Sex, lives and commissioning

An audit by the Advisory Group on Contraception of the commissioning of contraceptive and abortion services in England

April 2012

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Figures, tables and maps

Figure 1: Percentage of PCTs that responded to the Freedom of Information request.................................9

Figure 2: PCTs holding a definition of specialist open access contraceptive services.................................12

Figure 3: Percentage of PCTs able to provide information about the number of healthcare professionals in general practice trained to fit subdermal and intra-uterine contraceptive methods ........................................27

Figure 4: Percentage of PCTs able to provide information about the number of healthcare professionals in community settings trained to fit subdermal and intra-uterine contraceptive methods ......................27

Table 1: Commissioning and governance responsibilities for contraception and abortion services, as set out in the Health and Social Care Bill..........................................................................................................15

Map 1: PCTs which have restrictions in place on the prescribing or availability of contraceptives through primary care or other commissioned contraceptive services .........................................................19

Map 2: London PCTs which have some restriction in place on access to contraceptive services or contraceptives..............................................................................................................................................20

Map 3: PCTs which have an enhanced service agreement in place for fitting LARC methods....................24

Map 4: PCTs where an assessment of local need for additional training to provide subdermal implants and intrauterine contraceptive methods has been conducted in the last 2 years.................................29

Map 5: PCTs which have plans to increase capacity for fitting SDIs and IUCDs ........................................29

Map 6: PCTs where a strategy is in place to reduce unintended pregnancy, and the need for abortion and repeat abortions ..................................................................................................................................33

Map 7: PCTs where a review of abortion services had been undertaken since 2007 ..............................35

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Summary of key findings

- All 151 PCTs in England were sent Freedom of Information requests. Of these, 126 (83%) were able to provide a response and the below findings reflect these responses, as well as providing a rich picture of how contraceptive services are currently being commissioned in England.

Defining specialist open access contraceptive services

- 26% of PCTs which responded to our audit claimed that they held a definition of ‘specialist open access contraceptive services’ and a further 20% of PCTs denied having a precise definition but provided supporting evidence (such as a service specification) for what they would expect services to provide. Accordingly 54% of PCTs were not able to supply a definition of ‘specialist open access contraceptive services’.

- There was considerable variation amongst PCTs – even amongst neighbouring PCTs – of their definitions of contraceptive services, including their scope and ambition.

- Some PCTs were still referencing the Department of Health’s document Better prevention, better services, better sexual health: national strategy for sexual health and HIV 2001 as their reference point for defining specialist open access contraceptive services.

Delivering comprehensive, open access contraceptive services

- The overwhelming majority of PCTs (98%) said they did not have a policy or contract in place to restrict access to specialist open access contraceptive services to women on the basis of age, place of residence or contraceptive.

- However, when asked separately about prescribing or availability arrangements, over a third (35%) of PCTs confirmed they had a restriction in place – including through restrictions within their local formulary.

- Our calculations have found that over 3.2 million women of reproductive age (15-44) are living in areas where fully comprehensive contraceptive services, through community and / or primary care services, are not provided – representing almost one third of women in England of reproductive age. This is represented by restrictions in access to services or contraceptives.

- The average abortion rate in 2010 for PCTs who had some form of restriction in community and / or primary care in place was 20.4 per 1,000 resident women aged 15-44. This is higher than the national average in 2010 which stood at 18.6 per 1,000 resident women aged 15-44.

- One in six PCTs confirmed that red or black lists, or equivalent formulary arrangements, were in place to restrict access to particular contraceptives. These PCTs are responsible for meeting the contraceptive needs of over two million women of reproductive age.
Commissioner prioritisation of contraceptive services

- The audit identified a number of commissioners who have selected Commissioning for Quality and Innovation (CQUIN) indicators relevant to the delivery of effective sexual health services and improving the uptake of effective methods of contraception

- The vast majority of PCTs (91%) confirmed they had an enhanced service in place for the fitting of subdermal implants and/or intrauterine contraceptive methods in primary care. 75% of these commissioners had an enhanced service in place to fit both methods

- The audit uncovered variation relating to the number of GP practices signed up to the enhanced service with some PCTs having only 15-17% of their total number of GP practices signed up to local agreements

- Nine PCTs have chosen not to put an enhanced service in place for fitting LARC methods: these PCTs commission services for almost 350,000 women of reproductive age

Workforce planning and development

- Less than one fifth of PCTs that responded (17%) could supply information about the number of professionals in general practice who were trained to fit subdermal implants and intrauterine contraceptive methods. Only one in ten PCTs (10%) could provide the same information for professionals working in community services

- Almost one quarter of PCTs (24%) had not undertaken a local assessment in the last two years of additional training needs to provide subdermal implants and intrauterine contraceptive methods

- Of those PCTs who responded to the AGC audit and stated that they did not know how many healthcare professionals in general practice were trained to fit subdermal implants and intrauterine contraceptive methods, one half said that they had plans to increase capacity in this area

Reducing unintended pregnancies

- Out of those PCTs which responded to the AGC audit, just over half (53%) stated that they had a strategy in place to address unintended pregnancy and abortion rates. Another 23 said that they were in the process of developing a strategy, but over a quarter (28%) stated that they did not have a strategy in place and also indicated that a strategy was not under development

- Out of those PCTs who confirmed that they had a strategy in place to tackle unintended pregnancy and abortion, one quarter only provided strategies with a sole focus on teenagers and not all women of reproductive age

- The AGC asked PCTs if they had undertaken a review of abortion services since 2007. Just over one half of PCTs (53%) said that they had conducted such a review. However, over one third (36%) said that they had not undertaken a review.
Summary of recommendations

Defining specialist open access contraceptive services

1. We urge the Department of Health to publish the sexual health policy document without further delay and ensure that it sets out clearly the expectation for commissioners to commission comprehensive, open access services that reflect a life-course approach for people of all ages.

2. The Department of Health, with Public Health England, should clearly set out the arrangements for the transfer of the commissioning of sexual and reproductive health services from PCTs to new commissioning bodies to ensure continuity and quality of care.

3. Commissioners should ensure that the sexual health and reproductive services they are commissioning are comprehensive, integrated, open access services that reflect a life-course approach to meet the needs of users of all ages.

4. The AGC urges NICE to prioritise the development of the quality standard on contraceptive services, as this will be an essential reference document for commissioners in local authorities responsible for commissioning sexual health and reproductive services.

5. The AGC urges commissioners to remove any policies or contracts in place which limit an individual’s access to contraceptive services based on reasons of age or place of residence. Contraceptive services must be commissioned based on the principles of the NHS Constitution.

Delivering comprehensive, open access contraceptive services

6. Commissioners should ensure contraceptive services are truly open access – not restricting access to services to the local GP-registered population or by district of residence. They should be available at times which are convenient for users, including evenings and weekends.

7. Public Health England should establish national models for contraceptive pathways which can be tailored by local authorities to the needs of their areas.

8. PCTs and local authorities should ensure that their commissioning arrangements do not have perverse consequences and restrict access to contraceptive services for specific demographic groups, for example those on low incomes or those who need to see a female practitioner.

9. Commissioners should urgently reconsider any restrictions on prescribing new and effective contraceptives and make sure methods are prescribed on the basis of clinical quality and individual choice. Appropriate funding should also be made available for services to prescribe all effective contraceptives.

Commissioner prioritisation of contraceptive services

10. Where there is low uptake of effective contraceptive methods, commissioners should consider introducing relevant CQUIN schemes which set goals for improving access and uptake of the full
range of contraceptives. Information about the performance of providers in meeting these goals should be publicly available for scrutiny.

11. All commissioners should have enhanced service agreements in place for the fitting and removal of LARC methods, including SDI and IUD/S, or alternative local contracts in place which incentivise GPs to provide these methods.

12. Commissioners with enhanced service agreements for the fitting and removal of LARC methods must ensure adequate arrangements and resources are in place to ensure as many GP practices are signed up and, if not, that they participate in local referral pathways for fittings.

13. The NHS Commissioning Board should provide clarity about how enhanced services for sexual and reproductive health in the new NHS and public health service will be commissioned and delivered.

Workforce planning and development

14. Providers should be required to demonstrate to commissioners that their workforce has the appropriate skills as a key part of the ‘any qualified provider’ policy. This should include an ability to provide information on the number of healthcare professionals trained to fit and remove different types of LARC methods.

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 intra-uterine contraceptive methods.

16. In line with professional and regulatory requirements, healthcare professionals involved in delivering contraceptive services should undertake ongoing training so as to ensure that their knowledge and skills are up to date and they remain competent to deliver interventions such as LARC fitting.

17. The forthcoming sexual health policy document should address the need for a skilled sexual health workforce, including nurses, and indicate how there will be national level oversight of training needs such as LARC fitting. It should also emphasise the importance of continued professional development.

Reducing unintended pregnancies

18. Commissioners should ensure that up-to-date strategies are in place to reduce unintended pregnancy, and the need for abortion and repeat abortions which focus on the needs of women of all ages.

19. Regular reviews should be undertaken of abortion provision to ensure that this is in line with the needs of the local population.

20. Commissioners should ensure that access to the full range of contraceptives is made available by all providers of contraceptive services, including abortion providers.

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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. Given the policy focus which has previously been skewed towards addressing the needs of teenagers, the AGC came together in November 2010 and decided to focus on post-teen women to ensure that the contraceptive needs of all women, whatever their age, are met.

The AGC is keen to ensure that the current NHS and public health reforms deliver improvement in contraceptive services so that all women have access to high quality services which offer them information and choice from the full range of contraceptive options. That is why the AGC has welcomed the Department of Health’s commitment to adopt a life-stage approach to public health, accepting that people will require different support at different points in their life.

Previously, there has rightly been a major policy focus on tackling teenage pregnancy because:

- Teenage pregnancy can impact upon a woman’s life chances as well as those of her child
- There are links between teenage pregnancy and wider social issues, including deprivation
- It is relatively easy to measure and therefore progress on improving outcomes can be evaluated

However, this focus on teenagers and young people has given rise to the unintended consequence of neglecting the needs of women aged 20 and over. Sexual and reproductive health services, education programmes and information have often been designed around the needs of teenagers, with 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 four in five (80%) abortions occur in women aged 20 and over.

By applying figures from NICE to data on numbers of abortions, the cost to the NHS in England of unintended pregnancy in women aged 20 can be extrapolated:

Cost to NHS in England of abortions in women aged 20+: £71,904,966.00
Cost to NHS in England of unintended pregnancy in women aged 20+ ending in miscarriage: £14,870,475.22
Cost to the NHS in England of unintended pregnancy in women aged 20+ ending in live birth: £353,345,012.57
**Total cost to the NHS in England of unintended pregnancy in women aged 20+: £440,120,453.79**

Therefore the failure to address the needs of older women not only damages health outcomes for these women and their families, but also represents a significant cost burden to the NHS in England for unintended pregnancy in women aged 20 and over.
Set against this is the cost-benefit ratio for investment in contraception, which demonstrates that for every £1 spent on contraception, £12.50 could be saved in averted outcomes\textsuperscript{10}.

The Quality, Innovation, Productivity and Prevention (QIPP) agenda means the NHS is being required to find an unprecedented £20 billion of efficiency savings by 2015\textsuperscript{11}. Increasingly commissioners are looking for ways to do more for less and there is growing anecdotal evidence of cuts being imposed in access to clinical care at a local level, across all services and settings, including sexual and reproductive health.

Examples have been seen of commissioners cutting prescribing budgets for contraceptives to meet targets for savings, with consequences for choice and public health outcomes. In April 2011, the health magazine \textit{Pulse} undertook a Freedom of Information audit which showed that more than half of the 130 responding commissioners had lists of drugs that GPs were banned from prescribing – including new forms of contraceptives\textsuperscript{12}.

The Public Health Minister, Anne Milton MP, in a response to a parliamentary question tabled on contraceptive services, has also confirmed that the Department of Health has received “\textit{representations from clinicians and voluntary sector organisations on the current commissioning of contraception by primary care trusts (PCTs) and access to certain types of contraception by certain age groups}”\textsuperscript{13}.

The AGC believe 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. It is therefore crucial that contraceptive services are given adequate focus and resources within the new public health system and that women have full, open access to these services.

To better understand the current commissioning landscape, the AGC undertook its own audit of primary care trusts (PCTs) in England to assess local commissioners’ response to the drive for efficiencies and the impact this is having on sexual health services and access to contraceptive services. The audit also sought to compare and contrast the different approaches of PCTs in commissioning contraceptive services and to make recommendations for how these findings should impact on the new and emerging commissioning structures.

This report presents the findings from the audit and provides a detailed picture of how contraceptive services are being commissioned and the outcomes they are delivering. It is also intended to make a constructive contribution to the development of the Department of Health’s sexual health policy document and to provide recommendations for delivering a truly comprehensive, open access sexual and reproductive health service.
Methodology

The findings from this report are largely based on responses to a series of Freedom of Information requests submitted by the Advisory Group on Contraception to every PCT in England in January 2012.

The information requested included:

- The number of PCTs which held a definition of specialist open access contraceptive services
- Any PCT policies to restrict access to specialist contraceptive services on the basis of age, place of residence, or contraceptive
- Details of any policy or guidance held by the PCT on the prescribing of emergency contraceptive methods, long-acting reversible contraceptive methods and other contraceptive methods
- Information on any formal strategy put in place by the PCT to reduce the rate of unintended pregnancy, the level of abortions, and/or the level of repeat abortions
- Details of any standards of competence for healthcare professionals fitting long-acting reversible contraception
- Plans in place by the PCT to increase capacity for fitting subdermal implants and intrauterine contraceptive methods

A full list of the requests sent to PCTs is available in Appendix 1.

**Figure 1: Percentage of PCTs that responded to the Freedom of Information request**

All 151 PCTs were sent requests and 126 of these were able to provide a response. The AGC are grateful to all those PCTs which responded and a list of those PCTs is available in Appendix 2. All further analyses in this report are based on the responses of those PCTs which responded in full to the Freedom of Information requests.

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Although a minority, we are disappointed that 25 PCTs 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 and we hope the Department of Health will take this into account and work with PCTs and emerging clinical commissioning groups to make this happen.

PCTs 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 undertaken by the AGC’s secretariat, MHP Health Mandate. Analysis has also been undertaken of national abortion statistics which is included in this report.
Defining specialist open access contraceptive services

The AGC believe that women of all ages should have equal access to sexual and reproductive health services, including contraceptive services. Services should be comprehensive, integrated and have clear referral pathways in place between them.

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
- Community contraceptive services from the full spectrum of providers, for example NHS, pharmacy and NGO
- Termination of pregnancy (fully integrated services offering full range of contraception, STI testing and treatment)
- Provision of contraception as an integral part of other specialist services, for example maternity, medical specialties where drug treatment or medical problems specifically affect contraception 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

These services should be truly open access – not restricting the availability of services to the local GP-registered population only. 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.

Therefore, the AGC felt it important to examine what types of service were being commissioned by PCTs and to identify examples of good practice in commissioning comprehensive, open access sexual and reproductive health services. The AGC asked if PCTs held a definition of ‘specialist open access contraceptive services’ and, if so, to provide it.

33 of the 126 PCTs (26%) which responded claimed to hold a definition of ‘specialist open access contraceptive services’ and provided further detail on this. A further 25 PCTs (20%) stated that they did not have a precise definition, but provided supporting evidence (such as a service specification) for what they would expect such services to provide.
Figure 2: PCTs holding a definition of specialist open access contraceptive services

Level of detail in definitions

The definitions provided by PCTs varied considerably in scope and ambition – even between neighbouring PCTs.

For example, NHS Dudley’s response noted that a specialist open access service should include “a number of contraception and sexual health clinics that operate on a drop in and bookable appointment basis”\(^1\), while Sandwell PCT held an “expectation of contracted contraceptive services ... that they offer a range of walk-in and appointment-based services, at a range of different localities and opening hours to ensure access is enhanced.”\(^2\)

NHS Heart of Birmingham\(^3\), NHS Birmingham East & North\(^4\), NHS Birmingham South\(^5\), and NHS Solihull\(^6\), meanwhile, provided the definition outlined in their service level agreements with providers, which set out a comprehensive set of expectations:

1. Provision of a holistic reproductive service that is community-based
2. Improved access contributes to young people and socially excluded vulnerable groups and establish links with the appropriate agencies
3. Reduce unplanned teenage conceptions
4. Provide specialist contraception services
5. Contribute to local CSP
6. Provide routine, non-invasive testing for sexually transmitted infections (STIs)
7. Complete and submit KT31
8. Increase awareness of access to advice for unplanned pregnancies
9. Increase awareness about STIs

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10. Ensure mainstream contraception clinics are acceptable and accessible to all young people
11. Provide and expand specialist contraception clinics for this group
12. Enable women and men to choose acceptable and effective contraception to plan for pregnancy and to prevent unintended pregnancy
13. Ensure the range of sexual health needs of individuals are identified so that they can access services to achieve positive sexual health and well-being
14. Ensure that service users are able to receive accurate information about the full range of emergency, reversible and permanent contraceptive methods, to enable informed choice
15. Complement and support reproductive and sexual health service delivery in primary care
16. Provide specialist expertise in reproductive and sexual health, acting as a centre for clinical excellence, good practice and clinical governance
17. Provide reproductive and sexual health services to the groups of the population that do not, for a variety of reasons, access the services provided by their GP. These groups will include:
   - Young people who have concerns around confidentiality and / or wish to access services anonymously
   - BME communities who do not access their GP for reproductive and sexual health services, particularly in areas where there are single-handed, male GPs
   - Asylum seekers
   - Travelling families
   - Groups who are not registered with a GP, eg homeless people
   - Those who choose not to access routine contraceptive services from their GP
18. Implement integrated GUM and family planning services in community settings

Three PCTs (NHS East Sussex Downs and Weald, NHS Hastings and Rother and NHS Nottinghamshire County Teaching) signposted the 2001 Department of Health document Better prevention, better services, better sexual health: national strategy for sexual health and HIV as providing their reference point for defining specialist open access services. The Strategy sets out a comprehensive and holistic model, recognising the need for “access to information and services to avoid the risk of unintended pregnancy, illness or disease,” framed around seven principles:

- Shaping services around patients, their families and their carers
- Working with others
- Keeping people healthy and reducing health inequalities
- Providing a comprehensive service
- Responding to the different needs of different populations
- Continuously improving services
- Respecting confidentiality and providing open access to information about services, treatment and performance

More than a decade on, and with the changes to the commissioning environment, the AGC believes that an update to the Strategy is urgently needed. The Department of Health is developing a ‘policy document’ for delivering sexual health services in the new health landscape. Originally due in 2011, this is now expected to be published in spring 2012.
Recommendation 1: We urge the Department of Health to publish the sexual health policy document without further delay and ensure that it sets out clearly the expectation for commissioners to commission comprehensive, open access services that reflect a life-course approach for people of all ages.

Recommendation 2: The Department of Health, with Public Health England, should clearly set out the arrangements for the transfer of the commissioning of sexual and reproductive health services from PCTs to new commissioning bodies to ensure continuity and quality of care.

Recommendation 3: Commissioners should ensure that the sexual health and reproductive services they are commissioning are comprehensive, integrated, open access services that reflect a life-course approach to meet the needs of users of all ages.

The AGC is keen to work with the Department of Health as it formulates the sexual health policy document.

Defining remit of services in the new landscape

Setting out a clear definition for comprehensive, open access sexual health services is pressing, given the pace of NHS and public health reform. Under the proposals set out in the Health and Social Care Bill, different parts of contraceptive services will fall under the responsibility of different commissioners. To avoid error and omission, the Department of Health’s forthcoming sexual health policy document should set out the roles and responsibilities of each commissioning body in delivering a comprehensive sexual and reproductive health service.

The AGC understands that responsibilities will be assigned as set out in Table 1. It is essential that, given the complexity of the arrangements, efforts are made to prevent fragmentation of services. This could result in further unwarranted variation in the quality of services and a lack of continuity of care for the people using them. In addition, given the complexity of the new commissioning structures we are concerned that elements of sexual and reproductive health could fall through the gaps, thereby impacting on the outcomes of service users.

One example of the health care reforms and the transition of commissioning arrangements impacting on local service delivery and design was described in the response received from NHS Bexley which stated that:

“At present the PCT has no plans to change access to services during 2012/13. We are currently going through a transition to the local authority, once this is complete we will begin a process to review sexual health service provision within the borough to ensure that provision meets the needs of local residents and is equitable”\(^{25}\).\(^{25}\)
Table 1: Commissioning and governance responsibilities for contraception and abortion services, as set out in the Health and Social Care Bill

| Department of Health | • Development of sexual health policy document  
| | • National strategy for sexual health workforce education and training |
| NHS Commissioning Board | • Commissioning of general practice contraceptive services  
| | • Commissioning of contraception within other specialist services  
| | • Commissioning of HIV treatment and care  
| | • Development of all age outcome indicators for sexual health (in conjunction with PHE)  
| | • Development of tariff for sexual health services (in conjunction with PHE) |
| Public Health England (PHE) | • Development of model pathways for sexual health and contraception  
| | • Development of all age outcome indicators for sexual health (in conjunction with the NHSCB) |
| Clinical Commissioning Groups (CCGs) | • Commissioning of sexual health education and training for general practice staff  
| | • Commissioning of termination of pregnancy services (fully integrated services offering full range of contraception, STI testing and treatment)  
| | • Commissioning of vasectomy and female sterilisation |
| Local Authorities (LAs) | • Commissioning of:  
| | – Community contraceptive services  
| | – Pharmacy contraceptive services  
| | – Testing and treatment of STIs (including HIV testing and opportunistic chlamydia testing)  
| | – STI partner notification activity  
| | – Sexual health outreach  
| | – Sexual health education and training for community services |

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Under this model, local authorities will be expected to take on responsibility for the commissioning of some clinical services in relation to sexual health and contraception. It is essential that local authorities’ commissioners are equipped and supported to rise to this challenge.

One of the key levers for driving up standards of care in contraceptive services will be the forthcoming quality standard for contraceptive services (including emergency contraception). The AGC has welcomed the Department of Health’s decision to refer the quality standard for contraceptive services (including emergency contraception) to the National Institute for Health and Clinical Excellence (NICE) for development. However, we are concerned at the pace for the development of the library of 150 quality standards. Given that there are almost 8.7 million women of reproductive age living in England today, we believe this quality standard should be prioritised.

The AGC has already submitted a recommended set of quality statements on contraception to NICE for consideration. These are included in Appendix 3 and the AGC would welcome the opportunity to work with NICE to see how these can be taken forward.

**Recommendation 4:** The AGC urges NICE to prioritise the development of the quality standard on contraceptive services, as this will be an essential reference document for commissioners in local authorities responsible for commissioning sexual health and reproductive services.
Delivering comprehensive, open access contraceptive services

The QIPP agenda means that the NHS is being asked to deliver improved services at a time when it is also being required to find unprecedented efficiency savings. Anecdotal evidence suggests that there have already been cuts to contraceptive services despite the impact this can have on women’s access to services and their wellbeing.

Policies restricting access to contraceptive services

To better understand the current climate, the AGC asked PCTs whether they had a policy or contract in place to restrict access to specialist contraceptive services to women on the basis of age, place of residence or contraceptive.

It was encouraging to find that the overwhelming majority of commissioners (98%) did not have such an arrangement. However, we are concerned about the response from four PCTs who said that they had a restrictive policy in place:

- NHS Sussex, responding on behalf of NHS East Sussex Downs and Weald and NHS Hastings and Rother, said they commissioned specialist contraceptive services only “within the two PCTs boundaries”\(^{27}\)
- NHS Haringey Teaching said that from 1 October 2011 “women aged over 25 do not receive contraception pills from the local CaSH Service they receive this service from their GP”\(^{28}\)
- NHS Barnet, which responded after the statutory deadline for FOIs and has therefore not been included in the associated figures or maps, stated that “In 2010 the PCT introduced a restriction on over 25’s accessing integrated services for generic contraceptive advice. This service is provided by all GP practices within the borough. Only patients within this age group who have complex needs can be seen by an integrated service. This policy is still in place. No assessments have been carried out of the impact”\(^{29}\)

Placing restrictions on access to contraceptive services on the basis of age or place of residence 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. Women of different ages and circumstances will engage with health services in different ways and it is important that contraceptive services are configured in such a way as to address this.

For example, a woman may not wish to discuss her contraceptive needs with her GP particularly where this is a GP in a single-handed practice. In some cases, other sexual and reproductive health services in the community may be more or less accessible. The NHS Constitution also states that a patient has the right to access NHS services and should not be “refused access on unreasonable grounds”\(^{30}\).

Recommendation 5: The AGC urges commissioners to remove any policies or contracts in place which limit an individual’s access to contraceptive services based on reasons of age or place of residence. Contraceptive services must be commissioned based on the principles of the NHS Constitution.
Recommendation 6: Commissioners should ensure contraceptive services are truly open access – not restricting access to services to the local GP-registered population or by district of residence. They should be available at times which are convenient for users, including evenings and weekends.

Recommendation 7: Public Health England should establish national models for contraceptive pathways which can be tailored by local authorities to the needs of their areas.

Other forms of restrictions in access and what is available from services

It is essential that contraceptive services offer access to the full range of contraceptives so as to allow full patient choice and maximise concordance. Moreover, investment in contraceptive services offers value to the NHS and public health services, given that for every £1 spent on contraception the health service will save £12.50 in averted outcomes.

However, the ‘Nicholson Challenge’, which will see the health service having to make £20 billion of efficiency savings by 2015, means that commissioners are looking for ways to deliver more for less. Cutting prescribing budgets for contraceptives has already been identified as one of the routes used by PCTs for making short-term savings.

As part of its audit, the AGC asked PCTs to confirm whether, aside from policies, they had other types of restrictions in place on the prescribing or availability of contraceptives through GP or other commissioned contraceptive services. The AGC’s audit findings support the existing anecdotal evidence. Over a third (34%) of responding PCTs confirmed that they have restrictions in place on the prescribing or availability of contraceptives. Some PCTs denied having restrictions in place but did confirm that particular contraceptives were included on the PCTs’ red or black lists. The AGC has counted these as restrictions.

Based on population statistics for women aged 15-44 at PCT level, we have calculated that over 3.2 million women aged 15-44 are living in areas where a fully comprehensive contraceptive service is not provided. This represents almost one third of women in England (31%) in this age group. This takes no account of PCTs which did not respond and may also have restrictions in place.

It is notable that the average abortion rate in 2010 for PCTs which confirmed some form of restriction in access was 20.4 per 1,000 resident women aged 15-44. This is higher than the national average in 2010 which stood at 18.6 per 1,000 resident women aged 15-44.
Map 1: PCTs which have restrictions in place on the prescribing or availability of contraceptives through primary care or other commissioned contraceptive services.
Map 2 demonstrates that over half of all PCTs in London (16) have some form of restriction in place on access to contraceptive services or contraceptives. In 2010, 43% of all abortions in London were a repeat abortion which is higher than the England average of 36%\textsuperscript{36}. Giving women the right support after an abortion, including information about contraception, is essential to protecting a women’s wellbeing and preventing further unintended pregnancies.

The audit also uncovered variation relating to access to free emergency hormonal contraception (EHC). A number of PCTs confirmed they had Locally Enhanced Services (LES) in place which restricted access to free EHC based on the woman’s age – specifically restricting it to women under the age of 25 (for a fuller explanation of enhanced services please see the section Commissioner prioritisation of contraceptive services).

In London, NHS Brent Teaching provides EHC free to women under the age of 18 through pharmacies as part of their teenage pregnancy strategy\textsuperscript{37}, whilst women under the age of 30 in Lambeth are able to access free EHC\textsuperscript{38}.

The AGC welcomes steps by commissioners to improve access to EHC through LES agreements, as part of their efforts to reduce the level of unwanted, unintended pregnancies. However, the AGC is concerned that the focus on younger women makes an assumption that older women are less likely to have an unintended pregnancy and are able to afford EHC over the counter which will cost around £25\textsuperscript{39}. These PCTs may well argue that older women would be able to access EHC free via their GP or CaSH clinic, but this assumes that they are registered with a GP, are able to get an appointment within the time limit for EHC, or that there is a local CaSH clinic and they know where it is.

**Recommendation 8:** PCTs and local authorities should ensure that their commissioning arrangements do not have perverse consequences and restrict access to contraceptive services for specific demographic groups, for example those on low incomes or those who need to see a female practitioner.
The audit also uncovered evidence of guidance being set on the prescription of contraceptives based on cost rather than choice or quality:

- NHS Enfield and NHS Camden both said that providers of contraceptive services were “asked to ensure cost-effective choices as part of their Quality Innovation Productivity and Prevention (QIPP) plans by having first line choice options”\(^{40, 41}\)
- While the PCT said that no restrictions were in place, NHS Bromley’s “prescribing team encourages GP choice of cheaper, older contraceptive pills”\(^{42}\)
- NHS North Lancashire confirmed that one contraceptive was not prescribed “due to lack of funding/training for staff”\(^{43}\)

Worryingly, NHS Brighton and Hove confirmed that their “GP-led health centre will only prescribe Long Acting Reversible Contraceptive (LARC) methods to residents of Brighton and Hove. Non-residents attending with a filled prescription for LARC will be provided with fitting”\(^{44}\).

NICE Clinical Guideline No. 30: long-acting reversible contraception has found that LARC methods are more effective methods of contraception and can be more cost-effective\(^{45}\). As set out in NICE guidelines, women accessing contraceptive services should be given information about and choice of all methods, including LARC, as a priority. Women should also have information available to them about where to get LARC methods locally if they are not able to access these from their GP.

16% of PCTs confirmed contraceptives were included on the PCTs’ red or black lists (or equivalent) for prescribing. The majority of those included were newer contraceptive pills and the audit found that the decisions to include these had been based on cost, or the local clinical committee having not reviewed it, or uncertainty of the clinical evidence. NHS Lincolnshire’s Traffic Light Lists, which are publicly available, include a restriction on a routinely prescribed LARC method\(^{46}\).

The AGC is concerned that one in six PCTs confirmed red or black lists, or equivalent, were in place to restrict access to particular contraceptives. These PCTs are responsible for meeting the contraceptive needs of over 2 million women of reproductive age\(^{47}\).

Recommendation 9: Commissioners should urgently reconsider any restrictions on prescribing new and effective contraceptives and make sure methods are prescribed on the basis of clinical quality and individual choice. Appropriate funding should also be made available for services to prescribe all effective contraceptives.
Commissioner prioritisation of contraceptive services

The Coalition Government’s programme to reform the NHS and public health service presents a number of opportunities to drive improvements in contraceptive services and reduce the level of unintended pregnancy. Improving the quality of local contraceptive services is, and will continue to be, vital for commissioners looking to deliver better outcomes for women and the public’s health.

Incentivising choice and access in contraception

The Department of Health’s NHS White Paper emphasised the role of commissioning incentives in driving outcomes within the new health service, including the Government’s plans to “extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals”.

Under the CQUIN framework, a proportion of provider income is dependent on locally agreed quality and innovation goals. In 2009/10 this accounted for 0.5% of a provider’s contract value, rising to 1.5% for 2010/11 and 2.5% for 2012/13. At a local level, CQUIN schemes are made up of goals for quality and innovation that have been agreed between the provider and commissioners, and the level of improvement which is expected.

National guidance sets out that there should be at least one goal in each of the following areas:

- Effectiveness
- Innovation
- Patient experience
- Safety

Although the CQUIN scheme is still early in its development, having only been in place for three financial years, it is encouraging that the audit identified a number of commissioners who have selected CQUINs relevant to the delivery of effective sexual health services and improving the uptake of effective methods of contraception.

NHS Central Lancashire, for example, confirmed they had a CQUIN in place as part of their abortion service to “monitor and ensure women have access to contraception such as LARC as part of their episode of care”. NHS North of Tyne, which is made up of Newcastle and North Tyneside PCTs and Northumberland Care Trust, also confirmed that one of their CQUIN indicators was aimed at improving access and uptake of contraceptive methods.

Recent evidence has shown the potential of CQUIN indicators to deliver improvements in clinical areas. However, the AGC did not ask commissioners who confirmed they had a relevant CQUIN to provide information about the performance of providers in meeting the agreed goals as part of this audit. This is an area for future consideration and analysis.
Recommendation 10: Where there is low uptake of effective contraceptive methods, commissioners should consider introducing relevant CQUIN schemes which set goals for improving access and uptake of the full range of contraceptives. Information about the performance of providers in meeting these goals should be publicly available for scrutiny.

Enhanced services for contraception

In order to assess the commitment of commissioners in improving women’s access to the full range of contraceptive methods, the AGC asked PCTs to confirm whether they had an agreement in place for enhanced service delivery of fitting and care of subdermal implants and / or intrauterine contraceptive methods in primary care.

General practices are required to provide essential and additional services to their patients through General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contracts. However, enhanced services allow commissioners to expand the services available in primary care to meet local needs, improving choice and convenience for residents.

The Department of Health has developed a National Enhanced Service (NES) template for the fitting of intrauterine contraceptives, which sets out the standards GPs must adhere to and the payment structure. However, based on local requirements, commissioners can adapt this as a Local Enhanced Service (LES) for LARC.

Map 2 outlines which PCTs confirmed they had an enhanced service for subdermal implants and / or intrauterine contraceptives in place. The AGC welcomes the use of NES or LES to promote access and choice, and we were pleased to find from our audit that the vast majority (91%) were able to confirm they had such arrangements in place.
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While the AGC welcomes the actions of commissioners who have put enhanced services in place for the fitting of LARC, we are concerned at the findings from the audit which have shown a variation relating to the number of GP practices signed up to the enhanced service. For example:

- NHS Sandwell confirmed that only around 15-17% of their total number of GP practices were signed up to their LES for intrauterine contraceptive methods over the past three financial years.\(^{52}\)
- Only 28% of GP practices in NHS Blackburn with Darwen are signed up to the enhanced service to fit subdermal implants in 2011/12.\(^{53}\)
- NHS East Riding of Yorkshire has seen the number of practices signed up to an enhanced service for intrauterine contraceptive methods fall from 95% in 2010/11 to just 48% in 2011/12.\(^{54}\)
- 31% of all GP practices in NHS South of Tyne, which is made up of NHS Gateshead, NHS South Tyneside and NHS Sunderland, have no provision for the fitting of LARC methods.\(^{55}\)

Commissioners must put arrangements and resources in place to encourage as many GP practices as possible to sign up to enhanced service agreements for fitting and removing LARC methods. For those practices that have not signed-up, commissioners and practices should ensure that every woman who wants a LARC knows where she can get one fitted. Clear referral pathways are essential if a GP practice does not offer the LARC of a woman’s choice since each practice is likely to be looking after tens if not hundreds of women of reproductive age.

Nine PCTs have chosen not to put an enhanced service in place for fitting LARC methods. We recognize that these PCTs, which commission services for almost 350,000 women of reproductive age,\(^{56}\) may have other mechanisms in place for reimbursing the fitting of LARC. However, if not it could be having a negative impact on giving women access to the full range of contraceptives in these areas.

Anecdotal evidence indicates that some commissioners are considering abolishing enhanced services for fitting LARCs as they continue to look for ways to deliver efficiency savings. There also remain unanswered questions about how enhanced services will be commissioned and delivered under the new health structures – ie whether they will sit with local authorities and the NHS Commissioning Board – and, if not, what the alternative mechanisms will be.

**Recommendation 11:** All commissioners should have enhanced service agreements in place for the fitting and removal of LARC methods, including SDI and IUD/S, or alternative local contracts in place which incentivise GPs to provide these methods.

**Recommendation 12:** Commissioners with enhanced service agreements for the fitting and removal of LARC methods must ensure adequate arrangements and resources are in place to ensure as many GP practices are signed up and, if not, that they participate in local referral pathways for fittings.

**Recommendation 13:** The NHS Commissioning Board should provide clarity about how enhanced services for sexual and reproductive health in the new NHS and public health service will be commissioned and delivered.
Workforce planning and development

The fitting of LARC methods, especially intra-uterine contraceptive methods, is an invasive procedure which requires additional medical equipment and training. 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.

Where a woman opts for a LARC it is important this can be fitted and removed in the healthcare setting of her preference. Therefore, only by having a large and well-trained workforce will it be possible to deliver high quality contraceptive services.

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

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 this effective method of contraception. The AGC therefore requested that PCTs provide information about the number of healthcare professionals in general practice that are trained to fit subdermal implants and intrauterine contraceptives.

Less than one fifth of PCTs (17%) could supply information about the number of professionals in general practice who were trained to fit subdermal and intra-uterine contraceptive methods. Two thirds of PCTs were unable to provide any information at all about the number of practitioners trained to fit these contraceptives. For the remaining 16% of PCTs their response to this question was unclear.

There were a number of different reasons why the number of professionals trained to fit subdermal and intra-uterine contraceptive methods was unclear, including:

- Numbers of trained healthcare professionals were provided on behalf of a cluster of PCTs and not broken down to the individual PCT level
- The PCT gave figures relating to the number of practices where staff were trained to fit subdermal and intra-uterine contraceptive methods rather than the number of individual healthcare professionals
- The PCT provided information about the number of GPs trained to fit some type of LARC but did not break this down to each individual method
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Figure 3: Percentage of PCTs able to provide information about the number of healthcare professionals in general practice trained to fit subdermal and intra-uterine contraceptive methods

Information about the levels of trained staff to fit subdermal and intra-uterine contraceptive methods was even lower when PCTs were asked about the number of practitioners trained to fit these devices in community settings.

Figure 4: Percentage of PCTs able to provide information about the number of healthcare professionals in community settings trained to fit subdermal and intra-uterine contraceptive methods

There is a real need for improved data collection on the sexual and reproductive health workforce. It is worrying that PCTs do not know what the level of appropriately trained workforce is in their local area.
There is currently no audit or register of the number of health professionals qualified to fit each type of LARC. This information is important in allowing commissioners to ensure that they have a sufficient workforce to meet local needs.

Given the variety of contraceptive options, healthcare professionals advising and supporting women in meeting their contraceptive needs should have the appropriate training. Providers should be required to demonstrate to commissioners that their workforce has the appropriate skills as a key part of the ‘any qualified provider’ policy.

**Recommendation 14:** Providers should be required to demonstrate to commissioners that their workforce has the appropriate skills as a key part of the ‘any qualified provider’ policy. This should include an ability to provide information on the number of healthcare professionals trained to fit and remove different types of LARC methods.

**Assessing local need for additional training to fit and remove LARCs**

The AGC asked PCTs whether they had assessed local need for additional training to provide subdermal implants and intra-uterine contraceptive methods in the last two years. Almost one quarter of PCTs (24%) reported that they had undertaken no such assessment. For an additional 7% of respondents it was unclear whether an assessment had been made or they stated that a review was currently underway.
This lack of awareness of the local training needs to provide subdermal implants and intrauterine contraceptive methods was most stark in London, where only 50% of PCTs who responded to the audit confirmed that they had made an assessment of additional training needs in the last two years.

Of those PCTs who responded to the AGC audit and stated that they did not know how many healthcare professionals in general practice were trained to fit subdermal and intra-uterine contraceptive methods, one half said that they had plans to increase capacity in this area. Given that they were not able to provide information about the number of people already trained to fit subdermal and intra-uterine contraceptive methods it seems surprising that they are able to make an informed decision about the need to increase capacity.
We are concerned about the Department of Health’s proposals for the provision of workforce education and training to be made the responsibility of individual providers to fund and organise. There is already a shortage of healthcare professionals trained to provide and fit all forms of contraception, and we are worried that this problem will be exacerbated by the proposed changes to responsibility for training provision, as well as the lack of agreed standards or syllabus for nurse training for contraception. It is imperative that there is a co-ordinated approach to training, supported by sufficient funding.

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We believe that there is a need for Public Health England or the NHS Commissioning Board to work with appropriate professional bodies to establish national standards of competence for healthcare professionals delivering contraceptive services to inform requirements for local training provision, including nurses. These standards will need to take account of the different types of healthcare practitioner delivering contraceptive services. For example, the same qualification would not be appropriate for a practice nurse counselling and fitting an intra-uterine contraceptive in a general practice setting, and another healthcare professional fitting an intra-uterine contraceptive under general anaesthetic. A framework of different levels of competence will therefore be required to take account of different roles.

**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 intra-uterine contraceptive methods.

**Recommendation 16:** In line with professional and regulatory requirements, healthcare professionals involved in delivering contraceptive services should undertake ongoing training so as to ensure that their knowledge and skills are up to date and they remain competent to deliver interventions such as LARC fitting.

**Recommendation 17:** The forthcoming sexual health policy document should address the need for a skilled sexual health workforce, including nurses, and indicate how there will be national level oversight of training needs such as LARC fitting. It should also emphasise the importance of continued professional development.
Reducing unintended pregnancies

Unintended pregnancies place a significant financial burden on the NHS and also a physical and psychological impact upon women who find themselves in this situation. In 2010, there were 180,942 abortions carried out in England by the NHS and NHS agencies. It has been estimated that the costs to the NHS in England of unintended pregnancy stands at £755 million a year. Therefore reducing the number of unintended pregnancies could deliver a significant cost saving to the NHS.

Strategies to reduce unintended pregnancy, and the need for abortion and repeat abortions

The AGC therefore wanted to find out what strategies PCTs are putting in place to reduce unintended pregnancy, as well as the need for abortion and repeat abortion. Out of those PCTs which responded to the AGC audit, just over half (53%) stated that they had a strategy in place to address this area. Another 23 said that they were in the process of developing a strategy, but over a quarter (28%) stated that they did not have a strategy in place and did not suggest that a strategy was in development.

NHS Barking and Dagenham noted that, despite having a strategy in place, the PCT’s updated sexual health strategy is in draft form and will remain this way until the Department of Health publishes the forthcoming sexual health policy document. Only at this point will it be possible for NHS Barking and Dagenham to finalise their plans. Similarly, NHS Brent noted that they are awaiting clarity on the commissioning of sexual and reproductive health services before putting a formal local strategy in place. These comments emphasise the importance of the Department of Health’s sexual health policy document being published at the earliest possibility.
Map 6: PCTs where a strategy is in place to reduce unintended pregnancy, and the need for abortion and repeat abortions
Out of those PCTs which confirmed that they had a strategy in place to tackle unintended pregnancy and the need for abortion, one quarter provided only strategies focused solely on teenagers. The AGC has long argued that the exclusive focus on teenagers has given rise to the unintended consequence of neglecting the needs of women aged 20 and over.

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 contraception 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 older. In England four in five (79%) abortions occur in women aged 18 and over.\(^6\)

Therefore the failure to address the needs of women aged 20 and over not only damages health outcomes for these women and their families, but also represents a significant cost burden to the NHS in England for unintended pregnancy.

**Recommendation 18: Commissioners should ensure that up-to-date strategies are in place to reduce unintended pregnancy, and the need for abortion and repeat abortions which focus on the needs of women of all ages.**

**Reviewing abortion services**

Commissioners should also have a better understanding of the abortion services available in their local area and ensure that these are appropriate for the women that they serve. The AGC asked PCTs if they had undertaken a review of abortion services since 2007. Just over half of PCTs (53%) said that they had conducted such a review. However, over one third (36%) said that they had not undertaken a review. It is worrying that over a five year period no review had been undertaken on local abortion services in such a high number of PCTs.
Some PCTs did report excellent review processes and demonstrated how undertaking regular reviews improves local services. For example, in NHS Doncaster an annual review is undertaken of abortion services. As a result of this regular review the need for access via self-referral was identified. Since this was identified as a local need it has now been introduced as an entry route to abortion services.\(^{12}\)

NHS Central Lancashire stated that they are constantly reviewing ways to improve services, including developing a Choose and Book system for termination of pregnancy services, which will fast track women to a service provider of their choice, time and place. Termination of pregnancy providers are monitored in terms of their patient experience at quarterly meetings. NHS Central Lancashire also has a
CQUIN in place to monitor and ensure women have access to contraception such as LARC as part of their episode of care.\(^63\)

**Recommendation 19:** Regular reviews should be undertaken of abortion provision to ensure that this is in line with the needs of the local population.

**Restrictions in access to contraception provided by abortion services**

If a woman is having an abortion due to an unwanted pregnancy, this is a key intervention point to talk about the use of contraception for the future and prescribe it immediately. As with other settings – such as general practice or community contraceptive services – it is essential that a woman has access to and is able to choose from the full range of contraceptives.

Most PCTs do not place any restrictions on access to the full range of contraceptives through abortion services. However, three PCTs (NHS Lincolnshire\(^64\), NHS Herefordshire\(^65\) and NHS West Essex\(^66\)) all stated in their responses to the AGC audit that they did, in fact, place restrictions on the availability of contraceptives in this setting. At 20.2 abortions per 1,000 resident women aged 15-44\(^67\), NHS West Essex had a higher abortion rate than the national average in 2010, which stood at 18.6 per 1,000 resident women aged 15-44\(^68\). At 39% NHS West Essex also had a higher percentage of abortions which were repeat abortions, compared to the national average in 2010 which was 36%\(^69\).

Encouragingly, the NHS North of Tyne PCT cluster (NHS North Tyneside\(^70\), NHS Newcastle\(^71\) and NHS Northumberland\(^72\)) stated that although they had not undertaken a formal review of abortion services since 2007, they had put in place a CQUIN indicator to improve uptake of post abortion contraception which demonstrates that this is a priority in the local area.

**Recommendation 20:** Commissioners should ensure that access to the full range of contraceptives is made available by all providers of contraceptive services, including abortion providers.

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Conclusion

The AGC has welcomed the Coalition Government’s radical new approach to public health. We support the ambition to create a public health system that is responsive, resourced, rigorous and resilient. Contraceptive services have an essential role to play in improving public health outcomes by preventing unwanted, unintended pregnancies, preventing ill health, improving wellbeing and addressing inequalities.

The Government’s ambitions for the new public health service come at a time of significant structural change and budgetary pressures. Despite these challenges, our audit has found that some commissioners are continuing to commission high quality open access contraceptive services, with clear objectives for reducing the level of unwanted, unintended pregnancies. However, the audit has also confirmed that a number of PCTs are restricting access to contraceptive services and forcing prescribing decisions based on cost alone rather than choice or quality – thereby impacting on the outcomes and wellbeing of women using these services.

The findings from our audit, alongside the uncertain commissioning environment, reaffirm the urgent need for the Department of Health to publish its sexual health policy document. As well as addressing the concerns of healthcare professionals on the frontline, the sexual health policy document will be a vital tool in providing the strategic overview for new and emerging commissioners about how contraceptive services are going to be delivered within the new framework.

The sexual health policy document does not need to set out a root-and-branch overhaul of how contraceptive services are delivered. Great progress has been made over the past decade in how contraceptive services are being delivered and the outcomes they have achieved – most notably the dramatic reduction in teenage pregnancy rates. This progress should not be lost. Instead, the sexual health policy document should seek to build on examples of good commissioning and address examples of poor commissioning.

For example, in the absence of any associated indicators within the Public Health Outcomes Framework, the sexual health policy document must ensure it explicitly addresses the needs of all women, not just young people. This is particularly important given the four in five abortions that take place are amongst women over the age of 20 and the level of unmet need this represents. Guidance should also be developed for local authorities on how they can adequately assess local contraceptive need and ensure commissioning is based around this.

The purpose of this report has been to provide a picture of how contraceptive services are being delivered today against the current challenging backdrop of change. The AGC looks forward to working with the Department of Health, Public Health England and the NHS in improving the quality of these services and ensuring they deliver better outcomes for women of all ages.
Appendix 1 – Freedom of Information requests sent to PCTs

Request 1: Please confirm or deny whether the PCT holds a definition of ‘specialist open access contraceptive services’

a) If confirmed please supply the definition of ‘specialist open access contraceptive services’

Request 2: Please confirm or deny whether the PCT has any policy or commissioning contract in place that restricts access to specialist contraceptive services (not supplied by general practice) to women on the basis of i) age, ii) place of residence, or iii) type of contraceptive method

a) If confirmed please supply the PCT’s policy or commissioning contract on restricting access to contraceptive services
b) If confirmed please supply any assessment the PCT has carried out on the impact of its policy or commissioning contract on restricting access to contraceptive services

Request 3: Please confirm or deny whether the PCT has put any restrictions in place on the prescribing or availability through general practice or other commissioned contraceptive services of any i) methods of emergency contraception, ii) long-acting reversible contraceptive methods or iii) other contraceptive methods/formulations during the financial year 2011/12, including within commissioned abortion services

a) If confirmed please supply details
b) If confirmed please supply any assessment the PCT has carried out on the impact of these restrictions

Request 4: Please confirm or deny whether the PCT has any plans to place restrictions on the prescribing or availability through general practice or other commissioned contraceptive services of any i) methods of emergency contraception, ii) long-acting reversible contraceptive methods or iii) other contraceptive methods/formulations during the financial year 2012/13, including within commissioned abortion services

a) If confirmed please supply details
b) If confirmed please supply any assessment the PCT has carried out on the potential impact of these planned restrictions

Request 5: Please confirm or deny whether the PCT provides any policy or guidance on the prescribing of i) emergency contraception methods, ii) long-acting reversible contraception methods and iii) other contraceptive methods/formulations

a) If confirmed please supply the PCT’s policy or guidance on the prescribing of i) emergency contraception methods, ii) long-acting reversible contraception methods and iii) other contraceptive methods/formulations
**Request 6:** Please confirm or deny whether contraceptive methods/formulations including, but not limited to, all methods of emergency contraception are currently included on the PCT’s i) red lists or ii) black lists of prescription items

a) If confirmed please supply details of which products are listed  
b) If confirmed please supply any assessment the PCT has carried out on the impact of the decision to include contraceptive methods on the PCT’s i) red lists or ii) black lists

**Request 7:** Please confirm or deny whether the PCT has a formal strategy in place to reduce i) the rate of unintended pregnancy, ii) the level of abortions, and/or iii) the level of repeat abortions

a) If confirmed please supply the PCT’s strategy/strategies

**Request 8:** Please confirm or deny whether the PCT has undertaken a review of abortion services since 2007

a) If confirmed please supply details  
b) If confirmed please supply details where services have been changed to improve i) service access, ii) access to all methods of contraception as part of the episode of care, and iii) choice of provider

**Request 9:** Please confirm or deny whether the PCT commissions, as part of its abortion services, the provision of methods of contraception

a) If confirmed please supply details of this provision  
b) If confirmed please supply detail of any policy or commissioning contract on restricting access to methods/formulations of contraception

**Request 10:** Please confirm or deny whether the PCT has any standards of competence for healthcare professionals fitting long-acting reversible contraception (subdermal implants and intrauterine contraceptive methods) in any healthcare setting

a) If confirmed please supply details

**Request 11:** Please confirm or deny whether the PCT has an agreement in place for Enhanced Service delivery of i) subdermal implants and/or ii) intrauterine contraceptive methods

a) If confirmed please provide details  
b) If confirmed please confirm what percentage of general practices are signed-up to this Enhanced Service in each of the last 3 financial years

**Request 12:** Please confirm or deny whether the PCT intends to have an agreement in place for Enhanced Service delivery for methods of i) subdermal implants and/or ii) intrauterine contraceptive methods during the financial year 2012/13

a) If confirmed please provide details
Request 13: Please provide any service specification issued by the PCT to potential sexual health service providers in the last 3 years

Request 14: Please confirm or deny whether the PCT has, within the last 2 years, conducted an assessment of the local need for additional contraceptive training to provide subdermal implants and intrauterine contraceptive methods

   a) If confirmed please supply details of how many healthcare professionals in general practitioners are currently trained to fit i) subdermal implants and ii) intrauterine contraceptive methods

   b) If confirmed please supply details of how many healthcare professionals in community settings are currently trained to fit i) subdermal implants and ii) intrauterine contraceptive methods

Request 15: Please confirm or deny whether the PCT has any plans in place to increase capacity for fitting subdermal implants and intrauterine contraceptive methods

   a) If confirmed please supply details

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Appendix 2 – PCTs which responded to the Freedom of Information requests*

Ashton, Leigh and Wigan PCT
Barking and Dagenham PCT
Barnsley PCT
Bassetlaw PCT
Bath and North East Somerset PCT
Bedfordshire PCT
Bexley Care Trust
Birmingham East and North PCT
Blackburn with Darwen Teaching PCT
Blackpool PCT
Bolton PCT
Bournemouth and Poole PCT
Bradford and Airedale Teaching PCT
Brent Teaching PCT
Brighton and Hove City Teaching PCT
Bromley PCT
Buckinghamshire PCT
Bury PCT
Cambridgeshire PCT
Camden PCT
Central and Eastern Cheshire PCT
Central Lancashire PCT
City and Hackney Teaching PCT
Cornwall and Isles of Scilly PCT
County Durham PCT
Coventry Teaching PCT
Croydon PCT
Darlington PCT
Derby City PCT
Derbyshire County PCT
Devon PCT
Doncaster PCT
Dorset PCT
Dudley PCT
Ealing PCT
East Lancashire Teaching PCT
East Riding of Yorkshire PCT
East Sussex Downs and Weald PCT
Eastern and Coastal Kent PCT
Enfield PCT
Gateshead PCT
Gloucestershire PCT
Great Yarmouth and Waveney PCT
Greenwich Teaching PCT
Hammersmith and Fulham PCT
Hampshire PCT
Haringey Teaching PCT
Hartlepool PCT
Hastings and Rother PCT
Havering PCT
Heart of Birmingham Teaching PCT
Herefordshire PCT
Hertfordshire PCT
Hounslow PCT
Islington PCT
Kensington and Chelsea PCT
Kingston PCT
Knowsley PCT
Lambeth PCT
Leeds PCT
Leicester City PCT
Leicestershire County and Rutland PCT
Lewisham PCT
Lincolnshire Teaching PCT
Medway PCT
Mid Essex PCT
Middlesbrough PCT
Milton Keynes PCT
Newcastle PCT
Newham PCT
North East Essex PCT
North Lancashire PCT
North Lincolnshire PCT
North Somerset PCT
North Staffordshire PCT
North Tyneside PCT
North Yorkshire and York PCT
Northamptonshire Teaching PCT
Northumberland Care Trust
Nottingham City PCT
Nottinghamshire County Teaching PCT
Oldham PCT

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AGC Advisory Group on Contraception

Oxfordshire PCT
Peterborough PCT
Portsmouth City Teaching PCT
Redbridge PCT
Redcar and Cleveland PCT
Richmond and Twickenham PCT
Sandwell PCT
Sheffield PCT
Shropshire County PCT
Solihull Care Trust
Somerset PCT
South Birmingham PCT
South Gloucestershire PCT
South Staffordshire PCT
South Tyneside PCT
Southampton City PCT
Southwark PCT
Stockport PCT
Stockton on Tees PCT
Stoke-on-Trent PCT
Sunderland Teaching PCT
Surrey PCT
Sutton and Merton PCT
Swindon PCT
Tameside and Glossop PCT
Telford and Wrekin PCT
Torbay Care Trust
Tower Hamlets PCT
Trafford PCT
Wakefield District PCT
Walsall Teaching PCT
Waltham Forest PCT
Wandsworth Teaching PCT
Warrington PCT
Warwickshire PCT
West Essex PCT
West Kent PCT
West Sussex PCT
Western Cheshire PCT
Westminster PCT
Wiltshire PCT
Wirral PCT
Wolverhampton City PCT
Worcestershire PCT

* Correct as of 2 March 2012
Appendix 3 – 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 4 – Members of the Advisory Group on Contraception

Dr Anne Connolly, General Practitioner, The Ridge Medical Practice and Clinical Lead for Women’s and Sexual Health, NHS Bradford and Airedale

Ann Furedi, Chief Executive, bpas

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

Dr Kate Guthrie, Consultant Gynaecologist, Hull Community Healthcare Partnership

Natika Halil, Director of Information, FPA

Ruth Lowbury, Chief Executive, Medical Foundation for AIDS and Sexual Health (MedFASH)

Tracey McNeill, International Vice-President and Director of UK and West Europe, Marie Stopes International

Jill Shawe, National Association of Nurses for Contraception and Sexual Health

Dr Connie Smith, Consultant in Sexual and Reproductive Healthcare

Dr Anne Szarewski, Clinical Consultant, Clinical Senior Lecturer, Centre for Cancer Prevention, Wolfson Institute of Preventive Medicine and Associate Specialist, Margaret Pyke Centre

Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre

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References

6 Department of Health, Healthy lives, healthy people: transparency in outcomes, proposals for a public health outcomes framework, December 2010
8 National Institute for Health and Clinical Excellence Clinical Guideline no. 30: Long-Acting Reversible Contraception, 2005. This guidance estimates that 40.6% of unintended pregnancies end in abortion, 46.4% of unintended pregnancies result in a live birth, and 13% of pregnancies end in spontaneous abortion/miscarriage. The guidance also calculates the cost of an abortion as £497, the cost of a miscarriage calculated as £321, and the total maternity cost £2,137.
10 Bayer Healthcare, Contraception Atlas 2011, September 2011
11 HM Treasury, 2010 Spending Review, October 2010
12 Pulse, GPs face bans on high cost drugs, 12 April 2011, accessed on 8 February 2012, available at: http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/12198831/gps-face-bans-on-high-cost-drugs
13 Hansard, Col.679W, 20 February 2012
14 NHS Dudley, Response on file
15 NHS Sandwell, Response on file
16 NHS Heart of Birmingham, Response on file
17 NHS Birmingham East and North, Response on file
18 NHS Birmingham South, Response on file
19 NHS Solihull, Response on file
20 NHS East Sussex and Weald, Response on file
21 NHS Hastings and Rother, Response on file
22 NHS Nottinghamshire County, Response on file
24 Hansard, Col.548W, 31 January 2012
25 NHS Bexley, Response on file

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