

Contraception

Quality standard

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This standard is based on CG37, PH51 and CG30.

This standard should be read in conjunction with QS115, QS69, QS37 and QS178.

Introduction

This quality standard covers advice about all methods of contraception for women, including emergency contraception. It applies to young people (under 25) and adults. This includes all women of childbearing potential, and young people under 16 who are competent to consent to contraceptive treatment under the Department of Health's [Reference guide to consent for examination or treatment](#).

It does not cover sexual health or reducing sexually transmitted infections. For more information see the [contraceptive services topic overview](#).

NICE quality standards focus on aspects of health and social care that are commissioned locally. Areas of national policy, such as the Department of Health's [Commissioning sexual health services and interventions: best practice for local authorities](#), are therefore not covered, but should be read alongside this quality standard.

Why this quality standard is needed

An estimated 19% of pregnancies are unplanned^[1]. Some groups are at a greater risk of unplanned pregnancy, including young people. According to the 2010/12 'National survey of sexual attitudes and lifestyles'^[2], the median age of first intercourse was 17 for both sexes, but it was 16 in those aged 16–24 at interview. Between one-quarter and one-third of all young people are thought to have sex before 16.

Since 1998, the under-18 conception rate for England and Wales has dropped by 51%. The estimated number of under-18 conceptions in England and Wales fell from 24,306 in 2013 to 22,653 in 2014, a decrease of 6.8%. In women aged 15–17 the rate was 22.9 conceptions per 1,000 in 2014, the lowest since statistics were first recorded in 1969.

Current contraceptive methods

Current contraceptive methods include long-acting reversible contraception (also known as LARC), hormonal methods, oral and barrier methods.

Oral contraceptives are the most common form of contraception used by women ([NHS contraceptive services: England, community contraceptive clinics. Statistics for 2013–14](#) Health and Social Care information Centre). The male condom is another commonly used method in the UK.

In a 2008/09 survey, less than 1% of women reported using diaphragms and caps ([Contraception and sexual health](#) Office for National Statistics).

The uptake of long-acting reversible contraception has been slowly increasing. In 2013/14, 31% of all women who made contact with sexual and reproductive health services were enquiring about long-acting reversible contraception.

The effectiveness of oral contraceptive pills and barrier methods depend on their correct use every day or each time the person has sex. The effectiveness of long-acting reversible contraception does not rely on correct everyday use.

Abortion rates

Although 88% of women aged 15–44 in a heterosexual relationship report using at least 1 method of contraception, 184,571 abortions still took place in 2014 ([Abortion statistics, England and Wales: 2014](#) Department of Health). The Department of Health statistics also show that, in 2014, the highest abortion rate was among women aged 22, at 28 per 1,000 pregnancies. The rate for those aged under 16 was 2.5 per 1,000, and for those aged under 18 it was 11.1 per 1,000. In 2014, 37% of abortions were among women who had already had 1 or more abortions.

Contraceptive services

Contraceptive services aim to help men and women choose a method that best suits their individual needs and lifestyle, making it more likely that contraception will be used effectively.

In this quality standard 'contraceptive services' refers to the whole range of contraceptive, sexual and reproductive health services for all ages. It includes:

- primary care
- services offered by community, education and pharmacy outlets (commissioned by local authorities from the NHS, the private or voluntary sectors)
- services commissioned by clinical commissioning groups (such as termination of pregnancy)

- [abortion] services)
- services commissioned by NHS England (for example, contraceptive services provided as an 'additional service' under the GP contract).

[Adapted from NICE's guideline on [contraceptive services for under 25s](#) and [Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV](#) Public Health England]

The quality standard is expected to contribute to improvements in the following outcomes:

- under-18 conceptions
- abortion rate
- women having more than 1 abortion
- accessibility of contraceptive services
- provision of information about contraception
- use of long-acting reversible contraception.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS outcomes framework 2016–17](#)
- [Public health outcomes framework for England 2016–19](#)

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
4 Ensuring that people have a positive experience of care	<p>Overarching indicators</p> <p>4a Patient experience of primary care</p> <p>i GP services</p> <p>ii GP Out-of-hours services</p> <p><i>4d Patient experience characterised as poor or worse</i></p> <p><i>i Primary care</i></p> <p>Improvement areas</p> <p>Improving women and their families' experience of maternity services</p> <p>4.5 Women's experience of maternity services</p> <p>Improving people's experience of integrated care</p> <p><i>4.9 People's experience of integrated care**</i></p>
<p>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</p> <p>** Indicator is complementary</p> <p><i>Indicators in italics</i> in development</p>	

Table 2 Public health outcomes framework for England 2016–19

Domain	Objectives and indicators
1 Improving the wider determinants of health	<p>Objective</p> <p>Improvements against wider factors which affect health and wellbeing and health inequalities</p> <p>Indicators</p> <p>1.01 Children in low income families</p> <p>1.05 16–18 year olds not in education, employment or training</p> <p>1.11 Domestic abuse</p> <p>1.12 Violent crime (including sexual violence)</p>

2 Health improvement	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.04 Under 18 conceptions</p>
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Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to contraception.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and people who use services.

Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience, and are specific to the topic, are considered during quality statement development.

Coordinated services

The quality standard for contraception specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole contraception care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people accessing contraception.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality contraceptive service are listed in [related NICE quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in supporting access to contraception should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers may have in supporting people to access contraception. If appropriate, healthcare practitioners should ensure that family members and carers are involved in the decision-making process.

^[1]Wellings K, Jones KG, Mercer CH et al. (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet* 382: 1807–16

^[2]Mercer CH, Tanton C, Prah P et al. (2013) Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). *The Lancet* 382. 1781–94

List of quality statements

Statement 1. Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Statement 2. Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Statement 3. Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge.

Statement 4. Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.

Quality statement 1: Contraceptive information and methods

Quality statement

Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Rationale

Offering information about the full range of contraceptives available, including long-acting reversible contraception, will ensure women asking for routine or emergency contraception can make an informed choice. Helping women choose the method of contraception that suits them best, and increasing their awareness of how to use contraceptives effectively, will help to reduce unplanned pregnancies.

Quality measures

Structure

a) Evidence that accessible information is available about the full range of contraceptive methods, including long-acting reversible contraception, and the local services that provide them.

Data source: Local data collection.

b) Evidence of local processes and referral pathways to ensure that women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Data source: Local data collection.

Process

a) Proportion of women who ask for contraception from contraceptive services who are given information about all methods, including long-acting reversible contraception.

Numerator – the number in the denominator who are given information about all methods, including long-acting reversible contraception.

Denominator – the number of women who ask for contraception from contraceptive services.

Data source: Local data collection.

b) Proportion of women who ask for contraception from contraceptive services who are offered a choice of all contraceptive methods, including long-acting reversible contraception.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods, including long-acting reversible contraception.

Denominator – the number of women who ask for contraception from contraceptive services.

Data source: Local data collection.

Outcome

a) Contraceptive use in women.

Data source: Local data collection.

b) Uptake of long-acting reversible contraception.

Data source: Local data collection.

c) Women's satisfaction with their choice of contraceptive method.

Data source: Local data collection.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers (including GPs, community pharmacies and sexual and reproductive health services) ensure that processes are in place to offer women information about, and a choice of, all contraceptive methods, including long-acting reversible contraception. Service providers work together so that they can refer women to a suitable alternative service if they cannot provide the preferred method of contraception.

Healthcare practitioners (including GPs, community pharmacists, sexual and reproductive health consultants and nurses) ensure that they give women who ask for contraception information about, and a choice of, all contraceptive methods, including long-acting reversible contraception. If they

cannot provide the woman's preferred method of contraception they refer them to a suitable alternative service.

Commissioners (clinical commissioning groups, local authorities and NHS England) commission contraceptive services that provide information on all contraceptive methods, including long-acting reversible contraception, and offer all contraceptive methods to all women. Commissioners ensure providers work together to ensure women are provided with their preferred method of contraception.

What the quality statement means for women attending contraceptive services

Women attending a contraceptive service are offered a choice of all contraceptive methods, including long-acting reversible contraception, and the information they need to decide which method is suitable for them. If the service cannot provide their preferred method of contraception they tell them where they can get it from.

Source guidance

- [Long-acting reversible contraception](#) (2005) NICE guideline CG30, recommendation 1.1.1.1 (key priority for implementation)
- [Contraceptive services for under 25s](#) (2014) NICE guideline PH51, recommendation 3

Definitions of terms used in this quality statement

Contraceptive services

Contraceptive services include those offered in education, GP services, pharmacies, maternity and postnatal care services, walk-in centres, acute and emergency care, and the voluntary and private sectors. This includes open access contraceptive services that are available to everyone and provide walk-in and appointment clinics.

[NICE's guideline on [contraceptive services for under 25s](#), recommendation 3 and expert opinion]

Information about contraceptive methods

This information covers all contraceptive methods and includes:

- how the method works

- how to use it
- how it is administered
- insertion and removal (for implants and intrauterine devices)
- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from NICE's guideline on [long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection
- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from NICE's guideline on [long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- contraceptive vaginal ring
- contraceptive patch

- combined oral contraceptive pill
- progestogen-only pill
- male condom
- female condom
- diaphragm or cap with spermicide
- natural family planning.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the Faculty of Sexual & Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention, fertility awareness methods, progestogen-only pills and combined hormonal contraception]

Equality and diversity considerations

Contraceptive options may be limited for women with a learning disability or cognitive impairment. Contraceptive services should make it clear to women why specific methods cannot be offered to them.

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information about all methods and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Quality statement 2: Emergency contraception

Quality statement

Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Rationale

An intrauterine device (IUD) has a lower failure rate than oral methods of emergency contraception. Also, once in place, it can be used on an ongoing basis. If women use an IUD this will reduce the risk of unplanned pregnancies and avoid the need for emergency contraception. If a woman chooses to have an IUD as a form of emergency contraception, but the healthcare practitioner cannot fit it there and then, they should direct the woman to a suitable service and give her an oral method in the interim.

Quality measures

Structure

Evidence of local processes to ensure that women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Data source: Local data collection.

Process

Proportion of requests for emergency contraception where the woman is told that an intrauterine device is more effective than an oral method.

Numerator – the number in the denominator where the woman is told that an intrauterine device is more effective than an oral method.

Denominator – the number of requests for emergency contraception.

Data source: Local data collection. Quality and Outcomes Framework indicator CON003 captures data on the provision of information about long-acting reversible methods of contraception to women who are prescribed emergency hormonal contraception by their GP.

Outcome

a) Intrauterine device use as an emergency contraceptive.

Data source: Local data collection. The Health and Social Care Information Centre's [Sexual and Reproductive Health Activity Dataset](#) includes information on methods of contraception for people using dedicated sexual and reproductive health services.

b) Abortion rate.

Data source: Local data collection. The Department of Health's [Abortion statistics](#) can be analysed geographically.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers (including GPs, community pharmacies and sexual and reproductive health services) ensure that protocols and procedures are in place to tell women asking for emergency contraception that an IUD is more effective than an oral method. Service providers ensure that rapid referral pathways are in place for women who choose an emergency IUD if they are not able to fit one immediately. Service providers also ensure that protocols are in place to offer them an oral emergency method in the interim.

Healthcare practitioners (including GPs, community pharmacists, sexual health consultants and nurses) tell women who ask for emergency contraception that an IUD is more effective than an oral method. Practitioners unable to fit IUDs at presentation refer women to a service that can and offer them an oral emergency method in the interim.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that services providing emergency contraception tell women that an IUD is more effective than an oral method. Commissioners ensure that referral pathways are in place for women who choose to have an emergency IUD fitted if the service cannot provide this on presentation, and that the service offers an oral emergency method in the interim.

What the quality statement means for women

Women asking for emergency contraception are told that an intrauterine device (IUD, also known as the coil) is more effective than an oral method (an emergency pill) and can also be used as a long-

term method of contraception.

Source guidance

- [Contraceptive services for under 25s \(2014\)](#) NICE guideline PH51, recommendation 9
- [Emergency contraception \(2012\)](#) Faculty of Sexual & Reproductive Healthcare guideline, section 11

Definitions of terms used in this quality statement

Emergency contraception

If a woman has had sex without using contraception, or thinks that her contraception did not work, an emergency contraceptive can be used. There are 3 different types:

- emergency contraceptive pill, levonorgestrel 1.5 mg
- emergency contraceptive pill, ulipristal acetate 30 mg
- emergency intrauterine device.

Both emergency contraceptive pills are also referred to as the 'morning after pill'.

[Adapted from [Emergency contraception](#) (Faculty of Sexual & Reproductive Healthcare)]

Intrauterine device

Also referred to as an IUD or coil, this is a small, T-shaped copper device that is inserted in the uterus. It has 1 or 2 threads on the end that hang through the entrance of the uterus (the cervix).

[Adapted from [Intrauterine contraception](#) (Faculty of Sexual & Reproductive Healthcare)]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that

the woman can see another practitioner as soon as possible.

Quality statement 3: Contraception after an abortion

Quality statement

Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge.

Rationale

Ensuring women can make an informed choice about contraception following an abortion will reduce the risk of future unplanned pregnancies. Having the opportunity to discuss contraception when they are being assessed for an abortion will give them time to consider all the options. Further discussion before discharge from the abortion service can help ensure timely access to contraception.

Quality measures

Structure

a) Evidence of local processes to ensure that women discuss contraception and all contraceptive methods with a healthcare practitioner when being assessed for an abortion.

Data source: Local data collection.

b) Evidence of local processes to ensure that a healthcare practitioner offers women a choice of all contraceptive methods before discharge from an abortion service.

Data source: Local data collection.

Process

a) Proportion of women who discuss contraception and all contraceptive methods with a healthcare practitioner at an assessment for abortion.

Numerator – the number in the denominator who discuss contraception and all contraceptive methods with a healthcare practitioner.

Denominator – the number of women having an assessment for abortion.

Data source: Local data collection.

b) Proportion of women who are offered a choice of all contraceptive methods before discharge from an abortion service.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods before discharge.

Denominator – the number of women discharged from an abortion service.

Data source: Local data collection.

Outcome

a) Uptake of long-acting reversible contraception at the time of abortion.

Data source: Local data collection.

b) Contraception uptake rate after abortion.

Data source: Local data collection.

c) Women who have more than 1 abortion.

Data source: Local data collection. The Department of Health's [Abortion statistics](#) include data on repeat abortions.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers (including secondary care, community genitourinary medical and private sector services) establish protocols to ensure that healthcare practitioners discuss contraception and all contraceptive methods with women at their assessment for abortion and before discharge. Service providers offer women a choice of all contraceptive methods before discharge. If contraceptives are not provided at discharge, service providers ensure that referral pathways to a contraceptive service are in place.

Healthcare practitioners (including GPs, hospital doctors and nurses) discuss contraception and all

contraceptive methods with women at their assessment for an abortion and before discharge. Healthcare practitioners offer women a choice of all contraceptive methods before discharge. If contraceptives are not provided at discharge, they offer to refer women to a contraceptive service.

Commissioners (clinical commissioning groups) ensure that abortion services discuss contraception and all contraceptive methods with women at their assessment for an abortion and before discharge. Commissioners ensure that abortion services offer women a choice of all contraceptive methods before discharge, or offer a referral to a contraceptive service if contraceptives are not provided. Commissioners could consider a local performance indicator for abortion services to improve uptake of contraception at discharge.

What the quality statement means for women

Women who plan to have an abortion are offered the chance to discuss contraception with a healthcare practitioner during assessment for their abortion and again before they are discharged. They are offered a choice of all contraceptive methods before they are discharged or referral to a contraceptive service if contraception is not provided.

Source guidance

- [Contraceptive services for under 25s](#) (2014) NICE guideline PH51, recommendation 7
- [Long-acting reversible contraception](#) (2005) NICE guideline CG30, recommendations 1.2.3.2, 1.3.3.1 and 1.4.3.2

Definitions of terms used in this quality statement

Discussion about contraception

When discussing contraception, emphasise that women are fertile immediately after an abortion and give details of all contraceptive methods including:

- how the method works
- how to use it
- how it is administered
- insertion and removal (for implants and IUDs)

- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from NICE's guidelines on [contraceptive services for under 25s](#) and [long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection
- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from NICE's guideline on [long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- contraceptive vaginal ring
- contraceptive patch
- combined oral contraceptive pill
- progestogen-only pill
- male condom

- female condom
- diaphragm or cap with spermicide
- natural family planning.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the Faculty of Sexual & Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention, fertility awareness methods, progestogen-only pills and combined hormonal contraception]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information about all methods and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Quality statement 4: Contraception after childbirth

Quality statement

Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.

Rationale

Supporting women to make an informed choice about contraception after childbirth will reduce the risk of future unplanned pregnancies. Advice and information should be given as soon as possible after delivery because fertility may return quickly, including in women who are breastfeeding. Providing advice about contraception after childbirth also helps avoid the risk of complications associated with an interpregnancy interval of less than 12 months.

Quality measures

Structure

a) Evidence of local processes to ensure that women who give birth are given information about all contraceptive methods by their midwife within 7 days of delivery.

Data source: Local data collection.

b) Evidence of local processes and referral pathways to ensure that women who give birth are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Data source: Local data collection.

Process

a) Proportion of women who give birth who are given information about all contraceptive methods by their midwife within 7 days of delivery.

Numerator – the number in the denominator who are given information about all contraceptive methods by their midwife within 7 days of delivery.

Denominator – the number of women who give birth.

Data source: Local data collection.

b) Proportion of women who give birth who are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Denominator – the number of women who give birth.

Data source: Local data collection.

Outcome

a) Satisfaction with advice about contraceptive methods after childbirth.

Data source: Local data collection.

b) Contraception uptake rates in women who have given birth.

Data source: Local data collection.

c) Women who have a short interpregnancy interval.

Data source: Local data collection.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers (secondary care and community maternity services) establish protocols to ensure that midwives give women information about all contraceptive methods, and offer them a choice of all methods, within 7 days of delivery. Service providers ensure women are referred to a contraceptive service if their chosen contraceptive cannot be provided immediately.

Healthcare practitioners (midwives) give women information about, and offer them a choice of all contraceptive methods within 7 days of delivery. Midwives refer women to a contraceptive service if their chosen contraceptive cannot be provided immediately.

Commissioners (clinical commissioning groups) ensure that maternity services give women information about, and offer them a choice of all contraceptive methods within 7 days of delivery, and refer them to a contraceptive service if contraception cannot be provided immediately.

What the quality statement means for women

Women who give birth are offered a choice of all contraceptive methods and given the information they need to decide which method is suitable for them by their midwife. This happens within a week of delivery. The midwife tells them how to get their chosen contraceptive.

Source guidance

- [Contraceptive services for under 25s](#) (2014) NICE guideline PH51, recommendation 6
- [Postnatal care up to 8 weeks after birth](#) (2006) NICE guideline CG37, recommendation 1.2.58

Definitions of terms used in this quality statement

Information about contraceptive methods

Information covers all contraceptive methods and includes:

- how the method works
- how to use it
- how it is administered
- insertion and removal (for implants and intrauterine devices)
- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from NICE's guideline on [long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection
- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from NICE's guideline on [long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- contraceptive vaginal ring
- contraceptive patch
- combined oral contraceptive pill
- progestogen-only pill
- male condom
- female condom
- diaphragm or cap with spermicide
- natural family planning.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the Faculty of Sexual & Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention, fertility awareness methods, progestogen-only pills and combined hormonal contraception]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception healthcare practitioners should give information about all methods and allow the woman to choose the method that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [what makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health and public health practitioners and adults and young people accessing contraception, and their families or carers (if appropriate) is essential. Care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults and young people accessing contraception and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the [quality standards process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the quality standards advisory committee to develop the quality standard statements and measures.

- [Contraceptive services for under 25s](#) (2014) NICE guideline PH51
- [Emergency contraception](#) (2011) Faculty of Sexual & Reproductive Healthcare guideline
- [Postnatal care up to 8 weeks after birth](#) (2006) NICE guideline CG37
- [Long-acting reversible contraception](#) (2005) NICE guideline CG30

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department for Education (2015) [Working together to safeguard children](#)
- NHS England (2015) [Safeguarding vulnerable people in the reformed NHS: Accountability and Assurance Framework](#)
- Public Health England (2015) [Sexual and reproductive health in England: local and national data](#)
- Health and Social Care Information Centre (2014) [NHS contraceptive services, England – 2013–14, Community contraceptive clinics](#)
- World Health Organization (2014) [Ensuring human rights in the provision of contraceptive information and services](#)
- Department of Health (2013) [Commissioning sexual health services and interventions: best practice guidance for local authorities](#)
- Abortion review UK (2012) [UK: contraceptive services not reaching all women, audit finds](#)

Definitions and data sources for the quality measures

- Department of Health (2015) [Abortion statistics](#)
- Faculty of Sexual & Reproductive Healthcare guideline (2015) [Barrier methods for contraception and STI prevention](#)
- Faculty of Sexual & Reproductive Healthcare guideline (2015) [Fertility awareness methods](#)
- Faculty of Sexual & Reproductive Healthcare guideline (2015) [Intrauterine contraception](#)
- Faculty of Sexual & Reproductive Healthcare guideline (2015) [Progestogen-only pills](#)
- Health and Social Care Information Centre (2015) [Sexual and Reproductive Health Activity Dataset](#)
- NHS employers (2015) [2015/16 General Medical Services \(GMS\) contract Quality and Outcomes Framework \(QOF\): guidance for GMS contract 2015/16](#)
- Public Health England (2015) [Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV](#)
- Faculty of Sexual & Reproductive Healthcare guideline (2012) [Combined hormonal contraception](#)

Related NICE quality standards

Published

- [Antenatal and postnatal mental health](#) (2016) NICE quality standard 115
- [Ectopic pregnancy and miscarriage](#) (2014) NICE quality standard 69
- [Postnatal care](#) (2013) NICE quality standard 37

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Community pharmacy: promoting health and wellbeing
- HIV testing: encouraging uptake
- Reducing sexually transmitted infections
- Sexual health across the life course

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality standards advisory committee and NICE project team

Quality standards advisory committee

This quality standard has been developed by quality standards advisory committee 2. Membership of this committee is as follows:

Mr Barry Attwood

Lay member

Professor Gillian Baird

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Dr Ashok Bohra

Consultant Surgeon, Royal Derby Hospital

Dr Guy Bradley-Smith

Freelance GP and Clinical Commissioning Lead for Learning Disability, North, East and West (NEW)

Devon Clinical Commissioning Group

Mrs Julie Clatworthy

Governing Body Nurse, Gloucester Clinical Commissioning Group

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Mr Gavin Lavery

Clinical Director, Public Health Agency

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GP and Medical Adviser in Therapeutics, Aneurin Bevan University Health Board

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Area Service Manager, Learning Disability, Oxfordshire County Council

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Honorary Consultant Physician, London North West Healthcare NHS Trust

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Dr Amanda Smith

Director of Therapies, Health Service and Governance, Powys Teaching Health Board

Ms Ruth Studley

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The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathways on [contraceptive services with a focus on young people aged up to 25, long-acting reversible contraception and postnatal care](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- [NHS England](#)
- [Department of Health and Social Care](#)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made

aware of and encouraged to use the quality standard.

- Faculty of Sexual and Reproductive Healthcare
- Royal College of General Practitioners