The Time is Now
Achieving World Class Contraceptive and Abortion Services

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Contraception and Abortion Working Group Report
Independent Advisory Group on Sexual Health and HIV
Contents

Foreword ........................................... 2

1 Executive Summary ............................. 3

2 Priorities for Action and Recommendations .... 4
   2.1 Give women the information they need to make informed choices ................................ 4
   2.2 Actively commission services .............................................. 5
   2.3 Implement a workforce development strategy .............................................. 6
   2.4 A more radical option .............................................. 7

3 Background ...................................... 8

4 The Economic Argument for Contraception ...... 11

5 Achieving Good Contraceptive and Abortion Services .... 12
   5.1 The goal .............................................. 12
   5.2 Strategic commissioning .............................................. 12
   5.3 Data required for the development of the strategic framework and for performance management .............................................. 12
   5.4 Partnership with providers .............................................. 13
   5.5 The qualities of good contraceptive and abortion services .............................................. 14
   5.6 Quality standards .............................................. 15
   5.7 Continuing to improve and innovate .............................................. 15
   5.8 The skilled multi-professional team .............................................. 16
   5.9 Service configurations .............................................. 17
   5.10 Local information .............................................. 17

6 A Broken Service .................................. 18
   6.1 Teenage pregnancy strategy and contraception .............................................. 19

7 Conclusions ...................................... 21

Appendices ........................................ 23
   1 Contraceptive and abortion services today .............................................. 24
   2 The current state of sexual health commissioning .............................................. 26
   3 The workforce .............................................. 27
   4 Terms of reference and membership .............................................. 28
Foreword

Contraceptive and abortion services reach deep into the community. They have a profound and positive impact on women’s lives and wellbeing. In addition, their focus on prevention means they can and do save the NHS a great deal of money.

Yet, despite the tireless efforts of the many health professionals who have worked to protect and improve contraceptive and abortion services, these services are often fragmented, not properly signposted and sometimes disgracefully inadequate. It is time for all PCTs and SHAs to accord them the priority they deserve.

This is particularly urgent now. Current changes to provider services mean that many contraceptive and abortion services are under review and may be at risk of further neglect. On the other hand, the release of funding from the Department of Health for the three years 2008/11 offers real opportunity for innovation and improvement. Therefore, it is vital that commissioners and providers understand what constitutes good contraceptive and abortion services and act speedily to improve provision.

The Time is Now: Achieving World Class Contraceptive and Abortion Services, produced by a working group of the Independent Advisory Group (IAG) on Sexual Health and HIV, analyses current service provision and describes what it should be. It contains compelling arguments for investment in planning, health promotion and how, by linking contraceptive and abortion services, greater emphasis can be placed on effective prevention of unintended and unwanted pregnancy.

The IAG on Sexual Health and HIV was established in 2003 to monitor and advise on the progress of the National Strategy for Sexual Health and HIV. Last year, the group published a comprehensive review of the progress of the sexual health strategy which gave an important benchmark. The Time is Now goes a step further to propose exactly what steps SHAs and PCTs can take to improve services. There are four key recommendations, as well as an analysis of what the main priorities are.

We applaud the Department of Health’s three year investment in contraceptive and abortion services. It provides the potential for real change and improvement. One year has already gone. We urge PCTs and SHA’s to grasp this opportunity and offer them this report to help them do so.

Anne Weyman
Chair of the Contraceptive and Abortion Working Group
Deputy Chair of the Independent Advisory Group on Sexual Health and HIV

June 2009
1 Executive Summary

This report has been produced by a Working Group of the Independent Advisory Group (IAG) on Sexual Health and HIV following the publication of the IAG’s mid-term review of the National Strategy for Sexual Health and HIV.

It is an overview of the current state of contraceptive and abortion services in England and includes proposals for creating good quality services.

The conclusions and recommendations of this report are based on the recognition that while most women spend around thirty years trying to avoid pregnancy and therefore need high quality contraceptive services, there have been long term and systemic failures in the provision of contraceptive services. Furthermore, although there have been improvements in the availability and timeliness of NHS abortions in recent years, there is still unacceptable inequity in access and provision. This situation will remain unresolved until PCTs and SHAs engage effectively with these services and give them much higher priority through commissioning and performance management.

Changes in commissioning practices, tariffs and the advent of new and independent service providers represent both threats and opportunities for improving services.

The Government has allocated additional resources to contraceptive services during 2008/11, thus creating a three year window of opportunity to make significant improvements in service provision. One of the three years has already passed and there is little evidence of local progress. The Working Group hopes this report will provide helpful guidance to PCTs and SHAs to take immediate action.

While there are examples of excellent practice which address the needs of women, overall the provision of contraceptive and abortion services is unacceptably variable. A particular concern is the lack of strategic planning which integrates contraceptive and abortion services. Unless PCTs and SHAs understand, produce and commission services using data along the lines suggested on pages 14 and 15 for the development of a strategic framework and for performance management, the current service shortcomings will persist.

This report outlines the key steps to providing contraceptive and abortion services that meet women’s needs so that what is now a vision of good contraceptive and abortion services can become reality.

So far, despite the new Government funding, these services are still a low priority for the NHS at local level. There remain variations in access to services, fragile specialist services, weak commissioning and performance management with few quality standards and underdeveloped clinical governance systems. The rates of unplanned and unwanted pregnancies remain high, causing unacceptable levels of misery and distress, which could and should be prevented.

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2 Priorities for Action and Recommendations

The working group agreed three principles for contraceptive and abortion services:

- To enable women to have more control over their sexual health, choices and services
- To ensure that women from puberty to the menopause are able to choose whether and when to have children
- To expand the diversity of services and service providers of contraceptive and abortion care within a robust clinical governance framework to assure accessibility, clinical quality and patient safety.

Based on these principles, the working group has identified three priorities for immediate action:

2.1 Give women the information they need to make informed choices

Although contraception has been available free from the NHS since 1974 and there are currently 15 different methods of contraception available to them, many women still have difficulty in obtaining a method which works well for them.

Contraceptive methods

Methods without user failure: male and female sterilisation, intrauterine system (IUS), implant, injection, inter-uterine device (IUD)

Other methods: combined pill, contraceptive patch, contraceptive vaginal ring, progestogen-only pill, natural family planning, male and female condoms, diaphragms and caps

There are also two methods of emergency contraception, emergency hormonal contraception and the IUD. Yet few women are aware of this use of the IUD, which is more effective than emergency hormonal contraception and has the additional benefit of providing long term contraception, or how it can be accessed.

The IAG working group has identified that there is a lack of information provided about contraceptive methods and services. Myths about contraception and contraceptive methods abound and information from a trusted source is crucial in enabling women of all ages to understand the options open to them and to make their choices. Until now, there have not been any sustained national high profile campaigns with the exception of those relating to teenage pregnancy. Local sign posting is meagre. The group welcomes the Department of Health’s recently announced funding for a package of measures to promote contraception, including a £7 million ‘contraceptive choices’ campaign to raise awareness of the different options available to young people. However young women obtain much of their information from older women and comprehensive long term and sustained information campaigns are required.
RECOMMENDATION 1

The Department of Health should ensure that public information is provided about all contraceptive methods, through a combination of national sources of information and high-profile campaigns supported by local signposting with full information about what local services, including general practices, do and do not offer. Both national and local information will need to be tailored to meet the needs of all women.

2.2 Actively commission services

Even if women were aware of the contraceptive and abortion choices open to them, many would have considerable difficulty in obtaining their preferred method due to a combination of inadequate provision and budget restrictions. PCTs have the lead role to play in commissioning contraceptive and abortion services by working with partners (providers, users and potential users) to understand and meet local needs. There is little evidence that either service has been actively commissioned. Innovation tends to be provider-driven and dependent on a strong local specialist lead.

The information base will need to be strengthened significantly if commissioners are to commission effectively, perhaps in line with the recommendations of the recent needs assessment and service mapping project commissioned for all London PCTs.

In addition, more information is needed about women’s experiences and their preferences in terms of contraceptive and abortion methods and service delivery. Measures of clinical and cost effectiveness are also required for successful contracts, with local managed clinical network ensuring that commissioning is informed by clinical and organisational expertise.

RECOMMENDATION 2

PCTs should develop world class commissioning for contraceptive and abortion services with effective performance management based on rigorous comparative data. In many PCTs, additional resources need to be allocated to sexual health commissioning, and within this to develop a much stronger focus on contraceptive and abortion services as well as sexually transmitted infections, ensuring that services meet the range of needs of all sexually active women within their community. Commissioning of contraceptive and abortion services needs to be integrated. Both commissioners and providers should seek out innovation and the evidence for service improvement, and be prepared to resource and implement change.

MedFASH - London sexual health needs assessment and service mapping, November 2008
http://www.medfash.org.uk/publications/current.html
2.3 Implement a workforce development strategy

Specialist providers of contraceptive and abortion services have key roles in advising commissioners about service quality, patient safety and clinical governance. Moreover, they are an essential pre-requisite for training additional service providers, as well as assessing and monitoring their competencies. At the moment this necessary expertise is not available to all PCTs and there is concern that further decline may occur. As a result, there is considerable risk of greater fragmentation and variable quality of services, which will be detrimental to individual women and the public collectively.

At present there is no multi-professional workforce plan which covers all service providers including those in specialist services and general practice. With the exception of medical staff, no systematic framework exists for either basic or continuing education. The situation is particularly serious for nursing staff. The lack of nurse training programmes is a major barrier to implementing service improvements linked to an extended nursing role, an approach which has already proved very effective in a number of settings.

All sexual health providers within a PCT should work within a mutually supportive, collaborative clinical network within which innovation can thrive. Currently, managed clinical networks are patchy, and often under-resourced, as is the commissioning and contracting expertise within both PCTs and providers. An immediate priority is to safeguard community-based specialist contraceptive provider services. Not only do these deliver more complex services than those generally available from general practice, but they also provide the setting for most education, training, innovation and research. These functions all need to be sustained and developed.

There is an ageing workforce in abortion services, which is being addressed by recruiting doctors from outside the UK. A significant percentage of abortions take place in the independent sector and there are a lack of facilities for post 20 week abortions. New requirements for abortion services to provide post abortion contraception will bring particular challenges as many of the doctors and nurses working in the services are inadequately skilled to provide a comprehensive service.

Workforce strategies need to take account of all these factors.

RECOMMENDATION 3

A workforce development strategy – including a multi-professional workforce plan and training framework – should be agreed as a matter of urgency so that there are a sufficient number of trained staff to provide both contraceptive and abortion services. This should link to development plans to establish a managed clinical network in each locality. Many PCTs need to invest development resources in training and manpower planning as a matter of urgency. PCTs must ensure that, in the current restructuring of PCT provider services, specialist contraceptive services are able not just to survive but to thrive.

Implementation of these three recommendations would deliver a significant improvement in contraceptive and abortion services. All three are essential if these services are truly to have priority status in the immediate future, and realise the potential of the additional investment during 2008/11.
2.4 A more radical option

This is an area where, over the years, women’s safety has been paramount. This has reflected justifiable concerns about the introduction of new methods of service delivery or contraception where, even if the absolute level of risk is very low, were the method to be used by millions of women, there could still be significant numbers of adverse events. Current pathways for contraceptive services are “professionalised”, in line with many western countries, but in contrast with other parts of the world. The need to consult a doctor or nurse may reduce access to a service or may discourage some women from accessing services at all, or from accessing the right services for them, with all the consequences which unwanted pregnancy can bring.

In the light of the current very grave situation, the working group also has a fourth recommendation.

**RECOMMENDATION 4**

If, despite improvements in information, in commissioning, and in workforce development, unwanted pregnancies continue at anything like their present level, more radical options for delivering contraceptive services in a wider range of settings should be considered. In that case, the Government should appoint a national lead (czar) to assess how experience in other countries, based on World Health Organisations standards, to widen access to contraception could be adapted in the UK, especially to meet the needs of those women whom present services are most likely to fail.
3 Background

Established in 2003, the Independent Advisory Group on Sexual Health and HIV (IAG) advises Government on the implementation of the National Strategy for Sexual Health and HIV which was published in 2001³. This Strategy established the framework for the delivery of sexual health services and the promotion of sexual health in England. It set the reduction of unintended pregnancy as a priority and proposed three levels for sexual health services, depending on the increasing technical skills and facilities necessary for their provision.

For contraception and abortion these are:

- **Level 1**: Provision of information about contraceptive methods, prescription of oral contraceptives, pregnancy testing; abortion referral
- **Level 2**: Provision of methods requiring advanced technical skills (intrauterine methods and implants)
- **Level 3**: Contraception for women with complex conditions, requiring highly specialised services or those needing outreach services, clinical governance and abortion services

In July 2008, the IAG published a Review of the Strategy⁴ undertaken by MedFASH. This included recommendations for further action, and identified contraceptive services and late abortions as two of the four ‘areas requiring further attention’. The Review highlighted the following actions as priorities within contraceptive and abortion services:

- Improve access to the full range of contraceptive methods and regularly audit services
- Improve professional and public knowledge of the most effective methods of preventing pregnancy (focus on adults as well as teenagers)
- Protect and develop community contraceptive services to ensure their training and clinical governance role and preserve patient choice (but not excluding moves towards integration with STI services)
- Increase availability and uptake of Long Acting Reversible Contraception (LARC)
- Develop a best practice protocol for commissioning abortion services
- Improve access to NHS-funded early medical and surgical abortion and second trimester abortion
- Implement strategies to reduce the number of repeat unwanted pregnancies (by ensuring comprehensive care pathways for providing appropriate contraception as part of pre and post abortion and maternity care)
- Extend locations for abortion services to community settings
- Take a strategic, needs based approach to workforce capacity to ensure the contraceptive provider network meets service requirements.

In recent years there has been a welcome emphasis on encouraging men to be involved in decisions about contraception and on enabling men to use contraceptive services. This has been particularly true about campaigns and services for young people. Since women are the main users of contraception, and as contraceptive and abortion services have a major impact on their lives, this report focuses on how best to meet women’s needs.

³ National Strategy for Sexual Health and HIV, Department of Health, 2001
Because of concerns about high levels of teenage pregnancy, national policy has given priority to young people. In 2007/8 an estimated \( \frac{3}{4} \) of women under 50 were using at least one method of contraception\(^5\). As women manage their fertility on a daily basis for so many years of their lives, this report considers the position for women of all ages. It identifies the vital roles played by contraceptive and abortion services in supporting them to make choices, to reduce their risks of an unplanned and unwanted pregnancy, and to improve their health and wellbeing throughout their reproductive years.

The rising incidence of STIs, especially Chlamydia, has led to public health messages that single out condoms rather than other more effective contraceptive methods. However, while studies show that 1 in 10 sexually active young women may have Chlamydia, between 8 and 9 out of 10 sexually active young women who do not use contraception will become pregnant within a one year\(^6\). While these figures are not strictly comparable they do indicate that it is time to redress the balance and to focus more on contraception.

There are a number of recent policy developments each of which could impact positively on contraceptive and abortion services. These include:

- Lord Darzi’s report, High Quality Care for All\(^7\), which has made sexual health, including contraception and abortion, a priority for the NHS
- Additional funding for contraception of around £27 million for each of 2008/9 and 2009/10 and a further allocation for 2010/11 to improve women’s access to contraception and to help reduce the number of teenage pregnancies, abortions and repeat abortions\(^8\)
- The inclusion of three indicators for contraceptive advice in the new 2009/10 Quality and Outcomes Framework (QOF) for general practice\(^9\)
- The NHS Operating Framework\(^10\) and Contract\(^11\) for 2009/10 which requires PCTs to approve arrangements for abortion services to improve access for women using their services to a full range of contraception, including follow up arrangements for women who do not receive contraceptive advice or treatment at the time of the abortion

In addition, a number of Department of Health initiatives to improve contraceptive and abortion services are currently in place or underway. New guidance on commissioning, based on world class commissioning principles, is being developed. The South West Public Health Observatory, which leads on sexual health, is developing a sexual health balanced scorecard with data profiles for a number of sexual health indicators at local, regional and national level. The first phase of this work, which focuses on indicators relating to young people, will be published in July 2009.

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\(^{8}\) £26.8 Million to improve access to contraception, Department of Health press notice, 6 February 2008


\(^{11}\) Standard Multilateral Contract for Community Services, Gateway reference 11032
At the same time the Government has a continuing commitment to levers for change which include:

- Improving access to and choice in health care
- A continuing focus on clinical quality and patient safety
- Improving primary and community care, and bringing services closer to home
- Developing World Class Commissioning

These policy developments and new levers for change present a window of opportunity for contraceptive and abortion services. However, there are also significant threats. In particular, there is great concern that the requirement for PCT community services to prepare for market testing is putting already vulnerable contraceptive services at risk. Specialist community contraceptive services had 2.5 million visits recorded in 2007/8 and it is estimated that this comprises about 20% of contraceptive provision. Sufficient competence and expertise within both commissioning and service provision are essential to reduce the risk to these services and to realise their current potential.

4 The Economic Argument for Contraception

In 2006, 22% of conceptions ended in abortion. The figure varied from 19% to 37% across the country. It is evident that enabling women to use contraception effectively to reduce the number of unintended and unwanted pregnancies will result in financial savings.

A literature review undertaken by the University of Newcastle found that contraceptive services, in themselves, result in reduced cost and increase benefit overall. A recently published review of the health economics of contraception found that contraceptive provision results in substantial cost savings to healthcare systems and that the potentially high costs of initiation associated with the use of long acting methods should not be a barrier to their availability, as these methods have been demonstrated to be very cost effective.

A number of studies have attempted to quantify the financial savings from investment in contraceptive services. For example, one UK study found that for every £1 spent on contraceptive services, £11 is saved and a recent US study established a ratio of $1 to $4.02 in cost to savings.

The Newcastle researchers assessed the impact of a change from the 2005 profile of contraceptive use to an ideal profile, based on a consensus model of a 27% decrease in the use of combined oral contraceptives and an increase in all other methods, especially the implant by 9% and the IUS by 8%. They found that the annual net saving from switching to this profile would be £102.3 million.

In 2005, the Department of Health published a guide for commissioners and providers on the economics of sexual health, which stated that the average cost of a contraceptive failure was £1,500. In the same year, NICE guidance recommended the use of long acting reversible contraception as cost effective.

The Department of Health’s baseline audit of contraceptive services published in 2007 showed that the average amount spent on community contraceptive services was £11.67 per woman aged 15-49 years. However, this figure masked a range of 18 pence per woman to £102.25 per woman across PCTs. This wide variation suggests that many PCTs could not only improve the lives of women but could save significantly by investing in their contraceptive services.

14 Armstrong N and Donaldson C, The Economics of Sexual Health, London fpa, 2005
16 McGuire A and Hughes D, The Economics of Family Planning Services, Contraceptive Alliance, 1995
17 Frost J, Finer, Tapalas A, The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings, Guttmacher Institute, 2009
18 National Institute for Health and Clinical Excellence - Long acting reversible contraception: the effective and appropriate use of long-acting reversible contraception, 2005
5 Achieving Good Contraceptive and Abortion Services

5.1 The goal

The goal of contraceptive and abortion services is to support women in determining whether to have children, and, if so, when to have them and how many to have, thereby supporting women and men to have happy and fulfilling relationships.

5.2 Strategic commissioning

A fundamental requirement for good contraceptive and abortion services is a strategic framework for the development of comprehensive services across the PCT. This will ensure adherence to the principles of world class commissioning and engage providers and the public to develop an advertised, accessible, comprehensive, holistic, high quality and robust service with integrated care pathways which reflect and meet the needs of the local communities. For some more specialist services, such as those providing second trimester abortions up to the legal time limit, PCTs should consider forming commissioning consortia.

The local commissioning plan should ensure that the commissioning of contraceptive and abortion services links to and supports the delivery of the teenage pregnancy strategy and the Chlamydia screening programme, reflects NICE guidance on the provision of LARC\(^{20}\) and includes links to other sexual health services. A lead commissioner should have responsibility for implementation of the strategy. PCTs need to be committed to change and ensure that their plans are matched by adequate resources.

Appropriate commissioning mechanisms are essential. Currently, community contraceptive clinics are mostly commissioned on a block contract which is usually based on historic cost. PCTs should work with their local providers to develop and agree a set of tariffs to cover the different areas of work that are undertaken, reflecting both complexity and diversity and using the learning from the Payment By Results pilot currently in progress in Portsmouth.

In using the new community services contract to commission abortion services, PCTs should ensure that it is underpinned by a specific abortion service specification which is precise about the nature and quality of the service\(^ {21}\).

5.3 Data required for the development of the strategic framework and for performance management

PCTs will only be able to develop an effective commissioning framework if they have a comprehensive analysis of local needs and the current service map, including:

- Number of women aged 15-49, with a picture of the characteristics of the local community including indices of fertility, population diversity, and indicators of deprivation.
- Service marketing and advertising

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20 NICE clinical guideline no 30, 2005
21 The London Sexual Health Programme has produced commissioning guidelines for abortion services and these can be obtained from simon.mercer@londonscg.nhs.uk

14 • The Time is Now
• Existing contraceptive services (including signposting and all 3 levels of NHS provision) – community clinic locations and opening times, general practice provision, specialist outreach services, provision by the voluntary sector and in other health providers (e.g. GUM, abortion, maternity, health visiting, and school nursing services) – for all contraceptives, including IUD/S and implants
• Current usage of contraceptive methods from clinic returns and GP prescribing data, hospital data, commissioned outsourced services data, e.g. abortion care and NGOs
• Clinical capacity for level 2 contraceptive (and LARC) provision; map number of trained doctors and nurses in acute and community services and general practice
• Mapping of locations for access to abortion and whether open access or restricted to registered with practice, monitoring of abortion contract for waiting times, contraceptive provision (specifically LARC), sexual health screening/ treating/ partner notification/ referral on to GUM services, counselling provision as per contract
• The percentage of abortions funded by the PCT, specifying the numbers taking place before 13 weeks and before 10 weeks
• Staffing profiles across all providers - numbers of doctors (including GPs), clinic and practice nurses, midwives, health visitors and other workers and their qualifications
• Quality of premises and their suitability for a convenient and modern service
• Availability of appropriate IT equipment for booking appointments and collecting performance information
• Quantity of emergency hormonal contraception being provided by pharmacies, general practice and community clinics, school nurses and other health care professionals, A&E, and Walk-in Centres
• Numbers of emergency IUDs fitted and existence of a network for emergency IUDs
• Information about what services users think about current provision and their views about how the services could be improved
• Mapping of service provision in relationship to local indicators of need such as deprivation

In addition the PCT should review and assess:
• The existence of guidelines and pathways common to all providing members of the local managed network and use evidenced through audit and education
• The extent to which service users/clients and the community more widely are engaged in service review and planning

A project commissioned by the London Sexual Health Programme on behalf of the London PCTs, funded by the Department of Health and coordinated by MedFASH22 (the London Project) assessed needs and mapped services across London. It provides a model of what can be achieved even with present imperfect information systems. All PCTs should analyse their local data using the Design Options ‘How To’ Guide to sexual health needs assessment to review their own services and to compare their performance with similar PCTs23.

5.4 Partnership with providers

Data are necessary but not sufficient for effective commissioning. PCTs will also need to work with their providers to support the development of local managed networks, with guidelines and pathways, thus using the data to support a dialogue which will catalyse or enhance local service improvements.

22 MedFASH - London sexual health needs assessment and service mapping, November 2008
http://www.medfash.org.uk/publications/current.html
The new Quality and Outcomes Framework\textsuperscript{24} rewards general practitioners for providing information about LARC to all women consulting about contraception. This provides a significant opportunity for partnership between general practice and specialist contraceptive providers to ensure that the information being given about the different methods and where they are available is comprehensive and up to date. There is initial evidence that in areas where this partnership is occurring, GPs find it very helpful and report an increase in the uptake of LARC. PCTs should ensure such collaboration takes place.

\section*{5.5 The qualities of good contraceptive and abortion services}

Women need \textit{easy access to effective contraceptive services} from puberty until the menopause. No method of contraception is 100\% effective and, however good contraceptive services are, some women will continue to need \textit{timely access to high quality abortion services}. Post-menopausal women also need access to advice about sex and sexual health but their needs are often not recognised anywhere in the system.

\textbf{Information must be communicated effectively} to ensure that women understand the range of contraceptive methods available, and where they can obtain advice and access to their chosen method. This requires national information helplines and websites, complemented by local information which also provides details about what services are provided where, and what to do if there are any problems.

Women should be able to obtain their chosen method without difficulty, including the IUD for emergency contraception. All women using \textit{emergency hormonal contraception} should receive information about its \textit{effectiveness compared with other contraception}. They should also be given information and advice about \textit{regular contraception}.

Women should have \textit{open and timely access to abortion services}. They should be able to self-refer and there should not be any local eligibility criteria which restrict access to NHS abortions. Clinical guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) recommends that the period from first consultation to abortion should not be longer than three weeks\textsuperscript{25}. Women who pay for an abortion in the independent sector, typically have the procedure within three to seven days and women treated by the NHS should expect no less\textsuperscript{26}.

Women should have a choice of early medical and early surgical abortions at easily accessible locations. There should be urgent provision for women with complex medical conditions. Women who seek second trimester abortions should also receive speedy and sympathetic referral so that they can obtain an abortion as soon as possible.

There should be an integrated care pathway for pre- and post abortion care within which contraception and sexual health is integral and tailored to the individual’s specific needs. \textbf{Women should be offered and provided with the contraceptive of their choice at the time of the abortion procedure}, if not before. This should include the provision of an interim effective method for those who cannot have their chosen method immediately e.g. intrauterine contraception after medical abortion.

Contraceptive and abortion services should always be provided in a \textit{confidential and empathetic setting, and in a non-judgmental style}. The services should be provided in \textit{convenient locations} by a team of health and other \textit{professionals} who are qualified to practise in this demanding area of health care, and whose practice is regularly appraised. \textbf{The voluntary sector and local authority community services} should be recognised as key partners in providing accessible services and maximising sensitivity to local needs.

\begin{flushright}
\textsuperscript{25} The Care of Women Requesting Induced Abortion Evidence-based Clinical Guideline Number 7, September 2004 http://www.rcog.org.uk/resources/public/pdf/induced_abortionfull.pdf
\textsuperscript{26} Early abortion: promoting real choice for women, fpa 2003
\end{flushright}
Services should be open access and self-referring and there should be women only sessions for those women who prefer them, whatever the reason for this preference. Where the woman wishes to use a method of contraception which is not immediately available in the service she has attended, there must be clear, straightforward and speedy referral routes to suitable alternative services.

Women’s needs will change through their reproductive years, and services must be capable of meeting evolving contraceptive and associated needs, ensuring that women can also receive advice, diagnosis and treatment for co-existing and related conditions.

In many places abortion and contraceptive services have developed entirely separately. This seldom results in an effective network of services. PCTs need to tackle this by actively commissioning and performance managing a network of contraceptive and abortion services across primary and specialist care which reflect the assessed needs of their local communities.

5.6 Quality standards

The strategic framework should identify the capacity required to meet the contraceptive needs of the local population of women in the 15-49 age range. It should assume that there is a significant unmet need for LARC and determine the advertising, access, workforce, training and budget required to overcome this deficit.

It should also ensure that the NHS funds a minimum of 95% of abortions from within the PCT unless there is evidence that more than 5% of women wish to pay for their abortions. Every PCT should achieve at least the percentage of abortions that take place before 10 weeks gestation which are currently achieved by the top quartile of PCTs. Meanwhile, as an absolute minimum services should meet the RCOG guidelines27, moving over time from the minimum to the ideal standards.

The RCOG standards are predominantly about access and say very little about the quality of care which each woman receives. This is an area in which the professional bodies should take a stronger lead. At the same time PCTs should establish and monitor local quality standards, and work within their patient and public engagement programmes to understand better where local services work well and where service improvement is needed.

It is essential that women who use services are asked for feedback and that their views are taken into account in the development and monitoring of services. Ways should be found to reach those clients who have greatest difficulty in accessing services, to obtain their views. In carrying out these consultations it will be necessary to provide clients/potential clients with information about the full range of contraceptive methods and of abortion methods and the range of providers, locations and times where the different levels of services can be accessed and provided.

5.7 Continuing to improve and innovate

Good services recognise the urgent need to avoid simply sustaining or marginally improving an unsatisfactory status quo by finding new ways of tackling old problems.

Research, innovation, different ways of thinking and the ability to share and adopt successful practice rapidly are all essential if services are to make the significant leap forward required to improve outcomes for their populations.

27 The Care of Women Requesting Induced Abortion Evidence-based Clinical Guideline Number 7, September 2004
The King’s Fund has identified that despite the potential benefits of technology, its adoption within the health care sector is slow and disparate\(^28\). The private sector has shown the possibilities of utilising the internet to access services. The vast majority of women requiring contraceptive and abortion care are fit and healthy, and are not only capable of but indeed wish to take a greater degree of personal responsibility for their sexual health. Such opportunities must be created and grasped quickly if any significant impact is to be made to benefit the current generation of service users.

5.8 The skilled multi-professional team

An adequate and competent workforce is an essential prerequisite for the delivery of high quality and continuously improving patient centred care. All health and non-healthcare professionals, whether in the NHS or independent sector, working in contraceptive and abortion services should be trained and regularly appraised, and have access to updating to a level which enables them to perform well in their role.

There has been no Government analysis of current and future workforce requirements, and no systematic assessment of skill mix options, including the balance of roles between medical, nursing and other staff. There is no workforce plan or training framework for these priority services and these should be developed.

Commissioners should require and fund training capacity and capability to be a core element of the services they commission. This training should be quality assured to recognised national standards.

Nurse training should be grasped as the most urgent specific priority. Action is needed at both national and local level. The Royal College of Nursing has developed competencies for nurse training\(^29\) but these have not been adopted by all providers of training courses nor is there an overall framework to support a systematic approach to training. Nationally agreed core competencies and a curriculum together with suitable training placements are urgently needed to ensure that there are the required numbers of trained nurses. The workforce plan and training framework must include nurses in primary care as well as those working in specialist services.

Strong clinical leadership should be provided by a lead consultant in sexual and reproductive health and as a minimum there should be at least one lead consultant in each PCT. The Faculty of Sexual and Reproductive Healthcare national recommendation, which has been accepted by the Department of Health, is one consultant per 125,000 population. Steps are being taken to address the current workforce shortage. The formation of the specialty of Sexual and Reproductive Health which has been approved in principle, and the consequent Certificate of Completion of Training in Sexual and Reproductive Health, will have a significant impact.

Working with the consultant, there also needs to be a senior nurse to ensure robust systems for clinical governance, especially training, to support commissioning, and to lead a network of services across the PCT which includes all the elements in the three levels of contraceptive and abortion care described in the National Strategy for Sexual Health and HIV. The team will need an effective Business Manager. It is also vital that health promotion is integrated into all the services.

The system of clinical governance should cover all contraceptive providers within the PCT, such as those in general practice, community clinics, independent/charity providers, pharmacists, youth services, integrated sexual health services and GUM services. Working across different settings should be encouraged; general practitioners and practice nurses who have the appropriate qualifications should work in community clinics and community clinic staff provide support in general practice.

28 Liddell A, Adshead S and Burgess E, Technology in the NHS: transforming the patients’ experience of care, King’s Fund, 2008
29 www.rcn.org.uk
5.9 Service configurations

Services should be accessible by public transport and located in a range of clinical and non-clinical settings including static and itinerant community clinics, such as ‘clinic in a box’, general practice, school and college based health services, youth services and resource centres. Outreach services should be available for clients who for whatever reason find it difficult to attend mainstream services. Clinics should provide a mix of walk-in and by appointment sessions at times that are known to be convenient for users.

Specialist community services are going through further organisational change with the move to Autonomous Provider Organisations. As part of this change, PCTs should take the opportunity to establish a managed local network for contraceptive and abortion services to prevent specialist services being put under further strain as they cope with continuing uncertainties and potential destabilisation and to strengthen the quality of services available. PCTs must act to minimise counterproductive disruption, and ensure that a network of effective services, spanning current and future organisational boundaries is established as soon as possible, with robust network leadership in place.

Polyclinics and GP led-health centres have enormous potential as locations for accessible services. PCTs should also consider how they might provide early medical and early surgical abortions as part of community provision to reduce the need for women to travel and to increase the links between contraceptive providers and abortion providers.

Pharmacies are a much under-used resource for contraception. PCTs should consider introducing patient group directions to issue repeat provision of both contraceptive pills and patches. The pharmacy staff should share a common training and updating programme with other providers of the same care within the network. The quality of their sexual health services, including the provision of EHC and referral to services for emergency IUDs and continuing contraception, should be performance managed by commissioners as with any contracted service.

5.10 Local information

All parts of the service should provide information about the full range of emergency, reversible and permanent contraceptive methods, and have up to date information to signpost women to their method of choice. Similar information must also be available for abortion care. The services should be supported by specialist health promotion and multimedia campaigns to publicise services in the local area e.g. through local newspapers, local radio and service website and the distribution of leaflets and posters to local authority outlets, children’s centres, secondary and higher education, pharmacies, the voluntary sector, and health services which women use. Transport systems are also an excellent place to advertise services.

The PCT should provide information on its website and in its annual information booklet to local households about the contraceptive services available from each provider, but especially those in general practice, so that women know exactly what they can expect from their practice. This information should be included in practice leaflets. Local information should also cover access to pregnancy testing, and where to go for abortion advice and access, including which, if any, GPs do not make abortion referrals and where their patients can go instead. It also needs to clarify the arrangements for women who would prefer not to see their own GP, those who are not currently registered, and those who are not entitled to NHS non-emergency hospital care.

Voluntary organisations and the independent sectors are greatly underutilised as a source of information and basic service provision. Their role should be enhanced within community-based services supported by pathways, protocols and guidelines, clinical governance systems and training.
6 A Broken Service

In many areas contraceptive and abortion services are piecemeal and uncoordinated. Currently, community health services are being formed into Autonomous Provider Organisation and prepared for market testing. These services include the majority of specialist community contraceptive services and in many areas the organisational changes are putting them in serious jeopardy. The London Project\textsuperscript{30} indicated very significant variations in the funding, commissioning and provision of contraceptive and abortion services. This should alert SHAs to use their performance management framework to support PCTs in strengthening the commissioning and delivery of local contraceptive and abortion services.

Many services lack effective clinical champions and few PCTs have accorded priority to the commissioning and performance management of these services. Commissioning is further compromised by the fact that the evidence base about women’s needs is patchy, with very variable community engagement in service planning and improvement. In line with Government policy, the additional investment provided by the Government through PCTs and SHAs during 2008/09 is not ring-fenced and it is difficult to track how it is being spent and to assess its impact in improving contraceptive services.

Research evidence on women’s preference about contraceptive methods or about the contraceptive services available to them is sadly lacking. However, since NICE published guidance on the provision of LARC\textsuperscript{31}, there has been some increase in their usage to 23% in 2007/08 compared with 18% in 2003/04\textsuperscript{32} and this suggests that there is a significant unmet demand for these methods. From 2001, women have been able to buy emergency hormonal contraception in community pharmacies, and today they are the main source of this method. This provision has greatly increased access but it is not known whether women actually prefer to pay £25 or whether difficulty in accessing free NHS provision is forcing them to do so.

National and local policies have placed great emphasis on increasing awareness and availability of emergency hormonal contraception and women generally are aware that it can be used up to 3 days after unprotected sex. However they are less likely to know that its effectiveness falls from 95% if taken within 24 hours to 58% if taken after 48 hours. They are even more unlikely to know that the IUD can be used for emergency contraception for up to five days after unprotected sex and that it is 99% effective.

Information about the range of contraceptive services and where to find them is very variable. When women do access services, they may not be offered the full range of options, or the accompanying information which they need to make an informed choice. They may only receive a fragment of the services they require, such as emergency hormonal contraception, unaccompanied by a continuing method of contraception, or an abortion without contraceptive advice. About a third of women who had an abortion in 2008 had had one or more previous abortions. The huge range across PCTs from 11% to 35%\textsuperscript{33} implies a significant variation in the competence of local services in providing effective contraceptive advice and supply as part of abortion care. Indeed, many opportunities are missed to support women to use the method of contraception which best meets their current needs, and to provide the other associated services which can promote health and well being.

\textsuperscript{32} The Information Centre: NHS Contraceptive Services in England 2007-08, op cit
Sustained attacks by anti-abortion campaigners on the provision of legal abortion in this country have meant that abortion is frequently characterised as a highly contentious and sensitive issue moral issue and the health needs of women are neglected as a consequence. This stigmatisation of abortion has led to the marginalisation of services and created an environment in which myths about abortion and the women who seek abortion can flourish.

The National Strategy for Sexual Health and HIV provided a welcome impetus for improving abortion services. Timely access to NHS funded abortion services has improved markedly in recent years, but there are still considerable variations across the country. There are particular problems for many women in obtaining a second trimester NHS abortion.

In 2008, 91% of all abortions in England were NHS funded. In 2008, although 73% of NHS abortions took place under 10 weeks gestation, this rate varied from 85% to 47% across PCTs, indicating variations in waiting times across the country.

There is little information about the extent to which women are involved in determining the method of their abortion. In 2008, 38% of abortions were medical abortions. The proportion of medical abortions has more than doubled in the last 5 years but it is not known whether this is by choice or because that is the only option offered. Information is also lacking on whether early surgical abortions are performed using general anaesthetic, local anaesthetic, or conscious sedation, and to what extent women are informed so they can express their preferences.

In many areas, PCTs commission abortion services from providers who are outside their geographical area. This means that many women have to travel significant distances to have their abortion. Women who have difficulty in obtaining time off from work or have childcare issues and young women who are still at school may find this very problematic. Maintaining secrecy is difficult. It may also affect the choice of method because of the number of visits involved. Distances are often greatest for later abortion provision, which is of considerable concern because many of these women are particularly vulnerable. Travelling to another area excludes locally networked provision of counselling, support and contraceptive services.

### 6.1 Teenage pregnancy strategy and contraception

The Teenage Pregnancy Strategy was published in 1999 with twin aims: to reduce the level of under 18 conceptions by 50% by 2010 from the 1998 baseline figures and to reduce the social exclusion of young parents.

Conception data for 2007 showed a 10.7% decrease in conceptions compared to the 1998 baseline, but there is a wide variation across the country. Some areas have had significantly higher decreases, and some areas have seen static or increasing rates. The proportion of young women choosing an abortion has increased significantly, and the number of births has decreased by nearly 25%. This demonstrates clearly that young women are not receiving the contraceptive education, advice and services they need to avoid unwanted pregnancies and shows that greater efforts need to be made to motivate and encourage young women to access services.

The research that underpinned the Strategy showed that young people experienced a culture in which sex was all pervading but discussion of contraception was taboo. An information and media campaign aimed at young people and improved Sex and Relationships Education (SRE) in schools were identified as key weapons to change this...
situation. The Strategy also stressed the importance of the impact of gender relations on the sexual experiences, relationships and contraceptive usage of young people and of engaging young men in discussion about choice, control, rights and responsibilities.

Research carried out in for the Teenage Pregnancy Unit in 2007 by Define showed that many young people:

- Still don’t understand what contraception is and how it works
- Don’t want to access contraception because it looks as though are planning to have sex
- Don’t want to access contraception because they want to disassociate themselves from sex – they don’t want to think about what they are doing.

Despite the emphasis in the Strategy on improving SRE, in 2007 the Youth Parliament’s survey of over 20,000 young people showed significant dissatisfaction with current programmes\textsuperscript{37}. In response, the Department for Children, Families and Schools announced that Personal, Social and Health Education, including SRE, would be made statutory. How this decision is to be implemented is currently under consideration.

Research has also shown that young people have great concern about confidentiality\textsuperscript{38}. The requirement of some local safeguarding children’s boards for the mandatory reporting of sexual activity by under 13s has further confused the messages for both professionals and young people about the confidentiality of services.

Improving understanding of and access to contraception in school, mainstream and specialist services remains a significant challenge. Many PCTs do not provide services which are open in convenient locations for adequate periods of time and this lack of investment creates significant barriers to young people wishing to access services. However, encouragingly PCTs are beginning to include the You’re Welcome quality framework when placing contracts for young people’s services\textsuperscript{39} and a proportion of the additional funding for contraception from the Department of Health has been allocated to developing and delivering contraceptive services in colleges.

\textsuperscript{37} Youth Parliament, SRE – Are you getting it? 2007
\textsuperscript{38} Brook, Wise Up! Survey findings, 2005
\textsuperscript{39} http://www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH_4121562
7 Conclusions

As well as the four recommendations outlined in Section 2 of this report, the working group has reviewed the provision of contraceptive and abortion services against the findings of the review of the National Strategy for Sexual Health and HIV published in 2008.40

Five overarching priorities for contraceptive and abortion services were identified by the report. The working group has highlighted some themes within each of the five priorities which are of particular importance:

7.1 Prioritise sexual health as a public health issue and sustain high level leadership at local, regional and national levels

- Look imaginatively at the evidence and extend access for all women through a range of interventions, including advertising the service nationally, signposting the service locally, and offering a wider choice for women.
- Ensure that specialist contraceptive services are strengthened not further weakened in current organisational change within PCTs
- Use the opportunity of this change to establish a local managed clinical network

7.2 Build strategic partnerships

- Achieve local managed clinical network with guidelines, pathways, audit and education, and a strong clinical input to commissioning
- Deliver training across primary care and specialist services
- Work better together with staff working across services

7.3 Commission for improved sexual health

- Use all available levers including the Operating Framework 2009/10 and the new QOF
- Establish high quality commissioning based on needs assessment and best practice, informed by clinical leadership
- Develop a strong interface with managed clinical networks so that clinical and organisational expertise informs commissioning
- Strengthen joint commissioning including local authority involvement
- Continue to drive up the quality of the current portfolio of services
- Agree workforce plan and training framework to underpin commissioning

40 MedFASH Progress and priorities: Working together for high quality sexual health services, July 2008
http://www.medfash.org.uk/publications/documents/Progress_and_priorities_working_together_for_high%20qualitysexual_ health_FULL_REPORT.pdf
7.4 Invest in prevention

- All contraceptive and abortion services are about prevention.
- Enhance the prevention focus within key areas e.g. abortion and maternity services to prevent subsequent unwanted and unplanned pregnancy
- Design and deliver specialist sexual health promotion to meet the identified needs of each sub-group within the local population e.g. using a social marketing approach

7.5 Deliver modern sexual health services

- Ensure integrated pathways across primary and specialist services including independent providers where relevant with clinical guidelines and pathways, underpinned by clinical audit and education
- Link with STI services to ensure an integrated approach
- Test different ways of working and invent new ways
- Improve the information base, and invest in research including qualitative research
- When changes are effective, find out why, if this is not obvious, and spread the word effectively

It is imperative that SHAs and PCTs recognise that indeed the Time is Now. They should use the strategic approach offered by this report as a starting point to review their contraceptive and abortion services and take the significant opportunity of additional funding to provide the world class contraceptive and abortion services that women have a right to expect.
Appendices
Appendix 1

Contraceptive and Abortion Services Today

Provision of information

It is striking that, with the exception of the Teenage Pregnancy Strategy, Government sexual health awareness-raising campaigns have ignored contraception and abortion. Voluntary organisations such as fpa focus on contraception and abortion with campaigns such as Contraceptive Awareness Week. These campaigns reach a broad audience but are of short duration due to limited funding. Much more is needed. The Department of Health’s plans for social marketing campaigns to raise awareness of contraception options are very welcome. It is vital that these are aimed at all women and not just young women and that they are sustained in the future. Otherwise their effectiveness is likely to be very limited.

Signposting

Few PCTs have developed effective signposting to local services and currently it falls to the voluntary sector to bridge this gap. fpa and Brook have websites and telephone helplines to give the location and opening times of community clinics and are used by hundreds of thousands of people each year.

The not-for-profit abortion services advertise their services but have to contend with the anti-abortion messages of the anti-abortion lobby.

Information about methods of contraception and abortion

Sexual Health Direct, run by fpa and funded by the Department of Health, provides authoritative information on all methods of contraception, abortion and sexually transmitted infections. Clinical guidance specifies that fpa’s contraception leaflets should be provided to women as part of the consultation with a professional but many PCTs do not have adequate distribution systems to ensure that the leaflets reach all professionals who provide contraceptive advice.

Service provision

Contraception is provided within the NHS from general practices, in specialist, community-based contraceptive clinics and their outreach services, and in those sexual health services which bring together the diagnosis and treatment of sexually transmitted infections (STIs) with contraceptive provision. Some PCTs have contracts with Brook for provision of services for young people, and with other voluntary organisations to provide for women whose needs are not met well by mainstream services.

Specialist contraceptive services

In addition to contraceptive advice, specialist community clinics may provide some gynaecological services, as well as health advice appropriate for each woman’s age and life stage. Needs evolve through the childbearing years, and services must respond. For example, for younger women the focus also includes Chlamydia screening and the management of other STIs. For older women, approaching and going through the menopause, services can provide tailored information and care, as well as continuing to ensure effective contraception and access to cervical cytology.

The availability of these specialist services is very variable across the country. Whilst this has obvious implications for the quality and range of the clinical service provided, it also has more subtle effects. For example, the clinicians who work in these services should play a crucial role in advocating on behalf of contraceptive and abortion services, in promoting innovation and service improvement and in training. Almost all post-graduate medical clinical training and nurse training attachments in contraceptive care are delivered in specialist community clinics. Where services are weak, training and the subsequent maintenance of up-to-date clinical skills will be compromised.

Services in general practice

An estimated 80% of all NHS contraceptive care is provided from general practice (GP). Whilst some general practices provide excellent contraceptive advice and offer a choice of suitable methods, analysis of prescribing data shows some very significant differences in the range of methods and rate of contraceptive provision between practices. Provision of Level 1 contraceptive methods (oral contraceptives, barrier methods and the LARC injectable contraceptive) forms part of the GP contract. There is very little or no routine oversight, quality measurement or performance management of this high-volume work that is key to current access to contraception for so many women.


• The Time is Now
GP and practice nurses are not required to have a family planning qualification before giving contraceptive advice, and some practices have no-one trained to provide Level 2 contraceptive methods.

PCTs can commission enhanced services from General Practice for the provision of LARC methods and a number of them do so. However, they do not always build monitoring and audit into the contract.

Traditionally access to NHS funded abortion services has been via the GP. This can work well, although a minority of GPs may delay or block referral. In addition there are women who prefer not to consult their own GP, and others may not be registered at all and for these women access through specialist community contraceptive services can be important. Both the fpa and Brook helplines receive many calls from women who experience difficulty in getting a referral. Many young women report being received with hostile and negative comments when they seek help.

Some PCTs commission locally enhanced services (LES) for the provision of the Level 2 contraceptive methods, the intrauterine and implant LARCs, from specific practices in their area. This leaves many hundreds of thousands of women registered with practices that do not offer these methods. In many areas PCTs have been slow to introduce monitoring of the LES, so the quality of these services may again be variable. Where a practice is not able to provide the Level 2 LARC methods directly, they should always be able to give basic information for choice of these methods and refer women on to another service. This will necessitate robust local pathways.

Other contraceptive provision

Some PCTs run condom schemes which enable young people to obtain condoms from a range of community settings, including pharmacies and recently, Lambeth and Southwark PCTs have commissioned local pharmacists to provide the contraceptive pill to women in their areas.

Emergency contraception

Emergency hormonal contraception (EHC) is available free of charge at community contraceptive clinics, GUM clinics, from GPs, walk in centres and some accident and emergency departments. In some areas, the PCTs support patient group directions, which enable pharmacists to provide free EHC to some defined groups.

Although there is a detailed protocol for pharmacists selling EHC\(^42\), there has not been any audit of the quality of advice being given, or any analysis of which women use this service. While studies show that women welcome increased availability of EHC in pharmacies, they express concerns about the adequacy of information provided about future use of contraception and STI risks and management\(^44\).

The RPSGB is producing a toolkit to support sexual health provision in pharmacy\(^45\).

There is further concern that women may not be advised about the importance of continuing contraception, nor given information about where they can access the full range of methods to reduce their risks of an unintended pregnancy or an STI.

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42 Royal Pharmaceutical Society of Great Britain, Practice guidance on the supply of emergency hormonal contraception as a pharmacy medicine 2004 http://www.rpsgb.org/pdfs/ehcguid.pdf
44 Anderson C and Blenkinsop A, Community pharmacy supply of emergency hormonal contraception: a structured literature review of international evidence, Human Reproduction 21 (1) 2006 pp 272-284
45 Royal Pharmaceutical Society of Great Britain, A toolkit to support the integration of pharmacy into care pathways for sexual and reproductive health (2009)
Appendix 2

The current state of commissioning

The Department of Health baseline review\textsuperscript{46} and a survey by the All Party Parliamentary Pro-Choice and Sexual Health Group\textsuperscript{47} demonstrate that few PCTs have an evidence-based strategy for ensuring choice and quality in contraceptive and abortion services.

PCTs generally have not undertaken a systematic review of local contraceptive and abortion services, including analysing the prescribing data for GPs in their area, nor assessed local needs. Many community contraceptive clinics only have manual records and are therefore unable to produce a detailed analysis of the services they provide. Often, the budgets for the two services are separated, as are the responsibilities for commissioning. The position is further complicated by the differing national arrangements for contracts across contraceptive and abortion services which include block contracts, payment by results, and national and local enhanced services for general practice. The result is often piecemeal development resulting in fragmented services, with weak clinical governance arrangements, and a failure to respond to women’s needs and preferences.

There are no nationally binding quality standards for contraceptive services, although the Department of Health did commission MedFASH to develop a set of standards for sexual health services which were published in 2005\textsuperscript{48}. National standards developed by the Faculty Sexual and Reproductive Health Care for contraceptive services are available on the Faculty website, www.frsh.org. These set out the minimum that should be provided and also give the desirable standards to which services should aspire.

The RCOG guideline in 2004\textsuperscript{49} included standards for timely access to abortion
\begin{itemize}
\item Assessment appointment within 5 days of referral (10 days would be the minimum standard)
\item Abortion within 7 days of the decision (14 days would be the minimum standard)
\item Fast track system for women with medical problems
\end{itemize}

However, there is little evidence that local services are performance managed against these standards by either PCTs or SHAs. The systems of clinical governance for contraceptive and abortion services are generally weak, compounded by an absence of local professional networks to support the development of good clinical practice, effective teaching and training, and vital innovation and research.

\textsuperscript{46} Findings of the Baseline Review of Contraceptive Services in England May 2007
\texttt{http://www.dh.gov.uk/en/Publicationsandstatistics/publications/publicationspolicyandguidance/dh_074727}
\textsuperscript{47} A Report into the Delivery of Sexual Health Services in General Practice: A Survey by the All Party Parliamentary Pro-Choice and Sexual Health Group, APPG 2007
\textsuperscript{48} Recommended standards for sexual health services, MedFASH, 2005
\texttt{http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4106273}
\textsuperscript{49} The Care of Women Requesting Induced Abortion Evidence-based Clinical Guideline Number 7, September 2004
\texttt{http://www.rcog.org.uk/resources/public/pdf/induced_abortionfull.pdf}
Appendix 3
The workforce

There are serious concerns about training and workforce development. In contraceptive services there are particular issues as specialist community services, where most training takes place, are under great pressure. Training places are therefore insufficient. This affects not only training for specialist providers but also for GPs and practice nurses and the potential for increasing the provision of LARC. Contracts with not-for-profit contraception and abortion providers rarely include a training element thus putting at risk a sustainable skilled workforce for the future.

Each member of staff should also have an annual appraisal, to ensure that good practice is recognised and that a personal development programme is agreed.

Robust local specialist services will be essential to meeting both pre-qualification and continuing educational requirements, for those working in primary care (in particular, GPs and practice nurses) as well as staff within specialist services.

Medical staff

Specialist training for consultant medical staff is overseen by the Faculty of Sexual and Reproductive Healthcare (FSRH) of the RCOG which sets and maintains the standards for specialist practice. Currently, the Certificate of Completion of Training (CCT) requires membership of both the RCOG and the FSRH. Work is in progress to establish sexual and reproductive medicine as a full specialty rather than a sub-speciality and when this is completed, only membership of the FSRH will be required.

In addition the FSRH also offers a Diploma, which provides comprehensive training for doctors working in Level 1 services. Additional competencies in intra-uterine techniques and subdermal implants are recognised by a letter of competence which is awarded to diplomats who have undertaken further training. Those who wish to train other staff need to achieve a training qualification, such as the Faculty letter of competence in medical education.

The Department of Health, Royal College of General Practitioners and the College of Pharmacists have produced guidance on Practitioners with a Special Interest in Sexual Health which can support the development of a larger skilled workforce.

Nursing staff

Since the English National Board of Nursing, Midwifery and Health Visiting and the other UK country equivalents were disbanded, there has been no national accreditation of nurse training. Training is delivered through local universities but without a consistent curriculum and an adopted competency framework, despite the efforts of both the Royal College of Nursing and the FSRH. This means that the content and competencies of a qualification obtained from one university are not necessarily the same as in another.

This presents significant problems for nurses wishing to train in contraception and abortion. In addition to the wide variations in course content, there is also a comprehensive lack of financial support, suitable training placements and trainers.

The problem has been recognised by the Department of Health, although there seems to be little progress to date. Meanwhile, there are continuing shortages of competent nurses in many parts of the country. In the absence of a multi-professional workforce plan it is impossible to develop extended nurse roles – an approach which has proved successful in improving many other health services.

All staff

All staff working in settings where advice is given about contraception and abortion should be adequately trained. They should at least be familiar with sources of information about what is available, and be competent and confident to answer questions and ensure that clients are able to access a service which can meet their needs. Receptionists and administrative staff can have a significant impact on access services and need to be sensitive to users’ needs.

Both workforce planning and training packages should recognise the potential role which pharmacists could play as members of the multidisciplinary team and clinical network, as long as pharmacy services can be connected to the full range of contraceptive services.


Achieving World Class Contraceptive and Abortion Services • 29
Appendix 4
Terms of reference and membership

Terms of reference

• The provision of contraception and abortion services in England
• The range of services provided and their cost effectiveness
• The choice of contraceptive and abortion methods available to women
• The current funding arrangements for these and proposals for the future

Members

Chair
Anne Weyman, OBE Vice-Chair Independent Advisory Group (IAG) on Sexual Health and HIV

Members
Dr Sheila Adam, Public health specialist
Julie Bentley, Chief executive, fpa, and member of IAG on Sexual Health and HIV
Gill Frances OBE, Chair, Teenage Pregnancy Independent Advisory Group
Dr Kate Guthrie, Consultant in Sexual and Reproductive Health, The Sexual and Reproductive Healthcare Partnership, NHS Hull and member of IAG on Sexual Health and HIV
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Jane Hughes, Chief executive, Brook Oldham
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Dr Christine Robinson, Consultant in sexual and reproductive medicine, South East London, and President, Faculty of Sexual and Reproductive Healthcare
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