexual and Reproductive Healthcare’s Quality Standard for Contraceptive Services

The Faculty of Sexual and Reproductive Healthcare’s Quality Standard describes high-quality care for contraceptive services. A summary of the six quality statements within the Standard is copied below, and the full document can be viewed on the Faculty’s website: www.fsrh.org.

Access:

- Every individual requiring contraception to minimise the risk of unintended pregnancy should have access to contraception both from a GP and/or an alternative open access specialist provider to whom GPs can also refer for specialist advice and care
- All individuals within the area requiring contraception to minimise the risk of unintended pregnancy should have access to all methods of contraception directly through a contraceptive provider or by effective referral pathways
- Individuals should have timely access to the method of contraception of choice and to urgent contraceptive care

Service user input:

- The design and review of services should include input from the service users and the public

Staffing:

- Individuals requesting contraception to minimise their risk of unintended pregnancy have the right to expect appropriately trained and competent staff

Governance:

- Individuals have the right to expect all contraceptive providers to continually monitor, evaluate and benchmark themselves to maintain and improve the quality of care

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Appendix 6 – Data annex

Local authority	Does the local authority have a plan in place to reduce unintended pregnancies?	Does the local authority have a plan in place to increase access to all methods of contraception?	Did the local authority issued a service specification as part of its procurement process to potential sexual health providers?	How much funding was allocated for contraceptive services in 2013/14?	Does the local authority jointly commission and/or contract sexual health services and /or contraceptive services with other commissioners?
London Borough of Barnet	--	--	--	--	--
Barnsley Metropolitan Borough Council	Yes	Yes	Yes	--	No
Bath & North East Somerset Council	No	No	Yes	£471,707	Yes
London Borough of Bexley	In development	In development	Yes	--	Yes
Birmingham City Council	In development	In development	No	--	Yes
Blackburn with Darwen Borough Council	Yes	Yes	No	£604,789	Yes
Bolton Metropolitan Borough Council	No	No	No	--	Yes
Bracknell Forest Council	In development	In development	No	--	Yes
City of Bradford Metropolitan Borough Council	Yes	No	Yes	--	No
Brighton & Hove City Council	In development	Yes	Yes	£1,135,300	No
Bristol City Council	In development	In development	Yes	--	Yes
London Borough of Bromley	In development	--	Yes	£738,000	Yes
Buckinghamshire County Council	In development	Yes	Yes	--	No
Calderdale Metropolitan Borough Council	In development	In development	Yes	--	Yes

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Cambridgeshire County Council	No	No	In development	--	No
London Borough of Camden	In development	In development	Yes	£1,278,079	Yes
Central Bedfordshire Council	--	--	--	--	--
Cheshire East Council	In development	In development	No	£1,600,000	No
Cheshire West & Chester Council	No	No	No	--	No
City of London Corporation	In development	Yes	Yes	£690,000 - jointly with Hackney	Yes
Cornwall Council	Yes	Yes	Yes	--	Yes
Coventry City Council	No	No	No	--	No
London Borough of Croydon	Yes	Yes	In development	£1,272,304	Yes
Cumbria County Council	In development	In development	Yes	--	No
Darlington Borough Council	Yes	No	No	--	Yes
Derby City Council	No	No	No	£868,494	No
Derbyshire County Council	In development	No	No	£3,239,905	No
Devon County Council	Yes	Yes	Yes	--	Yes
Doncaster Metropolitan Borough Council	Yes	No	No	--	No
Dorset County Council	Yes	Yes	Yes	--	Yes
Dudley Metropolitan Borough Council	No	No	Yes	--	Yes
Durham Council	In development	Yes	Yes	--	Yes

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London Borough of Ealing	In development	In development	Yes	--	Yes
East Riding of Yorkshire Council	In development	--	Yes	--	Yes
East Sussex County Council	In development	Yes	Yes	--	No
Essex County Council	In development	In development	No	£2,900,000	No
Gateshead Council	No	No	Yes	--	No
Gloucestershire County Council	Yes	Yes	Yes	--	No
London Borough of Hackney	In development	Yes	Yes	--	Yes
Halton Borough Council	No	No	No	--	No
London Borough of Hammersmith and Fulham	In development	In development	Yes	£701,000	Yes
Hampshire County Council	Yes	Yes	Yes	£4,334,503	Yes
London Borough of Haringey	No	In development	Yes	--	Yes
Hartlepool Borough Council	No	No	No	--	Yes
London Borough of Havering	No	Yes	No	--	Yes
Herefordshire County Council	Yes	Yes	No	£213,500	No
Hertfordshire County Council	No	In development	Yes	£5,350,000	No
London Borough of Hillingdon	In development	In development	In development	--	Yes
London Borough of Hounslow	In development	In development	No	--	No

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Hull City Council	No	No	No	--	Yes
Isle of Wight Council	In development	In development	Yes	--	No
Isles of Scilly Council	No	No	No	£10,900	Yes
London Borough of Islington	No	No	Yes	£3,054,750	Yes
Royal Borough Kensington & Chelsea	In development	In development	Yes	£720,000	Yes
Kent County Council	In development	In development	In development	--	No
Royal Borough Kingston upon Thames	In development	Yes	Yes	--	Yes
Kirklees Council	In development	No	In development	£1,946,000	Yes
Knowsley Metropolitan Borough Council	In development	In development	Yes	--	No
London Borough of Lambeth	In development	In development	Yes	£221,873	Yes
Lancashire County Council	No	No	Yes	--	Yes
Leeds City Council	In development	In development	Yes	--	No
Leicester City Council	No	No	Yes	--	Yes
Leicestershire County Council	No	No	Yes	--	Yes
Lincolnshire County Council	Yes	In development	No	--	No
Liverpool City Council	Yes	Yes	No	£3,777,626	No
Luton Council	In development	In development	Yes	£1,074,546	No
Manchester City Council	Yes	No	No	£3,527,354	Yes

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London Borough of Merton	No	No	No	£576,249	Yes
Middlesbrough Council	No	No	No	--	No
Milton Keynes Council	No	No	No	--	No
Newcastle upon Tyne City Council	No	Yes	No	--	Yes
London Borough of Newham	No	No	No	--	No
Norfolk County Council	In development	Yes	No	£2,000,000	No
North East Lincolnshire Council	No	No	Yes	--	No
North Lincolnshire Council	Yes	Yes	Yes	--	No
North Somerset Council	In development	Yes	In development	--	Yes
North Tyneside Council	Yes	Yes	Yes	--	Yes
North Yorkshire Council	No	No	No	£473,000	Yes
Northumberland Council	No	No	No	--	No
Nottinghamshire Council	Yes	Yes	Yes	--	No
Oldham Metropolitan Council	No	No	No	--	Yes
Oxfordshire County Council	Yes	Yes	In development	--	No
Peterborough City Council	Yes	Yes	Yes	--	No
Plymouth City Council	Yes	Yes	No	--	No
Poole Borough Council	Yes	Yes	No	£740,100	Yes
Portsmouth City Council	No	No	Yes	£1,544,336	Yes

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Reading Borough Council	In development	In development	In development	--	Yes
London Borough of Redbridge	Yes	In development	Yes	--	Yes
Redcar & Cleveland Borough Council	No	No	No	--	Yes
London Borough of Richmond upon Thames	In development	In development	Yes	£412,000	Yes
Rochdale Metropolitan Borough Council	Yes	Yes	No	£167,500	Yes
Rotherham Metropolitan Borough Council	In development	In development	Yes	£1,102,000	No
Rutland County Council	No	No	In development	--	Yes
Salford City Council	In development	In development	Yes	£1,006,032	No
Sandwell Metropolitan Borough Council	No	No	Yes	--	Yes
Sefton Metropolitan Borough Council	No	No	In development	--	No
Shropshire County Council	In development	Yes	Yes	--	Yes
Slough Borough Council	No	No	In development	--	Yes
Solihull Metropolitan Borough Council	Yes	Yes	Yes	£688,000	Yes
Somerset County Council	In development	In development	Yes	£1,509,000	No
South Gloucestershire Council	In development	In development	Yes	£515,899	Yes
South Tyneside Council	No	No	Yes	£703,285	Yes

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Southampton City Council	In development	Yes	Yes	--	No
Southend on Sea Borough Council	In development	In development	Yes	--	Yes
London Borough of Southwark	In development	In development	Yes	£287 583.00	Yes
Staffordshire County Council	In development	In development	No	£2,431,000	No
Stockport Metropolitan Borough Council	In development	In development	In development	--	Yes
Stockton on Tees Borough Council	No	No	In development	--	Yes
Stoke on Trent City Council	In development	In development	Yes	£1,500,000	Yes
Suffolk County Council	In development	No	Yes	--	Yes
Sunderland City Council	No	No	No	£210,000	Yes
Surrey Borough Council	In development	In development	Yes	--	No
London Borough of Sutton	No	No	Yes	--	Yes
Swindon Borough Council	No	No	Yes	--	No
Telford & Wrekin Council	In development	In development	Yes	--	Yes
Thurrock Council	Yes	Yes	Yes	--	--
Torbay Council	No	No	Yes	£725,000	Yes
London Borough of Tower Hamlets	In development	In development	No	--	No
Trafford Borough Council	No	Yes	Yes	£963,846	No

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Local authority	Does the local authority have a plan in place to reduce unintended pregnancies?	Does the local authority have a plan in place to increase access to all methods of contraception?	Did the local authority issued a service specification as part of its procurement process to potential sexual health providers?	How much funding was allocated for contraceptive services in 2013/14?	Does the local authority jointly commission and/or contract sexual health services and /or contraceptive services with other commissioners?
Wakefield Metropolitan District Council	Yes	No	No	--	No
London Borough of Waltham Forest	In development	In development	Yes	--	Yes
London Borough of Wandsworth	In development	In development	Yes	--	Yes
Warrington Borough Council	Yes	Yes	No	--	Yes
Warwickshire Borough Council	--	--	No	--	Yes
West Berkshire Council	In development	In development	In development	--	Yes
West Sussex County Council	No	Yes	No	£2,200,000	No
Westminster City Council	In development	In development	Yes	£842,000	Yes
Wiltshire Council	In development	Yes	No	--	No
Royal Borough of Windsor and Maidenhead	In development	No	No	--	Yes
Wirral Borough Council	--	--	Yes	--	Yes
Wokingham Borough Council	In development	In development	No	--	Yes
Wolverhampton City Council	No	No	No	£1,500,000	Yes
Worcestershire County Council	No	No	No	--	No
York City Council	No	In development	Yes	--	Yes

There was no data available or it was unclear for boxes marked with '--'.

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