4-year surveillance (2016)

Patient experience in adult NHS services (2012) NICE guideline CG138

Appendix A: Summary of new evidence from surveillance

Knowing the patient as an individual

Recommendations derived from this area

1.1.1 Develop an understanding of the patient as an individual, including how the condition affects the person, and how the person's circumstances and experiences affect their condition and treatment.

1.1.2 Ensure that factors such as physical or learning disabilities, sight, speech or hearing problems and difficulties with reading, understanding or speaking English are addressed so that the patient is able to participate as fully as possible in consultations and care.[1][QS]

1.1.3 Ask the patient about and take into account any factors, such as their domestic, social and work situation and their previous experience of healthcare, that may:

- impact on their health condition and/or

- affect their ability or willingness to engage with healthcare services and/or

- affect their ability to manage their own care and make decisions about self-management and lifestyle choices.

1.1.4 Listen to and address any health beliefs, concerns and preferences that the patient has, and be aware that these affect how and whether they engage with treatment. Respect their views and offer support if needed to help them engage effectively with healthcare services and participate in self-management as appropriate.[1][QS]

1.1.5 Avoid making assumptions about the patient based on their appearance or other personal characteristics.[1]

1.1.6 Take into account the requirements of the Equality Act 2010 and make sure services are equally accessible to, and supportive of, all people using adult NHS services.

1.1.7 If appropriate, discuss with the patient their need for psychological, social, spiritual and/or financial support. Offer support and information to the patient and/or direct them to sources of support and information. Review their circumstances and need for support regularly.[1]

[1] **This recommendation is adapted from a previously published NICE clinical guideline – see appendix B for details.**

Surveillance decision

No new information was identified at any surveillance review.

Essential requirements of care

Recommendations derived from this area

Respect for the patient

1.2.1 All staff involved in providing NHS services[2] should:

- treat patients with respect, kindness, dignity, compassion, understanding, courtesy and honesty [QS]

- respect the patient's right to confidentiality

- not discuss the patient in their presence without involving them in the discussion.

1.2.2 Introduce students and anyone not directly involved in the delivery of care before consultations or meetings begin, and let the patient decide if they want them to stay.

Patient concerns

1.2.3 Be prepared to raise and discuss sensitive issues (such as sexual activity, continence or end-of-life care), as these are unlikely to be raised by some patients.[1]

1.2.4 Listen to and discuss any fears or concerns the patient has in a non-judgemental and sensitive manner.[1][QS]

1.2.5 If anxiety disorder or depression is suspected, follow the appropriate stepped-care model recommended in:

- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (NICE clinical guideline 113) or

- Depression (NICE clinical guideline 90) or

- Depression in adults with a chronic physical health problem (NICE clinical guideline 91).[1][QS]

Nutrition, pain management and personal needs

1.2.6 All healthcare professionals directly involved in patient care should receive education and training, relevant to their post, on the importance of:

- providing adequate and appropriate nutrition

- assessing and managing pain.[1][QS]

1.2.7 Ensure that the patient's nutrition and hydration are adequate at all times, if the patient is unable to manage this themselves, by:

- providing regular food and fluid of adequate quantity and quality in an environment conducive to eating

- placing food and drink where the patient can reach them easily

- encouraging and helping the patient to eat and drink if needed

- providing appropriate support, such as modified eating and/or drinking aids.[1][QS]

1.2.8 If a patient is unable to manage their own pain relief:

- do not assume that pain relief is adequate

- ask them regularly about pain

- assess pain using a pain scale if necessary (for example, on a scale of 1 to 10)

- provide pain relief and adjust as needed. [QS]

1.2.9 Ensure that the patient's personal needs (for example, relating to continence, personal hygiene and comfort) are regularly reviewed and addressed. Regularly ask patients who are unable to manage their personal needs what help they need. Address their needs at the time of asking and ensure maximum privacy. [QS]

Patient independence

1.2.10 Give patients using adult NHS services the support they need to maintain their independence as far as possible.

1.2.11 When patients in hospital are taking medicines for long-term conditions, assess and discuss with them whether they are able and would prefer to manage these medicines themselves.

Consent and capacity

1.2.12 Obtain and document informed consent from the patient, in accordance with:

- in England, Department of Health policy and guidance

- in Wales, advice from the Welsh Government.

1.2.13 Assess the patient's capacity to make each decision using the principles in the Mental Capacity Act (2005).[1]

[1] **This recommendation is adapted from a previously published NICE clinical guideline – see appendix B for details.**

[2] **This includes people such as chaplains, domestic staff, porters, receptionists and volunteers, as well as healthcare professionals.**

Appendix A: Summary of new evidence from 4-year surveillance of Palliative care for adults: strong opioids for pain relief (2012) NICE guideline CG140   3

Surveillance decision

This review question should not be updated.

2-year Evidence Update

Nutrition

A systematic review[1] examined the impact of several factors on patient nutrition including provision and serving of food and drink, patient illness and nutritional care provided by healthcare professionals. The review concluded that patients should be informed about the importance of nutrition, given guidance on how to overcome difficulties and be supported at meal times. These findings were considered to be consistent with recommendations in CG138 and felt to offer additional practical insights on how adequate nutrition and hydration may be achieved.

Requirements of palliative care

A systematic review[2] evaluated the effectiveness of patient-centred interventions (education and self-management), provider-centred interventions (education reminders) and interventions to integrate palliative care principles into daily practice on the quality of palliative care for patients with advanced and serious illness in both inpatient and outpatient

settings. The review, which evaluated different aspects of quality of care for patients receiving palliative care, was felt to add to the evidence base for CG138. Patient-centred interventions (education, self-management), provider-centred interventions (education reminders) and interventions to integrate palliative care principles in daily practice resulted in limited improvement in pain management of patients with advanced and serious illness receiving palliative care. It was considered that further research in this area is needed.

4-year surveillance summary

No relevant evidence was identified.

Impact statement

Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current recommendations on essential requirements of care. No new evidence was identified through the 4-year surveillance to change this conclusion.

> New evidence is unlikely to change guideline recommendations.

Tailoring healthcare services for each patient

Recommendations derived from this area

An individualised approach to services

1.3.1 Adopt an individualised approach to healthcare services that is tailored to the patient's needs and circumstances, taking into account their ability to access services, personal preferences and coexisting conditions. Review the patient's needs and circumstances regularly. [QS]

1.3.2 Inform the patient about healthcare services and social services (for example, smoking cessation services) that are available locally and nationally. Encourage and support them to access services according to their individual needs and preferences.[1][QS]

1.3.3 Give the patient information about relevant treatment options and services that they are entitled to, even if these are not provided locally. [QS]

Patient views and preferences

1.3.4 Hold discussions in a way that encourages the patient to express their personal needs and preferences for care, treatment, management and self-management. Allow adequate time so that discussions do not feel rushed.

1.3.5 Review with the patient at intervals agreed with them:

- their knowledge, understanding and concerns about their condition and treatments

- their view of their need for treatment.[1]

1.3.6 Accept that the patient may have different views from healthcare professionals about the balance of risks, benefits and consequences of treatments.[1]

1.3.7 Accept that the patient has the right to decide not to have a treatment, even if you do not agree with their decision, as long as they have the capacity to make an informed decision (see recommendation 1.2.13) and have been given and understand the information needed to do this.[1][QS]

1.3.8 Respect and support the patient in their choice of treatment, or if they decide to decline treatment. [QS]

1.3.9 Ensure that the patient knows that they can ask for a second opinion from a different healthcare professional, and if necessary how they would go about this. [QS]

Involvement of family members and carers

1.3.10 Clarify with the patient at the first point of contact whether and how they would like their partner, family members and/or carers to be involved in key decisions about the management of their condition. Review this regularly. If the patient agrees, share information with their partner, family members and/or carers. [QS]

1.3.11 If the patient cannot indicate their agreement to share information, ensure that family members and/or carers are kept involved and appropriately informed, but be mindful of any potentially sensitive issues and the duty of confidentiality.

Feedback and complaints

1.3.12 Encourage the patient to give feedback about their care. Respond to any feedback given.

1.3.13 If necessary, provide patients with information about complaints procedures and help them to access these.

[1] **This recommendation is adapted from a previously published NICE clinical guideline – see [appendix B](#) for details.**

Surveillance decision

This review question should not be updated.

2-year Evidence Update
Training providers to deliver patient-centred consultations

A Cochrane review[3] evaluated randomised controlled trials of interventions for healthcare providers that aimed to promote a patient-centred approach in clinical consultations

(defined as shared control in the consultation, shared decision-making or focus on the patient as a whole person rather than a body part or disease). Consultation process outcomes were reported in 16 studies. In the studies reporting dichotomous variables, the pooled analysis showed no effect. In the studies reporting continuous variables, the intervention showed a beneficial effect. Interventions showed a positive effect on patient satisfaction in studies using continuous measures but not in studies using dichotomous variables. The impact of training intensity on patient outcomes was unclear for healthcare behaviour and was not reported for satisfaction and health status. The Evidence Update concluded that the results suggest training of healthcare providers may help achieve the CG138 recommendation for a patient-centred approach to clinical consultations, with short-term interventions (less than 10 hours of training) seemingly as effective as longer training.

Patient views of care

A systematic review[4] of quantitative studies compared nurses' and adult patients' perceptions of caring behaviour in hospital or institutional settings. The majority of studies reported significant differences in nurses' and patients' perceptions of caring. Nurses assigned a significantly higher importance to the psychological skills of 'comforts', 'anticipates' and 'trusting relationships' than patients, with 'comforts' consistently ranked as most important. In contrast, patients considered technical skills and behaviours demonstrating competency in nursing activities as more important than nurses, with 'monitors and follows through' and 'explains and facilitates' considered important.

A longitudinal qualitative study[5] using semi-structured interviews examined influences on self-management priorities in 21 patients with multiple long-term conditions (diabetes, irritable bowel disease or chronic obstructive pulmonary disease, and 1 or more comorbid condition). The review found that although managing multiple conditions could become complex and burdensome, patients minimised the burden by applying strategies that worked for 1 condition to other conditions. In the face of limited resources for management, most respondents also reprioritised conditions over time, often in response to a negative impact of 1 condition (or its treatment) on another. Tipping points for reprioritisation arose in response to medication management, lifestyle changes, new understanding of a particular condition or additional diagnoses.

Taken together, these studies show that patient views of caring behaviour, and their priorities and strategies for the management of multiple conditions, may be different from those of healthcare professionals and may change over time. These findings were considered to reinforce the importance of holding discussions with patients so their views, preferences and expectations can be expressed, as recommended in CG138.

4-year surveillance summary
No relevant evidence was identified.

Impact statement
Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current recommendations on tailoring healthcare services for each patient. No new evidence was identified through the 4-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Continuity of care and relationships

Recommendations derived from this area

1.4.1 Assess each patient's requirement for continuity of care and how that requirement will be met. This may involve the patient seeing the same healthcare professional throughout a single episode of care, or ensuring continuity within a healthcare team. [QS]

Appendix A: Summary of new evidence from 4-year surveillance of Palliative care for adults: strong opioids for pain relief (2012) NICE guideline CG140   6

1.4.2 For patients who use a number of different services (for example, services in both primary and secondary care, or attending different clinics in a hospital), ensure effective coordination and prioritisation of care to minimise the impact on the patient. [QS]

1.4.3 Ensure clear and timely exchange of patient information:

- between healthcare professionals (particularly at the point of any transitions in care)

- between healthcare and social care professionals in line with the Health and Social Care Safety and Quality Act 2015. [QS]

1.4.4 All healthcare professionals directly involved in a patient's care should introduce themselves to the patient. [QS]

1.4.5 Inform the patient about:

- who is responsible for their clinical care and treatment

- the roles and responsibilities of the different members of the healthcare team

- the communication about their care that takes place between members of the healthcare team. [QS]

1.4.6 Give the patient (and their family members and/or carers if appropriate) information about what to do and who to contact in different situations, such as 'out of hours' or in an emergency. [QS]

Surveillance decision

This review question should not be updated.

2-year Evidence Update
Defining continuity of care

A review[6] assessed what defines and influences continuity of care. The analysis found that the Freeman model of continuity of care remained valid as a broad framework for understanding continuity, although some further refinements were suggested. With regard to management continuity, the review found that this concept should be extended to include family and carers, particularly relating to their involvement in discharge planning and maintaining treatment. It was also felt that informational continuity was more complex than suggested in the current model, with understanding being more important than the provision of information. With respect to relationship continuity, the review found that service users valued having a good relationship more than familiarity. Patients accepted that professionals had different roles in care pathways and therefore accepted that they

were likely to see a range and succession of different staff. Discontinuities in care were not always seen as negative (for example, cancer users valued being able to return to normal activities and being able to forget the illness during periods between treatment).

The evidence shows that continuity of care is a dynamic concept that may be defined in terms of a single framework with multiple components. In establishing a more detailed concept of continuity of care, this evidence was considered to add to CG138.

Discharge from hospital to primary care

A systematic review[7] assessed interventions that aimed to improve patient discharge from hospital to primary care. The results of the review indicated that interventions to improve the exchange of information can have a positive impact on transition from hospital to primary care. Evidence from a second study[2] which focused on patients with advanced and

serious illness also found that a range of interventions to improve continuity, coordination or transitions of care had beneficial effects on patient-reported outcomes. This information was considered to be consistent with the recommendations in CG138.

Roles and responsibilities

A study[8] evaluated patient perceptions about the role of nurses involved in chronic disease management at 7 sites in England and Wales. The nurse contribution was valued most when patients felt particularly vulnerable (for example, at initial diagnosis or on acute exacerbation). Patients were most satisfied with nurse-led delivery of services if they saw the nurse as responsible for diagnosis, prescribing and management of the condition (that is, emulating a medical approach). Patients were less satisfied if they had been transferred from a GP-led service or from a secondary care setting to a nurse-led service. Overall, the study was felt to highlight the importance of informing patients about the roles and responsibilities of healthcare professionals, particularly when care has been transferred from other care settings or services, so that patient expectations can be managed. This evidence was considered to be consistent with CG138.

4-year surveillance summary
No relevant evidence was identified.

Impact statement
Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current recommendations on continuity of care and relationships. No new evidence was identified through the 4-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Enabling patients to actively participate in their care

Recommendations derived from this question

Communication

1.5.1 Ensure that the environment is conducive to discussion and that the patient's privacy is respected, particularly when discussing sensitive, personal issues.

1.5.2 Maximise patient participation in communication by, for example:

- maintaining eye contact with the patient (if culturally appropriate)

- positioning yourself at the same level as the patient

- ensuring that the patient is appropriately covered (if applicable).

1.5.3 Ask the patient how they wish to be addressed and ensure that their choice is respected and used.

1.5.4 Establish the most effective way of communicating with each patient and explore ways to improve communication. Examples include using pictures, symbols, large print, Braille, different languages, sign language or communications aids, or involving an interpreter, a patient advocate or family members.[1][QS]

1.5.5 Ensure that the accent, use of idiom and dialect of both the patient and the healthcare professionals are taken into account when considering communication needs.

1.5.6 Avoid using jargon. Use words the patient will understand, define unfamiliar words and confirm understanding by asking questions.[1]

1.5.7 Use open-ended questions to encourage discussion.[1]

1.5.8 Summarise information at the end of a consultation and check that the patient has understood the most important information.

1.5.9 Offer the patient copies of letters between healthcare professionals. These should be in a form that is accessible to the patient and if possible use language that they will understand. Answer any questions the patient may have about these.

1.5.10 All staff involved in providing NHS services should have demonstrated competency in relevant communication skills.[1][QS]

Information

1.5.11 Give the patient information, and the support they need to make use of the information, in order to promote their active participation in care and self-management.[1]

1.5.12 Give the patient both oral and written information.[1]

1.5.13 Give the patient information in an accessible format, at the first and subsequent visits. Possible formats include using written information, pictures, symbols, large print, Braille and different languages.[1]

1.5.14 Explore the patient's preferences about the level and type of information they want. Based on this, give the patient (and their family members and/or carers if appropriate) clear, consistent, evidence-based, tailored information throughout all stages of their care. This should include, but not be limited to, information on:

- their condition and any treatment options

- where they will be seen

- who will undertake their care

- expected waiting times for consultations, investigations and treatments.[1]

1.5.15 Ensure that mechanisms are in place to:

- provide information about appointments to patients who require information in non-standard formats

- alert services of any need for interpreters and non-standard formats to be available when patients move between services.

1.5.16 Ask the patient whether they want to be accompanied at consultations by a family member, friend or advocate, and whether they would like to take notes and/or an audio recording of the consultation.

Appendix A: Summary of new evidence from 4-year surveillance of Palliative care for adults: strong opioids for pain relief (2012) NICE guideline CG140   9

1.5.17 Give the patient (and/or their family members and carers) information to enable them to use any medicines and equipment correctly. Ensure that the patient and their family members and carers feel adequately informed, prepared and supported to use medicines and equipment and to carry out self-care and self-management.[1]

1.5.18 Advise the patient where they might find reliable high-quality information and support after consultations, from sources such as national and local support groups, networks and information services.[1]

1.5.19 Give the patient regular, accurate information about the duration of any delays during episodes of care.

Shared decision making

1.5.20 When discussing decisions about investigations and treatment, do so in a style and manner that enables the patient to express their personal needs and preferences. [QS]

1.5.21 Give the patient the opportunity to discuss their diagnosis, prognosis and treatment options.[1][QS]

1.5.22 When offering any investigations or treatments:

- explain the medical aims of the proposed care to the patient

- openly discuss and provide information about the risks, benefits and consequences of the investigation or treatment options (taking into account factors such as coexisting conditions and the patient's preferences)

- clarify what the patient hopes the treatment will achieve and discuss any misconceptions with them

- set aside adequate time to allow any questions to be answered, and ask the patient if they would like a further consultation.[1][QS]

1.5.23 Accept and acknowledge that patients may vary in their views about the balance of risks, benefits and consequences of treatments.[1][QS]

1.5.24 Use the following principles when discussing risks and benefits with a patient:

- personalise risks and benefits as far as possible

- use absolute risk rather than relative risk (for example, the risk of an event increases from 1 in 1000 to 2 in 1000, rather than the risk of the event doubles)

- use natural frequency (for example, 10 in 100) rather than a percentage (10%)

- be consistent in the use of data (for example, use the same denominator when comparing risk: 7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5)

- present a risk over a defined period of time (months or years) if appropriate (for example, if 100 people are treated for 1 year, 10 will experience a given side effect)

- include both positive and negative framing (for example, treatment will be successful for 97 out of 100 patients and unsuccessful for 3 out of 100 patients)

- be aware that different people interpret terms such as rare, unusual and common in different ways, and use numerical data if available

- think about using a mixture of numerical and pictorial formats (for example, numerical rates and pictograms).[1][QS]

1.5.25 Offer support to the patient when they are considering options. Use the principles of shared decision making:

- ensure that the patient is aware of the options available and explain the risks, benefits and consequences of these

- check that the patient understands the information

- encourage the patient to clarify what is important to them, and check that their choice is consistent with this. [QS]

1.5.26 Be aware of the value and availability of patient decision aids and other forms of decision support such as counselling or coaching. If suitable high-quality decision aids are available, offer them to the patient.[1][QS]

1.5.27 Give the patient (and their family members and/or carers if appropriate) adequate time to make decisions about investigations and treatments.[1][QS]

Education programmes

1.5.28 Ensure that patient-education programmes:

- are evidence-based

- have specific aims and learning objectives

- meet the needs of the patient (taking into account cultural, linguistic, cognitive and literacy considerations)

- promote the patient's ability to manage their own health if appropriate.[1]

1.5.29 Give the patient the opportunity to take part in evidence-based educational activities, including self-management programmes, that are available and meet the criteria listed in recommendation 1.5.28.[1]

[1] **This recommendation is adapted from a previously published NICE clinical guideline – see appendix B for details.**

Surveillance decision

This review question should not be updated.

Views on patient-centred care across Europe

2-year Evidence Update

A qualitative study[9] to determine the specific aspects of care that are important to patients undergoing infertility treatment across Europe was identified. No new aspects of care were identified, and the detailed description of what was valued by patients for each dimension of care showed little difference across the study centres. The authors concluded that perspectives of patients across different European countries on important aspects of patient-centred care appear to be similar, with provision of information consistently rated as an important dimension. The Evidence Update concluded that current recommendations in CG138 appear to be aligned with these

perspectives, and the evidence therefore indicates that the patient-centred approach as described in the guideline is likely to be appropriate for Europeans who access care in the UK.

4-year surveillance summary

No relevant evidence was identified.

Impact statement

Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current guidance. No new evidence was identified through the 4-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Patient-centred care in chronic disease management

2-year Evidence Update

A systematic review[10] of patient-centred care in adult chronic disease management in primary care suggested that interactions between patients with chronic diseases and primary healthcare professionals should encompass legitimising the illness experience and offer realistic hope, in addition to other previously recognised aspects of patient-centred care. This review was considered to add to the evidence base on conceptual frameworks for patient-centred care, providing further insights that are consistent with CG138.

4-year surveillance summary

No relevant evidence was identified.

Impact statement

Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current guidance. No new evidence was identified through the 4-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Non-verbal communication

2-year Evidence Update

A systematic review and meta-analysis[11] included experimental or observational studies of interactions between adult patients and healthcare professionals that examined associations between non-verbal communication and clinically relevant outcomes. The study demonstrates the importance of healthcare professional non-verbal communication skills – particularly listening, warmth, and avoiding negativity – in achieving patient satisfaction. The study was felt to add to the evidence base for CG138, and

provides insights that could inform healthcare professional skills training.

4-year surveillance summary

No relevant evidence was identified.

Impact statement

Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current guidance. No new evidence was identified through the 4-year surveillance to change this conclusion.

New evidence is unlikely to change guideline recommendations.

Information

2-year Evidence Update

A study[12] was included which conducted a synthesis of publications about information for patients with cancer. Patients showed differing needs and preferences for information or participation, depending on their individual characteristics and healthcare interactions. When receiving and using information, patients were selective and creative, with their preference for learning closely linked to emerging practical and emotional needs. The results of the study suggested that the provision of information to patients can be seen as an ongoing and flexible process that supports navigation through the illness and care landscape. This evidence was felt to be consistent with CG138 and provides additional insight on information provision.

4-year surveillance summary

No relevant evidence was identified.

Impact statement

Overall, the evidence identified through the 2-year Evidence Update was considered to be consistent with current guidance. No new evidence was identified through the 4-year surveillance to change this conclusion.

> New evidence is unlikely to change guideline recommendations.

Risk communication

2-year Evidence Update

No relevant evidence was identified.

4-year surveillance summary

The guideline currently recommends that risks and benefits should be personalised as far as possible and offers guidance on principles to follow when discussing risks and benefits. New evidence from an updated Cochrane review[13] supports this recommendation by reporting an increase in knowledge with personalised risk communication.

Finally, one Cochrane review[14] considering alternative statistical formats for presenting risks was identified but this was used to inform the guideline and has not been updated since the guideline was developed.

Impact statement

The new evidence is supportive of current guidance and is unlikely to impact on guideline recommendations on improving patients' understanding of the risks and benefits associated with their treatment options.

> New evidence is unlikely to change guideline recommendations.

Decision aids

2-year Evidence Update

An updated Cochrane review[15] reported the value of decision aids in increasing patient knowledge and having a positive effect on patient-practitioner communication. The guideline recommends that clinicians should be aware of the value and availability of patient decision aids and other forms of decision support such as counselling or coaching. If suitable high-quality decision aids are available, they should be offered to the patient. The results of this updated Cochrane review are supportive of the guideline recommendation.

4-year surveillance summary

An updated Cochrane review[16] concluded that women who received midwife-led continuity models of care were less likely to experience intervention and more likely to be satisfied with their care compared with women who received other models of care. The conclusions of the review are similar to the evidence already included in the guideline as the Guideline Committee considered midwife-led care as an example of an intervention that improves continuity of care, which has good evidence of benefit and an absence of evidence of harm.

In addition, an updated Cochrane review[17] concluded that there was limited evidence about what helps people choose an appropriate

method of contraception. The conclusions of the review are similar to the evidence already included in the guideline.

Impact statement
The new evidence is supportive of current guidance and is unlikely to impact on guideline

recommendations to offer high-quality decision aids to patients if available.

New evidence is unlikely to change guideline recommendations

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