PRIMARY CARE
WOMEN'S HEALTH FORUM

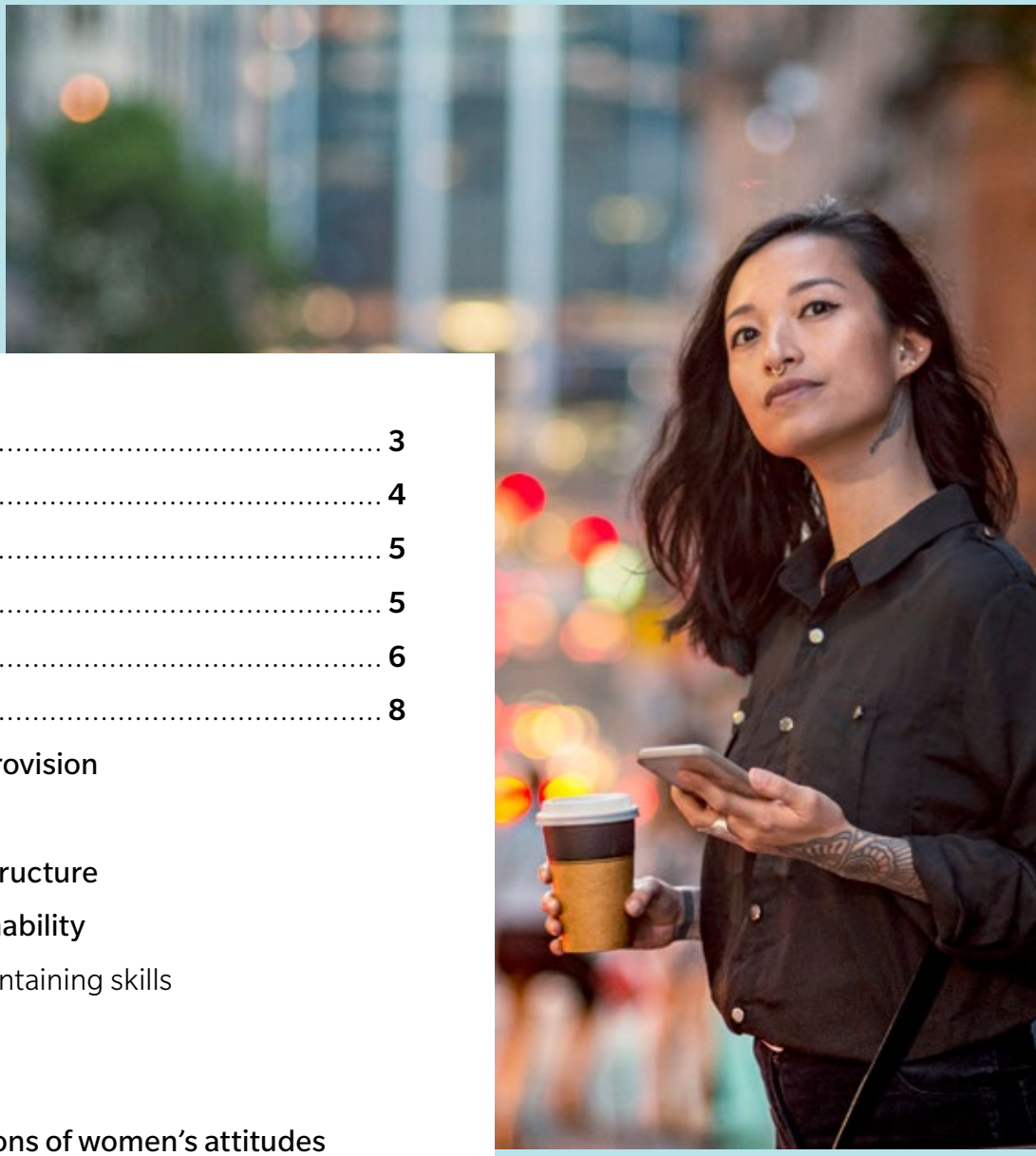
# Workforce Needs Assessment

to deliver patient access, provision and sustainability of Long-Acting Reversible Contraception (LARC) in primary care

AUTHORS: MIMI ISMAIL & LESLEY WYLDE

SEPTEMBER 2021

# Contents





## ABOUT THE AUTHORS


### Mimi Ismail

Mimi is an independent public health researcher based in London. Her past projects include work on reproductive health, cystic fibrosis and female genital mutilation. She received her MPH from George Washington University in Washington, D.C., and a M.A. in Near Eastern Studies from the University of Michigan, Ann Arbor.

### Lesley Wylde

Lesley has 25 years' experience working in the field of women's health, supporting commissioning and provision of women's health services across primary and secondary care, resulting in an extensive knowledge on the background and changes in the structure of commissioning, funding, training and more recently impact on workforce sustainability.

Not wanting to give up her passion to support, develop and improve health services for women, upon retirement Lesley accepted an invitation in April 2020 to join the Primary Care Women's Health Forum as a Non-executive Director.



**The authors would like to extend thanks to everyone who contributed to this report and provided their valuable time.**

# Executive Summary

**Women's access to contraception is essential, yet primary care providers' ability to continue offering one of the most efficient and cost-effective methods of long-acting reversible contraception (LARC) appears to be at risk.**

In England provision of LARC is an enhanced service commissioned by Public Health; it is not a core service, and it is therefore optional whether a LARC service is provided by primary care providers. For many general practices and healthcare professionals, provision of LARCs is viewed as not financially viable, time consuming and is not classed as a priority. The LARC 'fitting' workforce is ageing and access to training can be an issue, all of which are threatening the sustainability of LARC provision in the future.

**This report, led by the the Primary Care Women's Health Forum (PCWHF) with support from Public Health England, has been created using the following methods:**

1. Review of a recent online survey of LARC provision in primary care conducted by the Primary Care Women's Health Forum (PCWHF).
2. Selected 6 Local Authorities that differed by demographics, population size, urban/rural areas, and varying contracting structures.
3. Conduct of one-on-one interviews with a range of stakeholders: local authority commissioners, public health practitioners, sexual health providers, practice managers, general practitioners and practice nurses.
4. Analyse the recordings by listing emergent themes, first separately by different members of the team, then once again once themes agreed upon.

We set out to assess whether general practice is at risk of a decline in the number of LARC fitting services currently available, what the biggest challenges to maintaining the services are and what would encourage or incentivise general practice to maintain or expand LARC services. We also wanted to know what information resources could help general practice better understand funding and training opportunities.

These questions formed the basis of an in-depth mixed methods study to determine how to reverse a worrying trend: the likely decline in LARC availability in England due to the variation in funding and complications/complexity surrounding training.

## Goals

**This project aims to:**

1. Understand the drivers and obstacles to the delivery of LARC in primary care in 6 contrasting local authorities.
2. Determine organisational, commissioning and workforce needs to ensure LARC delivery in primary care across a defined population footprint.
3. Develop policy recommendations and use the findings to inform an Integrated Care Systems/ Primary Care Networks (ICS/PCN) tool to support development of an appropriate model to structure the workforce for the delivery of LARC within primary care.

**Mimi Ismail & Lesley Wylde**

1. https://pcwhf.co.uk/resources/larc-fitting-in-primary-care-survey-results/

# Findings

## 1. Drivers to LARC provision:

LARC provision is not deemed to be a priority when compared to other areas of healthcare and not mandatory in primary care. The majority of healthcare providers who offer LARC fittings are motivated more by a personal dedication to offering contraceptive services rather than clear financial incentives. Similarly, most commissioners who are driven and passionate about women's health secure funding to provide LARC services for all indications. In some areas, funding is made available from pooled budgets, ie Local Authority (LA) and Clinical Commissioning Groups (CCG) pooled budgets/funding agreements.

## 2. Obstacles to LARC provision:

The opportunity cost of fitting LARCs is high for primary care healthcare providers. Not only do LARCs not appear to generate enough profit to the practice, but there is also a hidden cost in rooms that cannot be used for other services and in staff that cannot focus on other (potentially more profitable) tasks. Many practices are losing LARC-trained doctors and nurses. Replacing these providers is difficult, because fewer and fewer providers are choosing to learn how to fit LARCs as there is little incentive. Where a practice does offer LARCs, having enough patient interest to maintain the skill is perceived to be another challenge to the practice.

## 3. Commissioning structure:

The structure setting out how services are commissioned impacts the delivery of services. If the commissioner has consulted with providers and then ensures – no matter who is contracted to deliver the service – that service specifications are well communicated with clear measures of success outlined, the provision is more likely to meet the needs of the local population, irrelevant of the demographics.

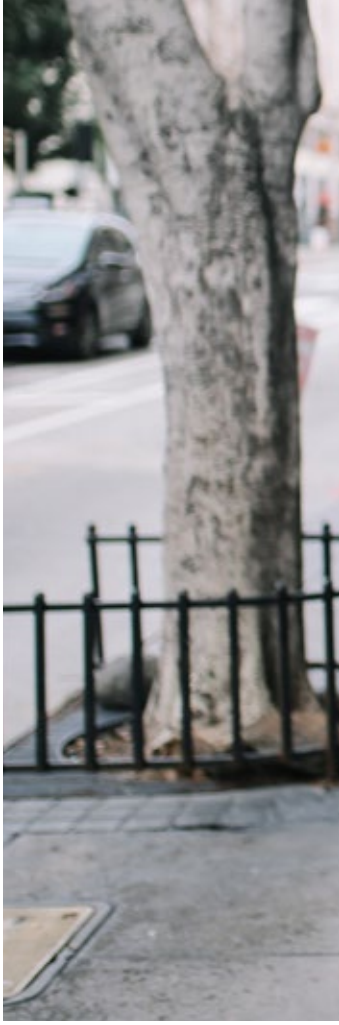
## 4. Sustainability of workforce:

**a. Training:** To fit LARCs is deemed to be expensive in terms of time, arranging backfill of current position and expensive online and specialised in-person training. Many providers have found it hard to find trainers for the in-person practical component, a challenge made even more difficult by COVID-19 restrictions. Training to be a LARC trainer is also time consuming and expensive. Along with it being difficult to access, it results in interested doctors and nurses struggling to qualify or being put off by the process.

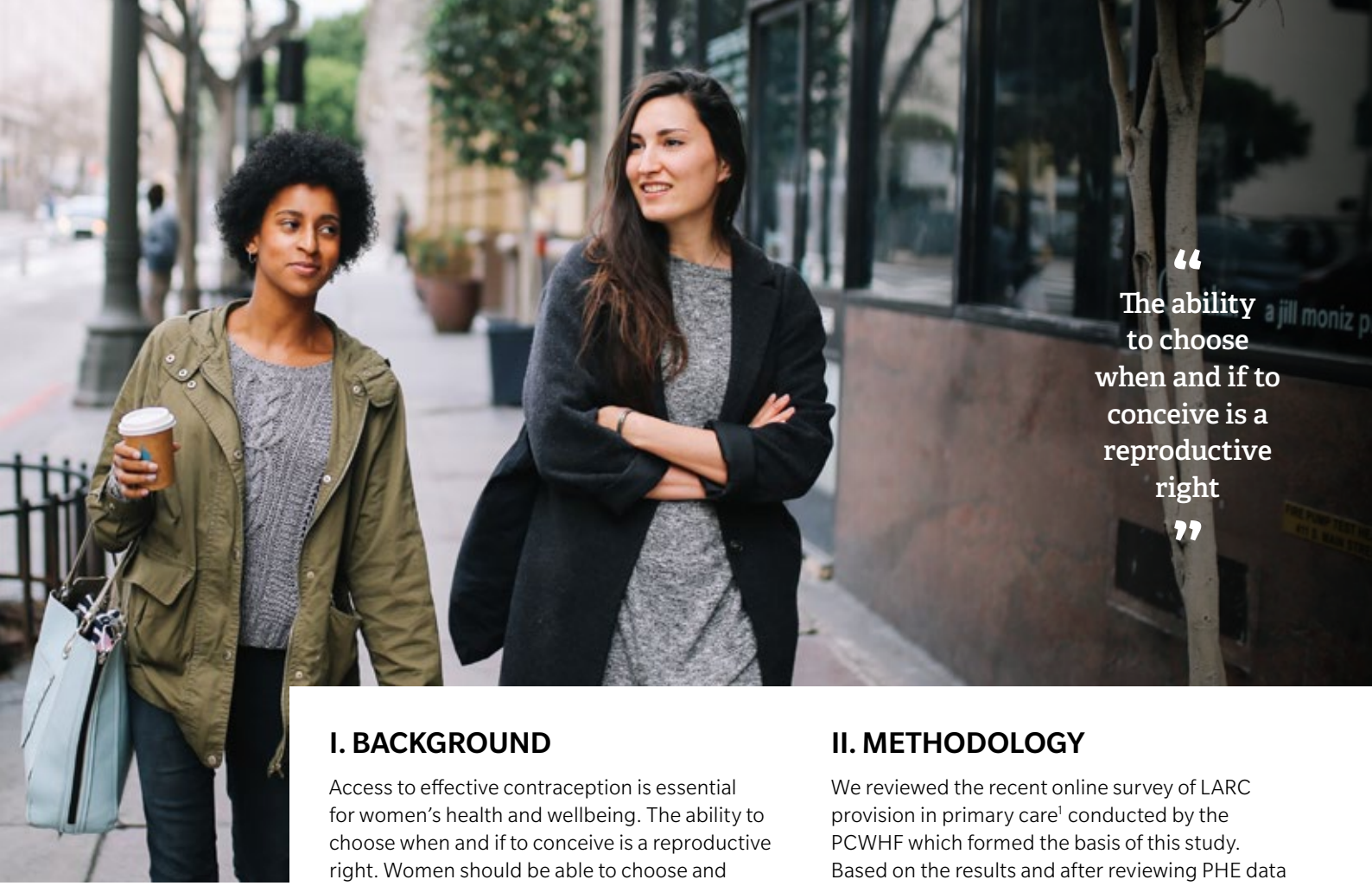
**b. Role of nurses:** Increasing the number of nurses and other allied healthcare providers trained to fit LARCs (especially implants) can help ease the pressure on doctors and is deemed to be more cost effective. With the right training and support, nurses can lead LARC fittings in primary care.

## 5. Women's access to LARC:

According to the providers interviewed, access is predominantly determined by 3 things: good counselling, what referral pathways are in place and women's perceptions of LARC methods. Most providers see the importance of offering options and choice – and endorse the need for improved counselling by non-fitters and fitters alike. Many interviewees voiced concern that providers in non-fitting practices may not be counselling patients on all LARCs and are relying on familiar, user-dependent methods. Another concern is when non-fitting practices and non-fitters are not familiar with who to refer to for which indications, the patient can be referred to the wrong service at an emotional/time cost to the patient and a financial cost to the NHS. Common misperceptions about LARCs (for example, that a coil can disappear in the body) cause many women to prefer other forms of contraception. Good counselling can help.



> "The majority of healthcare providers who offer LARC fittings are motivated more by a personal dedication to offering contraceptive services rather than clear financial incentives"




## I. BACKGROUND

Access to effective contraception is essential for women's health and wellbeing. The ability to choose when and if to conceive is a reproductive right. Women should be able to choose and access their preferred type of contraceptive without any significant obstacles. Long-acting reversible contraceptives (LARCs) are an attractive choice to many women because they last 3-10 years, depending on type. LARCs are also more effective than user-dependent methods like the pill, patch and ring.

Many challenges exist which affect women's ability to obtain LARCs. Many women prefer getting their LARCs fitted by their GPs rather than going to a specialist service. In recent years, however, GPs have reported that offering this service may not be cost-effective at an individual practice level, requires expensive recurring training and certification, and is subject to a confusing array of funding sources. These challenges imperil GPs' long-term ability to continue inserting LARCs, the most effective contraception methods.

This project builds on a recent survey[1] regarding payment issues and training among GPs and practice nurses conducted by the Primary Care Women's Health Forum (PCWHF). The PCWHF survey highlighted the severity of the problem; this project identifies possible remedies to develop recommendations or a tool to support local authorities in strategising for an appropriate workforce and skill mix.

## II. METHODOLOGY

We reviewed the recent online survey of LARC provision in primary care[1] conducted by the PCWHF which formed the basis of this study. Based on the results and after reviewing PHE data on reproductive health and LARC provision in primary care, we chose 6 local authorities for an in-depth qualitative study. The 6 local authorities differed in their rural and urban demographics along with a variety of contracting structures. One of our aims was to identify if either of these factors were associated with high levels of LARC provision in primary care and barriers associated with low levels of provision.

We then conducted in-depth one-on-one phone interviews with local authority commissioners, public health practitioners, sexual health providers, practice managers, GPs and practice nurses from the target local authority populations. The topic guide covers challenges and facilitators to:

- LARC provision
- funding for LARCs
- training
- number of fitters and clinics fitting
- sustainability of LARC fitting in general practice
- women's attitudes towards LARCs.

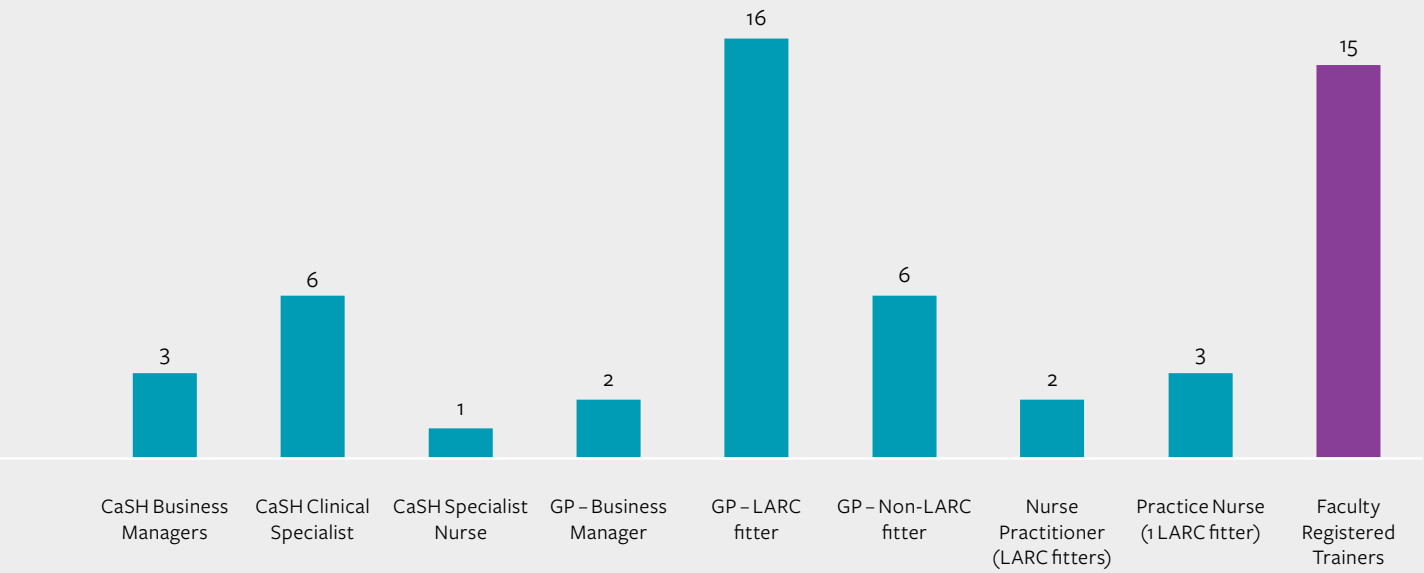
We analysed the interviews using excel to compare between the different local authorities more easily. Two team members separately listed the emergent themes that came up. We then performed a more in-depth analysis on the agreed upon themes and pulled relevant quotes.

1. https://pcwhf.co.uk/resources/larc-fitting-in-primary-care-survey-results/

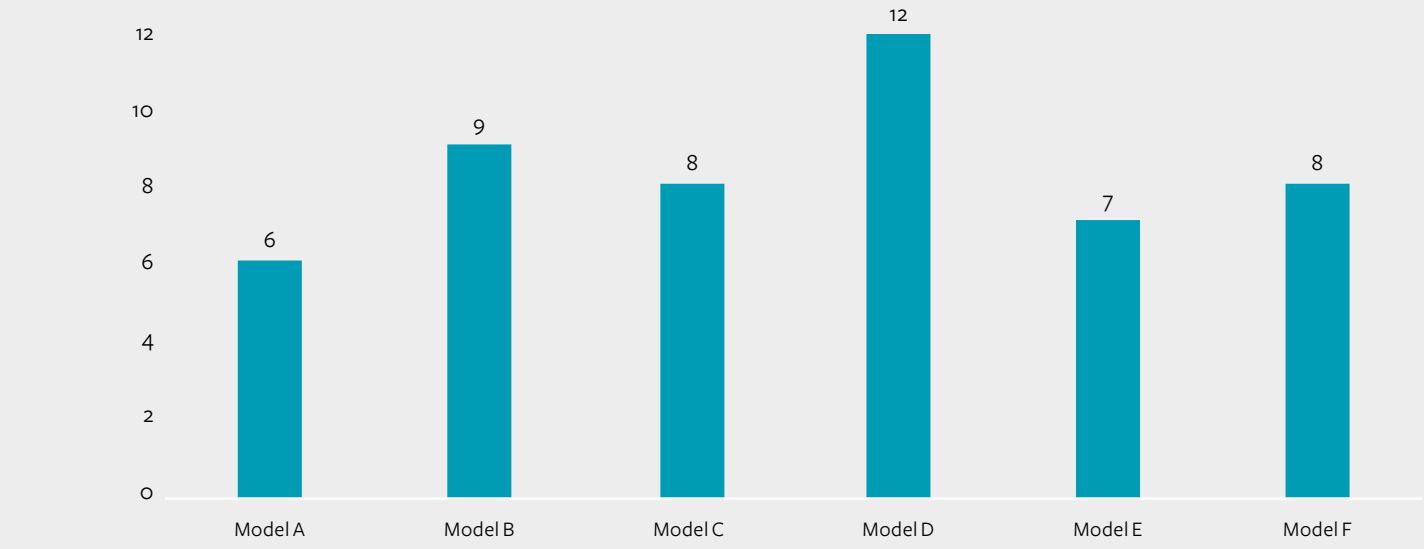
## III. RESULTS

| SUMMARY OF INTERVIEWS | |
|---|---|
| ROLES OF INTERVIEWEE | NO. |
| Director of Public Health | 1 |
| Commissioner – LA Sexual Health | 7 |
| Commissioner – CCG | 1 |
| Gynae/Reproductive Health Consultant | 2 |
| Contraceptive Services – Business Manager | 3 |
| Contraceptive Services – Clinical Specialist | 6 |
| Contraceptive Services – Specialist Nurse | 1 |
| General Practice – Business Manager | 2 |
| General Practice – LARC fitter | 16 |
| General Practice – Non-LARC fitter | 6 |
| General Practice – Nurse Practitioner | 2 |
| General Practice – Practice Nurse | 3 |
| Total Interviewed | 50 |
| of which LARC FR Trainers (2 nurses) | 15 |


## INTERVIEWS COMPLETED




## NUMBER OF INTERVIEWS BY LOCALITY



## IV. COMMON THEMES AND QUOTES EMERGING ACROSS ALL 6 LOCAL AUTHORITIES

> "Many recognise that this is not about the money, and where possible they should continue the service despite the lack of profits"

### 1. Drivers to LARC provision

The majority of healthcare providers who offer LARC fittings claim to be motivated by a personal dedication to ensuring women have access to holistic contraceptive services, however they are often challenged by other members of the practice to demonstrate financial viability. Others in the practice may not see LARC fittings as a priority service in general practice, preferring to focus on traditional GP services and leaving LARC fittings to sexual health clinics. Providers who are passionate about offering a wide range of contraceptives, particularly LARCs, look for ways to make LARC services more financially viable. For example, by offering LARC procedure clinic sessions or days. Many though recognise that this is not about the money, and where possible they should continue the service despite the lack of profits.

#### WHY DOES IT MATTER?

*"A passion for it. A feeling that it is an appropriate service for women. I think particularly where we are - we are further away from mainstream services... It's a good close to home service so it's about my passion, my interest but also providing a good service for women. We don't honestly make money out of it."* ***(GP fitter, Model D)***

*"Personally for me I'm experienced and I enjoy contraception. It's the part of my role where I actually see 'well' people. You know they're not sick when they come to see me, they're well women. In general practice really you do see people from cradle to grave so it's the continuity, you've built up a relationship with the patient and rather than doing all the contraceptive counselling and passing them on to a sexual health clinic they want to see someone that they know and that they trust."* (***Practice Nurse, Model A***)

**Commissioners who believe in the benefits of providing an accessible holistic contraception service, and in many cases a 'women's health service' secured funding to provide LARC services for all indications. In some areas, funding is made available from pooled budgets ie Local Authority (LA) and Clinical Commissioning Groups (CCG) pooled budgets/funding agreements.**

*"[There are] A lot of really passionate GPs around this topic. They do this because they think this is the right thing to do. We hope we reimburse them and see the business side of things as well but they really care about this as a topic. I have heard of GPs coming in on their days off to do emergency coils and things like that because they are just so passionate about it and that is something we really appreciate and value here and we have really good rates of LARC fit and we really value our GPs' enthusiasm for it."* ***(LA commissioner, Model A)***

### 2. Financial Viability

**The cost of providing a LARC fitting service in general practice was perceived to be high by healthcare providers. In general, LARCs do not generate enough, or sometimes any, profit to the practice. There are hidden costs in rooms that cannot be used for other services and in staff that cannot focus on other (potentially more profitable) tasks. Some providers offer LARCs on separate clinic days to make the service more efficient and therefore cost-effective.**

*"... looked at all of the tariffs associated and broken it down to every single level of equipment; to couch rolls, injectables [and] everything you might need as part of the process, heating, lighting, electrics... those are sorts of levels you should be looking at in a table suggesting what you should pay...plus incentivising the fit."* (***LA commissioner, Model B***)

*"There is also the cost-reward side of the argument. At the end of the day GP practices are still independent businesses so what will drive some behaviours for some practices are financial decisions and they may decide it's not "worth their while" because it doesn't produce any significant financial benefit."* (***GP non-fitter, Model B***)

*"Most practices will think of the money. I love doing it which is why I do it and I'm a partner so I can influence the decision making. But if you had a salaried GP it would have to be financially viable for the practice. So, if you are a salaried GP, you might be contracted to do 6 sessions so that 7th session could be a LARC session, but then is it financially viable for a practice to then pay them their salary plus the HCA?"* (***GP fitter, Model E)***

*"Are people supportive? on the whole yes, bit of a juggle going back over finances and funding, the claims process is complicated and we had a financial viability meeting not long ago about it... what's really hard with LARC is getting people to understand you can't look at those cold hard figures of fitting, it is looking at the long term investment but it's hard to quantify that...it's an upfront payment...a well-chosen LARC fit for the right patient, you might not see them again for 10 years and you have to put that in the mix when you are weighing up finances and funding, it's really hard to persuade non-fitters and GP partners to take a step back and see it like that, not only what is right for the patient and provision and patient preference but even if they think they are out of pocket up front they have to realise if someone coming back every 3 months for a repeat pill check it is monetarily rewarding as well, not top priority but has to be factored in."* (***GP fitter, Model B***)

*"Then there's that cost to the practice. Is the practice going to have to invest in resources just to start that clinic? We're not just talking about paying for the doctor or using that session to fit LARC instead of seeing other patients, you also have to think about the assistant which at the very least needs to be a healthcare assistant so you have to pay for their time and also equipment. They're not expensive but they're not cheap either and you then have to buy the actual device which again is not expensive and you can always claim it back. So, they kind of add up and if you're only giving £80-90 per fitting, let us say you do one every half hour - just to be very conservative. In 1 hour, you do 2 fittings, that is £180. And for a salaried doctor I have to pay them about £60-70 an hour and another £12-15 an hour for a health care assistant plus equipment cost, that's maybe about £10. There's very little left so it doesn't make financial sense for some practices."* (***GP fitter, Model E***)

*"By the time you factor in equipment, cost of device, GP or nurse cost, chaperone, you break even. There is no profit. Over the years I've had a lot of pressure from partners and managers [who] ask "How are you going to make this more cost effective?"* (***GP Fitter, Model C***)

## 3. Commissioning structures

Commissioners map their current access to LARC provision and resources are structured to meet the needs of the local population, taking local demographics into consideration.

Provision varied across the 6 LAs – some were predominantly through general practice in primary care, others in specialist community contraception services or alternatively a combination of both depending on availability of LARC provision. Irrelevant of the structure, the provision of an accessible LARC service relies on good relationships and two-way communication through a stakeholder network with an interest in providing accessible LARC provision across the area.

Commissioning structures for provision of LARCs varied between:

- Established contract between LA and Community Interest Company who are responsible for specialist contraception service and subcontracts with general practices.
- New contract between LA and Hospital Trust who are responsible for specialist contraception service contract. As part of this contract the specialist contraception service is responsible for the subcontracts with general practices.
- LA commissions the specialist contraception service contract and multiple individual GP contracts directly.
- PCNs/GP confederations are directly commissioned to deliver a LARC service across primary care on behalf of the local population (in some cases using peripatetic fitters).

*"We've got a chance to deliver a 'general practice reproductive health' model through primary care networks."* (***LA Commissioner, Model B***)

*"New contract holder over the summer. [We had] 2 weeks to complete a process [and I'm] uncertain whether [we are] still registered as a fitting practice...[I'm] uncertain whether referrals to other practices for coil fits are allowed with the new contract."* (***Practice manager, Model D***)

*"It's often a battle to say "This is a priority" when so many pressures are on general practices."* (***GP fitter, Model C***)

## 4. Workforce Sustainability

### A. TRAINING AND MAINTAINING SKILLS

Many practices are losing LARC-trained doctors and nurses. Replacing these providers is difficult. Fewer providers are choosing to learn to fit LARCs as there is little incentive financially or otherwise. Where a practice does offer LARCs, having enough patient interest to maintain the skill is another challenge that providers perceive they face. Patients rely on the skills of non-fitting healthcare professionals to raise awareness of LARCs, counsel and refer for treatment.

*"I think that the 12 [coils] the faculty suggested as the minimum number for reaccreditation...I personally think that is too low...I'd be concerned if a small practice would be doing this service because I don't think they'd be getting their numbers through [to maintain their skills]"* (***GP fitter, Model D***)

*"For LARC training, it's really really hard because after your training as a GP you get 'spat' out of your training program and you work as a locum possibly and you don't always work somewhere regularly and you won't have that opportunity to use your skills and to get trained."*(***GP fitter, Model E***)

Fitting LARCs requires expensive online and specialised in-person practical training. Many providers have found it hard to find trainers for the in-person component, a challenge made even more difficult by COVID-19 restrictions. Training to be a LARC trainer is expensive, time consuming and not easy to access, resulting in interested doctors and nurses struggling to qualify or being put off by the process.

*"I've not really looked into [training in the area] it but I guess for me it's really the funding, if I want to do it I would need to pay for it and I find that crazy, so I think access to funding...As medics we have to pay for everything that we do and if it's for a service that you're not massively passionate about initially then you're certainly not going to do it. I don't know about the local availability for training because I haven't looked at it because I just can't afford it right now."* (***GP non-fitter, Model F***)

*"If you want to get retrained [the] hassle of getting a temporary contract takes a minimum of 3-4 months and that's if you're eager and organised... one of the things we are hopeful about [is] we have friends who haven't fitted for a year or 2 and want to get back into it. We're qualified to train, I'm in the process of completing my certificates for that so we will be able to help with that."* (***GP fitter and trainer, Model B***)

*"They make you jump through a lot of hoops. I'm not convinced that's actually really necessary... too much effort to become a trainer. There's lot of people out there who fit lots of implants and coils who could very easily train a lot of people. but to actually become a trainer is quite an arduous task."* (***GP fitter and trainer, Model C***)

*"I've done a lot of training recently for nothing because you know I think things are just becoming impossible for people to afford."* (***Gynae consultant and trainer, Model B***)

*"Faculty has been slow to recognise that there is a wealth of talent in general practice not just in sexual health services...they need to be more pragmatic and allow for more training in general practice."* (***GP fitter, Model D***)

Having someone at the practice that is already trained in LARC fitting will make providing the service much easier, despite the financial and time obstacles discussed by most providers.

*"Everyone in the practice knows I've got an interest in coil fitting, so I think that influences the number of patients that actually come for coils. If we didn't have a coil fitter in the practice that would maybe have some sort of bearing. I think that is one of the biggest reasons we do fit coils. Plus, I love doing them."* (***GP fitter, Model E***)

> “As wonderful as nurses are, it helps to have a doctor to guide the services”

**B. ROLE OF NURSES**

Increasing the number of nurses trained to fit LARCs, especially subdermal implants, could help ease the pressure on budgets, as funding a nurse to provide a LARC clinic is more cost effective than a doctor. With the right training and support, nurses can take more of a lead in LARC fitting services in primary care. However, many providers agreed that they would continue to need doctor support for complicated cases.

*“As a nurse if you are not in a service that does it all the time where you’re going to get the support when you need it, that I think is another barrier…I don’t see them as stand-alone fitters in a practice.” (**GP fitter, Model B**)*

*“I think general practice is so busy. You know we’re being pulled in all sorts of different directions. It is, you know, GPs’ time particularly if they’re part time, how are they going to make the best use of their time for the patients and contraception may fall down a little bit. This is why nurses generally, I think, can offer more because we have more time to offer that sort of sort of side of nursing care really.” (**Nurse practitioner fitter, Model A**)*

*“It’s more cost effective to allow a nurse to run that clinic than it is for a GP. GPs are an expensive commodity…But you need doctors to help lead the service in my opinion and make the difficult decisions and work outside the box. As wonderful as nurses are, it helps to have a doctor to guide the services.” (**GP fitter, Model C**)*

*“No real profit in it. Implants are more attractive because they require less costs: you don’t need someone in the room, it’s fairly easy to insert and is an attractive method to nurses unlike coils.” (**GP fitter, Model D**)*

*“Ideally this would be a nurse-led service.” (**GP fitter, Model C**)*

*“Practice nurses were the best trainees I have had, I’ve never met a practice nurse that wasn’t a good trainee ever, they were all raring to go but then the realisation that there was no uplift in salary or study leave or any perks, no acknowledgement.” (**SRH lead clinician, Model D**)*

## 5. Accessibility

LARCs are not always easily accessible. Women's ability to get LARCs appears to be driven by postcode. Patients attending fitting practices or specialist services are likely to be offered a full choice of methods as they are all available, while those in non-fitting practices are potentially not offered all methods and/or not referred on to fitting services. This was found to be the case across both rural and urban authorities.

*"It's not fair at the moment because you've got practices that do coils, and you've got practices that don't do coils so it's not a fair distribution for patients actually. It is not equal. We need to think of something that is a bit fairer for distribution."*
*(**GP fitter, Model E**)*

Where non-fitting practices and non-fitters are not familiar with who to refer to for which indications, the patient can be referred to the wrong service at an emotional/time cost to the patient and a financial cost to the NHS.

*"If I knew what the family planning clinics are allowed to do that would be a good start for me, so I have a clear idea of what they are commissioned to do...We provide depo[provera] so I signpost to the nearest LARC provision a few miles from our practice. I google the number, write it down and explain what to expect: ring this number and someone will ring you back...Don't have any structure in place to call them back and ask whether they did go." (**GP non-fitter, Model B**)*

Providers offered a few suggestions for ways to improve access. They believe increasing the number of GPs offering LARCs, improving existing capacity or allowing providers in general practice to book the appointment for their patients at external services could ease women's journeys for contraceptive services. One way to increase capacity and streamline services is to create a Women's Health Hub[1]. Non-fitting GPs can work with fitting practices to set up a referral pathway for their patients.

*"I think the arrangements that the GPs have amongst themselves, where they have a Hub that they can refer to a local fitter who will take patients from other services is great so long as everybody knows about that." (**Sexual Health Consultant, Model E**)*

*"[A] win-win situation whereby there is a Hub in 3 localities - North, West and South - and then supply 6 days a week service and staff it with people working in the Hub and our nurses who are fitters like XX and XX who have just retired. [There's] no reason why we can't have 3 big Hubs where women could have an emergency coil any day of the week...could train people in the Hubs and it is very efficient...most important thing is to provide women [with] a more convenient place to have their LARC 'on tap'" (**Sexual Health lead clinician, Model D**)*

*"Increas(ing) the number of places that offer it, or increase the capacity in our current services. So, none of us have a problem referring to [sexual health clinic]. It's easy. You just [say] "Here are the details, go and contact them." But I guess the thing is if a patient has come to you saying they want LARC, what is really nice is if you are able to book them into something. Otherwise, it depends on when the patient can be bothered to call sexual health. And at the moment, you have to do it online, you can't even call them and the waiting times are huge and there is a risk they can get pregnant in between the times they wait for their LARC."*
*(**GP Partner and fitter, Model E**)*

*"Do you not think that we all know that this is a problem up and down the country and we've been talking about Hubs and all that forever. Do you not think at some point you will need the PCNs to come forward, people who have the budgets, because there is money I do believe that but it is all fragmented...we need somebody who has the general idea of what is happening so that the money can be better spent and appropriately spent - probably it's just about moving things."*
*(**Sexual Health lead clinician, Model D**)*

*"More appointments because especially if somebody is considering a coil, they often don't want to bridge the gap with a pill because of the side effects and they may not be suitable for the pill so more appointments so they can get booked in sooner. Also I think we probably lose a lot of patients if they have to wait. For instance, I had to wait 6 months or something, mainly because of COVID, but if there's more obstacles in the way less people are going to get it done and it's going to seem less 'normal' so I think if we offer more clinics, I think it would normalise it a lot more." (**GP non-fitter, Model F**)*

1. www.whh.pcwhf.co.uk

# 6. Provider perceptions of women's attitudes towards LARC

It is perceived by providers of LARC services that a lack of awareness and common misperceptions about LARCs (for example, that a coil can disappear in the body or that women may have long-term fertility problems) may cause many women to choose other forms of contraception. Good counselling can help ease patients' anxieties and dispel common myths.

Providers fear that many women will trust the experiences of friends and family members, even women on internet forums, rather than the advice of the healthcare professionals. There are also women who may not know what contraceptive options are available to them and may not seek out LARCs. Providers committed to the reproductive health of their patients will take every opportunity available to discuss women's contraceptive choices.

*"It's about opportunistic discussions... contracept[ion] and women's health [are] always on my mind as a GP and there aren't many under 20-year-olds that will leave my room, or I'll end a telephone discussion with where I don't ask them what contraception they are using and whether they have had a chlamydia test recently."* (***GP fitter, Model C***)

*"Knowing how and where to access them, particularly in the health inequality piece, making sure that it is not just informed middle class women who feel empowered to be able to ask for these and seek out these methods of contraception but actually looking at women's community group. Because I work in a very diverse community so thinking about African and African Caribbean women who have lots of issues with fibroids as well as contraception so actually you would be wanting women to become empowered to understand that actually the coils can have lots of benefits for them for managing bleeding patterns and things like that as well as contraception. So, for me there is something around that outreach piece."* (***GP fitter, Model F***)

*"Most of the women that have wanted it have had a...relative who has...told them have this and don't have this so they have some pre-conceived ideas. So when I have my conversations with them, I can address those and say everyone is different ... There is still a little bit of that old idea around the effect on fertility and some still ask me that question."* (***GP fitter, Model C***)

*"Oh my friends got that so I want it, or my mum's had a coil and she likes it so that's why I'm having it...anecdotal stories always impact patients so young, every now and again [I] come across a patient where you know Mirena would be a great idea for them but they are adamant that their mum and their friend next door had a horrendous time with it and they won't go near it...no matter what you explain to them [about the] evidence they go by their mate's story. Word of mouth [is] what prevents them from getting LARCs."* (***GP fitter, Model B***)

*"It's word of mouth. If they have spoken to someone they know and trust they'll put more trust in that person than the clinician of contraception. And myths as well and that is because they don't understand necessarily how that method works...Some patients don't really know about contraception and the variety of contraception available and how they work."* (***Nurse practitioner fitter, Model A***)

Some women may not know how to access services, and where to go depending on their health issue. This has been particularly confusing since 2013 when Integrated Contraception and Sexual Health services stopped providing routine gynaecology services due to the changes in commissioning and funding.

*"Patients get lost in the system; for instance the HMB patients, patients wanting smears, fitting a coil but not allowed to do smears so have to go back to GP and go through that again. All sorts of things we used to be able to do in Sexual Health we have to send them all back* to the GPs now and quite often the GPs have less experience than we have, and they have often sent them to us in the first place. Sometimes they end up having to go to secondary care because we are not commissioned to treat them and that costs a huge amount more money." (***GP, Model D***)

*"In years gone by we did fit for hormone replacement therapy, heavy menstrual bleeding, we used to see people with menopause problems, premenstrual syndrome and it worked much better because of course these things come up as part of your consultation. We have many women who have been coming to our services for many years for their IUS for example, and they suddenly get to post-menopausal and they still want it as part of HRT and we're not allowed to do it and its deeply frustrating for all concerned. And also, a complete waste of NHS money. It's obviously awful for the patient who comes and is told they can't have it, they've gone away again, they've got to make another appointment with their GP, their GP maybe isn't so sure where to send them because they're not IUS fitters themselves. We used to be their pathway but now we're not and it's just, you know, if you look at the amount of time the NHS as a whole spends on it, it just doesn't seem like a cost-effective pathway at the moment."* (***Sexual Health Lead, Model E***)

*"[I] don't understand those patients who don't know about LARCs or might have asked GP and been told they don't provide service, that hidden group of women we don't pick up on."* (***Specialist Contraception Service Commissioner of GP contracts, Model D***)

# RECOMMENDATIONS TO IMPROVE PATIENT ACCESS, PROVISION AND SUSTAINABILITY OF LONG ACTING REVERSIBLE CONTRACEPTION (LARCs) ACROSS PRIMARY CARE.

## To overcome the obstacles

**PRIORITISATION (LEADERSHIP):**

- To ensure prioritisation of women's health there needs to be integrated clinical leadership with responsibility and oversight for contraception delivery (including LARCs) across Public Health (PH) and NHS England at national, regional and local levels

**FINANCIAL VIABILITY (INCENTIVISATION)**

Explore incentive schemes for improving access to full range of contraceptive choices e.g.

- Agree and introduce a national 'fair' fitting/removal fee for LARC methods in primary care
- Re-invigorate the contraception quality outcomes framework (QoF) measure in primary care
- Reward collaboration in commissioning and provision of LARC services for all indications (including non-contraceptive benefits)

**ACCOUNTABILITY:**

- Ensure joint responsibility across different commissioning and provider bodies for delivering and communicating a holistic approach to ensure access to LARC methods for all indications
- Require all local areas to develop a costed recovery and sustainability plan accountable to Integrated Care Partnerships/Services (ICP/S) for delivery of holistic contraception/LARC provision
- Specify common access and outcomes metrics for benchmarking including reporting on number of active fitters per unit population

## Provision

**COMMISSIONING FRAMEWORK:**

- Provide a national guidance/specification or 'making it happen' document to support commissioning for a population footprint, keeping the patient journey at the focus:
  - Models of collaborative commissioning – agree the structure then cost/source funding
  - Fair fitting fee for primary care
  - Demonstrate return on investment
  - Specification for commissioning a central booking system for self-referral at population level
  - Workforce planning tool

**NEW MODELS OF DELIVERY:**

- Consider Women's Health Hubs[1] (from menarche to menopause) ensuring good referral pathways and signposting to improve capacity
- Communication – required 2 ways between the key stakeholders/providers to ensure 'buy-in' to drive and develop the model
- Develop a costed service model for local adaptation and commission hub pilots for a national evaluation

1. www.whh.pcwhf.co.uk

## Sustainability

**WORKFORCE AND TRAINING:**

- Training to be included in the national commissioning framework (consideration given to costs of funding and time taken out of practice for training for both Trainers and Fitters)
- Simplify training programme for LARC and reaccreditation
- Review and develop training pathways
- Widen LARC training to reach more allied healthcare professionals
- Create a joint women's health training/ competency framework
- Non-fitters and non-fitting practices – Training on counselling on all methods of contraception/update on women's health issues. Introduce/improve referral pathways – signposting to appropriate colleagues/services
- COVID-19 – review the positive impact on contraception services, telemedicine increased capacity for face-to-face fitting appointments. Consider whether the vaccination appointment booking system is suitable for booking LARC appointments systems.

## Improving patients' awareness/access to LARCs

- Improve counselling and access to information about all methods
- Contraception social media campaign, with a focus on how and where to access all methods of contraception

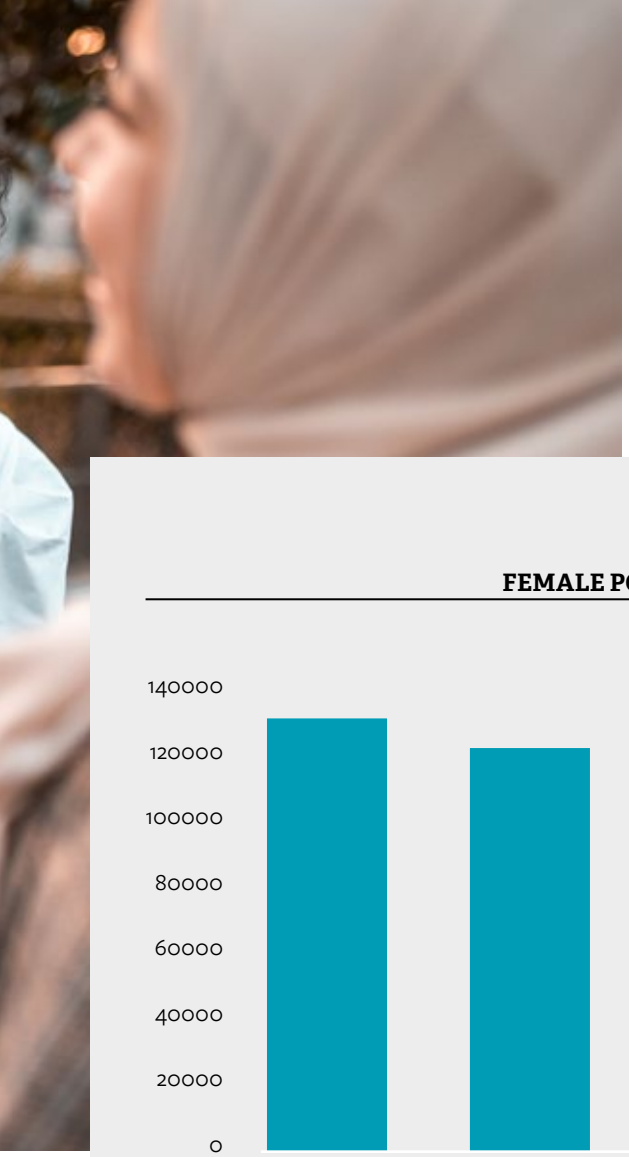
# APPENDICES

## Appendix 1:

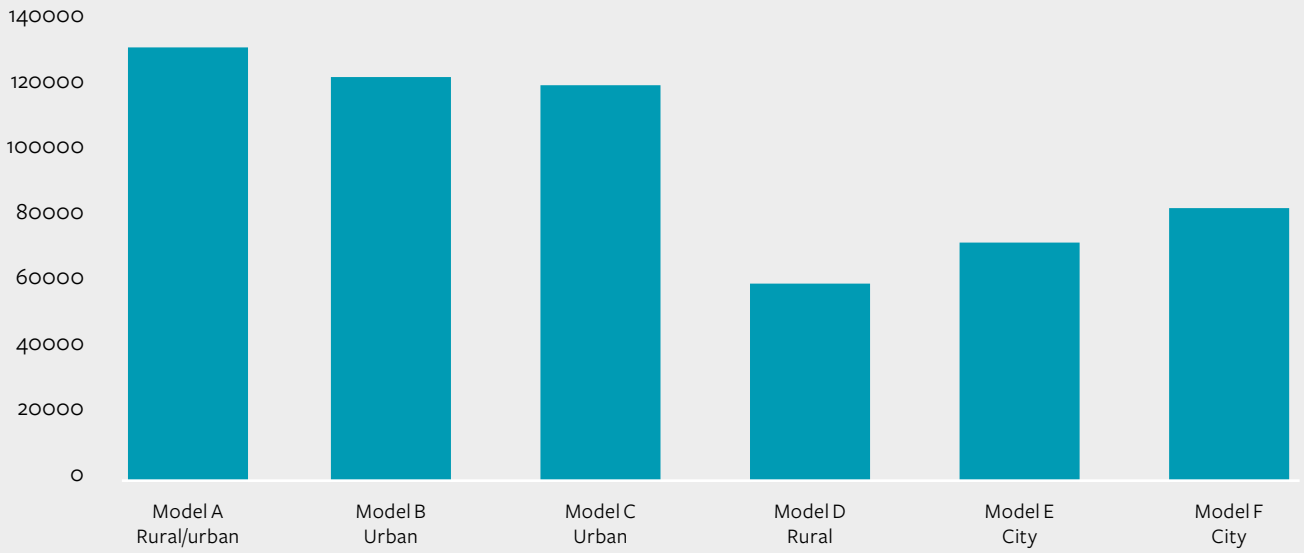
**We selected 6 Local Authorities looking at baseline data compared the variation in size of female population, demographics, commissioning structures and provision of LARC through Specialist Contraception and Sexual Health Services (CaSH) and primary care/ general practice.**

- **Models A and D** are predominantly **rural areas** with higher-than-average rates of LARC provision in primary care (5.64% and 3.39% respectively) and lower-than-average termination of pregnancy rates. Both models managed all contracts directly, however **Model D** have recently subcontracted the GP LARC contracts to the NHS Foundation Trust who manage the specialist contraception services (CaSH). As of August 2020, the CaSH service is responsible for managing GP contracts.
  - **Model A** CaSH service is only available to under 25-year-olds, hence a low level of provision compared to the primary care provision where the majority of practices offer a LARC fitting service.
- **Models C, E and F** are predominantly **urban/city** demographics with lower-than-average LARC provision in primary care (2.9, 1.11 and 0.75% respectively) with termination of pregnancy rates on par with the England average.
  - **Model C** LA subcontracted CaSH and GP contracts to a Community Interest Company (2014)
  - **Model E** LA manage CaSH service and all individual GP contracts (2013)
  - **Model F** LA manage CaSH services directly and subcontract GP contracts through GP Confederation (2019)
- **Model B** is an **urban area** with a low level of LARC provision in primary care (1.23%) and higher than average termination of pregnancy rates. The LA is in the process of tendering the Specialist Contraception Service and GP contracts – all will remain direct between the LA and providers.

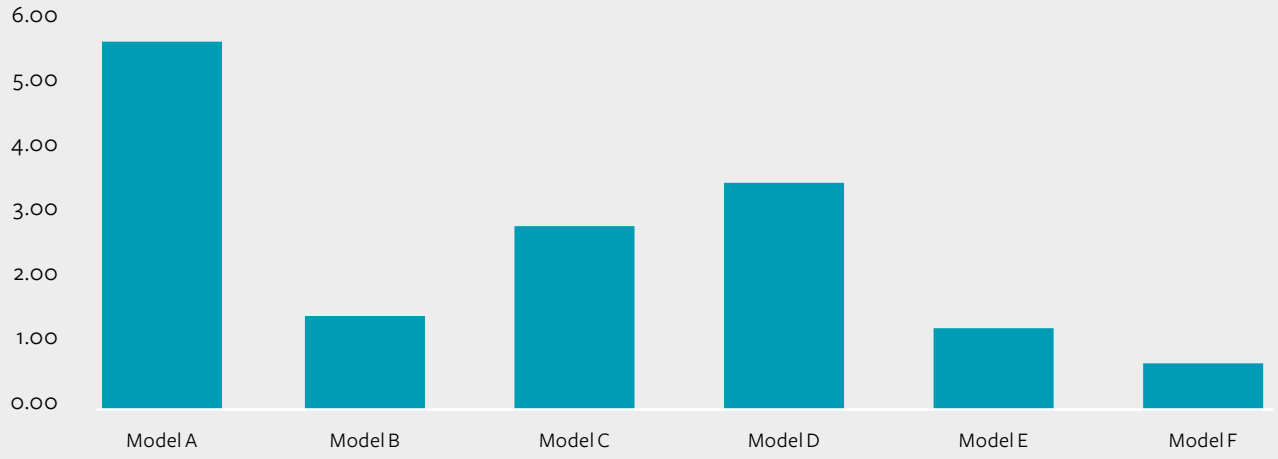
During interview it became clear that Models B, D, E and F recognised a need to improve Women's Health services and increase access to LARC methods for all indications. All four models have recently introduced changes to improve services and it would be worth reviewing these models to see if these improvements are reflected in workforce perceptions and uptake of LARC for all indications.



**FEMALE POPULATIONS FOR 6 SELECTED AREAS**

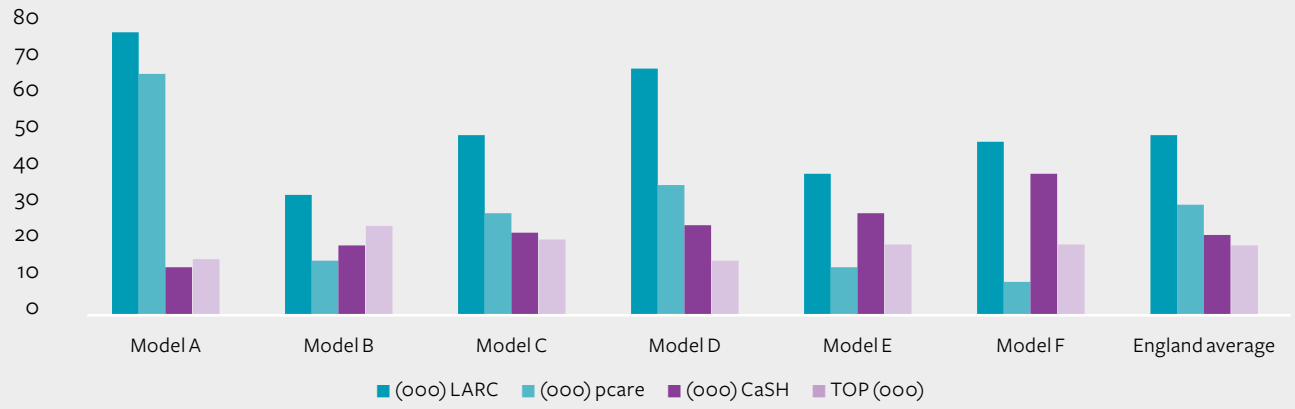



**% FEMALE POPULATION FITTED WITH LARC IN PRIMARY CARE**

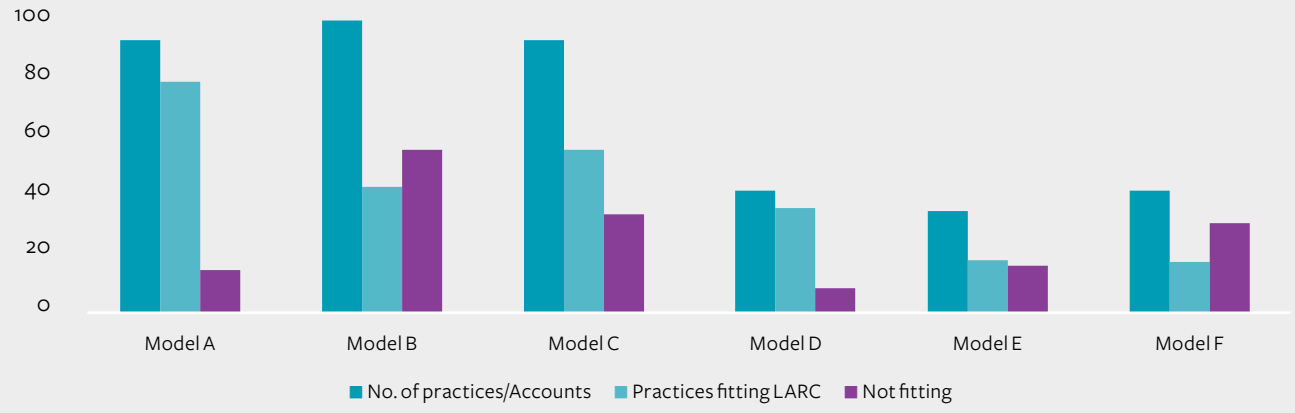


| FEES FOR SERVICES | MODEL A | MODEL B | MODEL C | MODEL D | MODEL E | MODEL F |
|---|---|---|---|---|---|---|
| **Implant fit** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Implant remove** | Yes | Yes | Yes | Yes | Yes | Yes |
| **implant replacement** | | | | Yes | | |
| **IUS fit** | Yes | Yes | Yes | Yes | Yes | Yes |
| **IUS remove** | | Yes | Yes | Yes | Yes | Yes |
| **IUS review** | | | | | Yes | |
| **IUS replacement** | | | | Yes | | |
| **IUD EC** | Yes | | | | | |
| **DNA/inappropriate referral** | | Yes | | | | |

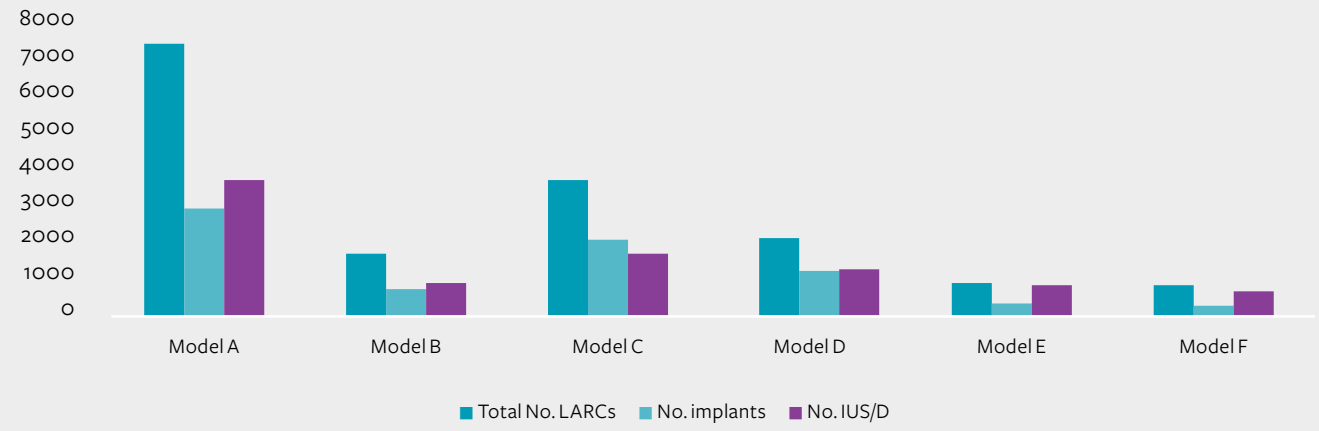
**TOTAL LARC (000) v PRIMARY CARE PROVISION v CASH v TOP**



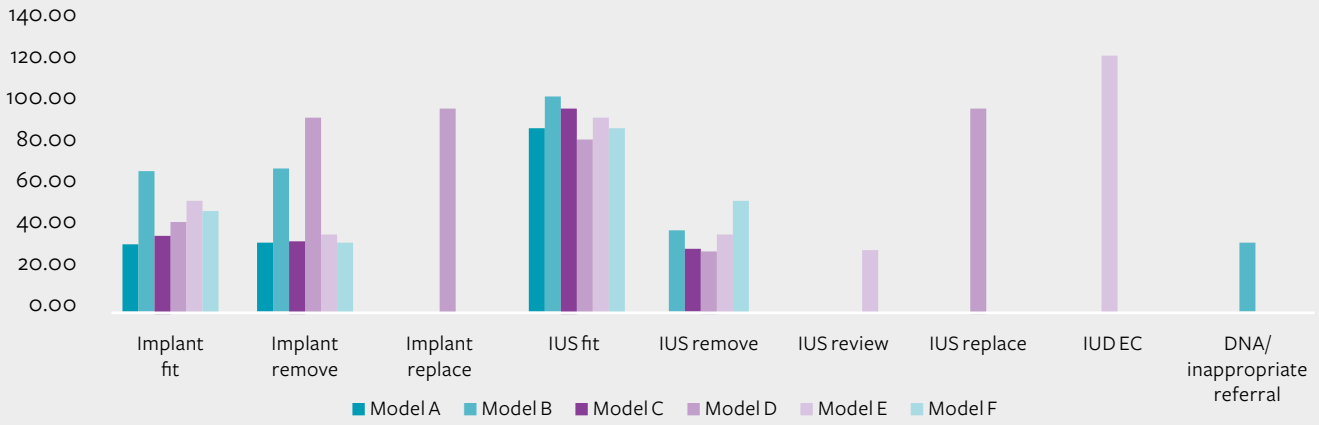

**NUMBER OF PRACTICES FITTING LARC IN GENERAL PRACTICE**



## PROVISION OF LARCS IN GENERAL PRACTICE –BREAKDOWN BETWEEN IMPLANTS AND IUS/D




## LARC FITTING/REMOVAL FEES ACROSS GENERAL PRACTICE



## APPENDIX 2: PROMINENT THEMES FROM INTERVIEWS – RURAL AREA

### 1. Commissioning structure

**LOCAL AUTHORITY CONTRACT INCLUDES:**

- Contraception and Sexual Health service (<25 only and vulnerable women)
- General practice individual contracts to deliver LARC

Local Authority enhanced service specification (LES) stipulates that funding covers contraception only, however, practices currently claim fits for all indications. When Public Health took over the contract from 2013 the understanding was it included monies to cover HMB and menopause fits. CCG does not provide any additional funding at present to support fitting of IUS for non-contraceptive benefits i.e. heavy menstrual bleeding (HMB) or menopause fits; this includes sexual health service.

*"Our spec is for contraceptive use. [This is] sometimes a grey area. Officially, we don't [pay for non-contraceptive use]. It's only done for contraceptive purposes, but we can't monitor every fit that's done. And for some women it will have a dual benefit so it's difficult to pick apart."* (***LA Commissioner***)

*"I think the only time I would not claim a fee for Mirena, and they are predominantly Mirenas, for HMB would be if it was absolutely not going to be used for contraception as well. But in my view 99% of women are having it, it's also for contraception...I think when this moved over to the local authority, all the funding for coil fitting moved to the local authority and that included at the time heavy menstrual bleeding fits, I think that new enhanced services say for contraception purposes only, but nobody has ever drilled into it. I think there was an argument at the time between the CCG; if it wasn't going to include heavy menstrual bleeding, all the money shouldn't have gone so I think there is a commissioning gap there." (Practice manager)*

*"We don't have the capacity [to fit over 25s]. We are not commissioned to fit coils for non-contraceptive reasons and if someone is referred for HRT or menorrhagia only then, again, we would not be able to fit Mirenas."* (***Sexual health service lead***).

### 2. Drivers and obstacles for LARC provision

Local authority has high LARC prescribing in primary care with about 90% of general practices offering LARC services. Sexual health services only see vulnerable women (for example, women who had undergone recent abortion or women with disabilities), women 25 and under, and for cases with difficult fits or removals. Providers in general practice deliver a LARC service because they have support from their practice, a personal interest, particularly a passion for women's health, in offering contraception. Cost and financial viability are not seen as sufficient obstacles to LARC provision, despite the lack of profit from the service.

*"They don't really do it for the money...I know we lose money on it but actually where we might lose money on the fit we gain so much more because the contraception is in place [for years]...It's a lifetime of attendance."* (***Practice manager***)

*"I think it depends if there is a passion for it in the individual clinician. I personally wouldn't want a fitter who isn't passionate in the area."* (***Practice manager***)

*"A lot of really passionate GPs around this topic do this because they think this is the right thing to do. We hope we reimburse them and see the business side of things as well, but they really care about this as a topic, and I have heard of GPs coming in on their days off to do emergency coils and things like that because they are just so passionate about it and that is something we really appreciate and value here. We have really good rates of LARC fit and we really value our GPs' enthusiasm for it."* (***LA Commissioner***)

One potential obstacle for continued provision of LARC services is the loss of trained providers. With insufficient in-person training opportunities available, losing a trained provider to retirement or a new practice can leave practices without the ability to continue offering LARCs. One nurse was unable to find someone to take her on for the in-person training required for coil fits. She feels there is "definitely a training deficit at the moment."

"One potential obstacle for continued provision of LARC services is the loss of trained providers"

*"[Practices] often have only one trained fitter then if they go off sick or leave, it leaves a bit of a gap for that practice while they then either recruit or train up a member of staff. Merged or bigger practices can perhaps afford to have a number of fitters, so they've got more resilience. Particularly for smaller practices might be difficult to have more than one fitter might be an issue. [We] do our best helping [and] encourage practices to refer to one another and utilise those additional clinics - one of the main barriers. Something we try to keep an eye on things through audits but sometimes [we] hear about waiting times for women in practices can be down to lack of fitters." (**LA Commissioner**)*

*"Because of COVID and [limiting] the number [of people] in the room and the safe distance so that training was sort of stopped for some few months from between March and September, but then we had again started but then I was affected by COVID and I'm on phased return so as the training lead I had to [stop]. But we have got sexual health doctors who train in our service, especially those trainees who are about to finish their training who are on the previous old FSRH model; we were making sure we would complete their training before their time runs out." (**Sexual health lead**)*

*"The only thing that would stop us at the moment are COVID restrictions. Room access is quite often a problem right now. We are a vaccination centre, so we are trying to work around them to keep [LARC fitting clinics] going." (**Practice manager**)*

*"Commitment to allow staff to take time to do training takes out of practice time. In our contract we have with practices we have a small amount of money practices can claim each year – a few hundred pounds per practice per year educational allowance [is] something we are keen to look at to see if there is something better, we can do with that pot of money around training...get feedback from GP practices to see what we could do better to help support."(**LA Commissioner**)*

## 3. Accessibility

**Accessibility to LARC is determined by whether there are sufficient clinics that offer the services and whether women know where to go to get those services. But providers also voiced concern that some women still don't know what contraception options are available to them. There is a need for better counselling, advertising and education.**

*"[Access to LARCs] is a high priority but I still think it is not ideal. I think the ideal is somewhere they have the choice to walk into. They don't have the choice to walk into us. They have to make an appointment and sometimes we still have Do Not Attends (DNAs)...there's a bit of me that thinks if only we had better, quicker access then we might get those people who want it now that we lose because we don't have that...I think they aren't sure where to go at the moment...I think there is a reluctance to contact your own practice...my dream would be a national website that you could go into, put your postcode in, your age and then it would tell you where you could go and give you a confidential inquiry box that came through to us. So, you're not ringing the surgery where you're known coming into the waiting room." (Practice manager)*

*"Still surprised that women still don't know about their contraceptive choices. There is a need for education and better advertising." (**Nurse practitioner**)*

*"It's word of mouth. If they have spoken to someone they know and trust they'll put more trust in that person. And myths as well and that's because they don't understand necessarily how that method works...some patients don't really know about contraception and the variety of contraception available and how they work." (**Practice Nurse**)*

*"...We also have a maternity contraception service, it was a pilot which we have now established as routine, we train up [the] maternity service to be able to provide contraception. They can provide implants but can't do the coils." (**Commissioner**)*

## PROMINENT THEMES FROM INTERVIEWS – URBAN AREA

### 1. Commissioning structure

Historically, there has been a low provision of LARC services both in primary care and specialist services. As a result, and as of 2019, services are in the process of being redesigned with contracts going out to tender.

**LOCAL AUTHORITY CONTRACTS INCLUDE:**

- Specialist service (Contraception and Sexual Health) contract – currently delivered by 3 organisations. New service specification is for one provider to deliver a service that complements the current LARC provision in primary care.
- Primary Care Networks/General Practice contracted to deliver LARC have been redesigned and released.

Local Authority funds IUS for non-contraceptive purposes, i.e. HMB or menopause fits. GP practices and CaSH fit for all indications agreed with LA. The new specialist service contract will include fitting for postpartum contraception (maternity and TOP services). There is still no additional funding from CCG for community gynaecology services.

*"Funding; I think we might be in a unique position where we can move things and do what we need to do with it, thinking about other people from a funding perspective, the 'integrated' bit would be fine but 'general practice' bit would be tricky...Some are coming forward suggesting incentive schemes we have in place [but it] doesn't quite add up ... thinking through those spending models and if you've put GP provision into the main contract with [the] integrated provider...how they funnel and move this money around could be a critical barrier but could be a massive opportunity and [a] huge success if they could see what potential there is to do more LARC and things in other places. But funding is tight and in lots of cases people haven't had enough to deliver...offer with what they've got, let alone give money to general practice. [There are] lots of barriers. [I] could go on all day [on] funding and viability. But I have lots of solutions..."* (***LA Commissioner***)

*"Dependent on people who have a bit of individual thinking about them, our LA commissioner is very unusual, most commissioners just do what they are told or not inventive at all with what they are given to work with."* (***Gynae Clinical Lead***)

### 2.Drivers and obstacles for LARC provision

Lack of LARC services across primary care, insufficient payments for fitting LARCs, few LARC fitting training opportunities and maintaining competence of fitters were just a few of the obstacles facing primary care in the local authority. Similar to the other models, passion and personal interest are driving a new push towards offering better LARC services across the local authority. PCNs are seen as the opportunity for improved primary care provision.

*"Essentially [the] system wasn't delivering optimal care for patients...people floating between the cracks as if they were lost to follow-up, sent via 2-3 sites in the city to get care that they need...trained workforce have to send on to another provider - those people don't get there, or [they do] get there and the journey is awful."* (***LA commissioner***)

*"Practice Manager said to me "I know that this won't make us money, but I want to offer it to our patients"... not everybody has that attitude. I have a GP trained LARC fitter herself who said "Why would I do an extra LARC clinic? It doesn't pay" ...even her as a fitter was reluctant to do an extra clinic as she was worried about finance for her practice."* (***GP LARC fitter***)

*"There is also the cost-reward side of the argument. At the end of the day GP practices are still independent businesses so what will drive some behaviours for some practices are financial decisions and they may decide it's not 'worth their while' because it doesn't produce any significant financial benefit."* (***GP non-fitter***)

*"Once you factor in all the equipment and making sure somebody else is there, the time, the things like that, there isn't much profit for the practice."* (***GP non-fitter***)

*"...If you could change something, at the very least each PCN has somebody who could fit coils - that's difficult, it's almost become to be seen as not worth the money. It is so odd, would you not do somebody's diabetes management because it's not worth the money? You just wouldn't, it's like everything is belittled. If you provide somebody with the right contraception it doesn't just prevent unplanned pregnancy, it improves quality of life and finances and everything - very little respect for it. Almost viewed as not important."* (***Gynae consultant***)

## 3. Training and maintaining skills

**Fitting LARCs, particularly coils, requires an expensive online theoretical training course as well as specialised in-person training. Many providers have found it hard to find trainers for the in-person component, do not have the set up in their practice to fit coils, or do not have enough patients interested to get enough insertions in to become confident fitters.**

*"... [Some providers] come through qualified and then sadly LARC fitters (maybe 3-4 years ago) because of finance, practice stopped allowing them to fit and they then get deskilled and apprehensive about fitting."* (***GP Fitter/ Trainer***)

*"I think its availability to start with. Most of my female trainees will leave my practice with either implants training onboard or coil training...So I think it's how accessible it is for them. For example, if I wasn't a coil trainer or an implant trainer, I don't think they would have ever shown interest, or we wouldn't ever have talked about it...I also know a few of my ex-registrars where they tried to start having training in their own practice etc, if the practice itself doesn't fit LARC then it's like a big barrier. They couldn't set everything up. And in the past, you used to be able to get sessions quite easily in the family planning clinic and get confident that way but nowadays, I think with the way funding is going etc. there's not many sessions that you can do."* (***GP fitter and trainer***)

*"We've always been really keen to make those connections with interested GPs and to support them to both provide LARC and to support access to training...We've tried different models over the years where we've sent trainers out to GP practices to train there. And I think in many ways that's a better model for training because you're ensuring that they are set up to do the fittings in their own practice. They've got the right equipment, the right support, they've already recruited patients and so on. But then there have been issues around...large numbers of DNAs."* (***CaSH clinician***)

*"[I'm] interested in training other staff but [it's] difficult due to other work commitments."* (***GP fitter***)

*"...Only two fitters of implants and coils across [the] PCN...one other GP in one of the practices who initially was very much onboard is an implant fitter but has let things lapse a bit and has fallen off the radar a bit probably because she's a partner and pulled in many other directions especially with COVID."* (***GP fitter***)

*"Nurse keen but gone on maternity leave...[it's] not just about us being there to train them for the procedures, they've got to be motivated to do the studies and the exam...in the same way that you've got to have quite a motivated GP to want to do their training the same is true, maybe even more so for a nurse [with the] kind of risks, headache and stress. If you're passionate about it, [it's] worth that journey. But if you were to survey practices in the area you would only get a handful of people saying, "Yes I would like to do that training." [We] don't need hundreds, just need a few eager beavers."* (***GP Fitter / Trainer***)

## 4. Accessibility

**Women need to know where to go to get their contraception and what options work best for their circumstances. Non-fitters are not familiar with who to refer to for which indications. The patient can be referred to the wrong service at an emotional/time cost to the patient and a financial cost to the NHS.**

*"Insight work in 2015 told us quite a lot of women weren't too sure of choices, didn't have enough information...so we placed emphasis on the contraceptive choices discussion we've brought in - GPs utilising good tools to be able to explain, go to this link, go to this video...tell you more about it, dispel any myths."* (***LA commissioner***)

*"If I knew what the family planning clinics are allowed to do that would be a good start for me, so I have a clear idea of what they are commissioned to do. Somebody has to clarify who does endometrial sampling and how we make sure we are not missing endometrial cancer."* (***Non-fitting GP***)

> **"Many providers have found it hard to find trainers for the in-person component"**

## PROMINENT THEMES FROM INTERVIEWS – URBAN AREA

### 1. Commissioning Structure

**LOCAL AUTHORITY CONTRACTS A COMMUNITY PARTNERSHIP, COMMUNITY INTEREST COMPANY (CIC) TO MANAGE THE:**

- Contraception and Sexual Health service contract
- General Practice contracts to deliver LARC.

No additional funding from CCG to support HMB or menopause fits – practices and CaSH fit for all indications as indication not specified when claiming for fits in GP.

*"One contract for Sexual Health and Reproductive Health services commissioned in 2015 went to one provider, a CIC. Includes GP contracts subcontracted from CIC. Local contract for 5 years with 2+1 options effectively runs out around July 22."* (***LA commissioner***)

*"Who funds treatment of HMB? I don't know, I could find out but don't know if I'm completely honest. I know it has been an area of contention but I'm not sure what the latest position is."* (***CCG commissioner***)

*"We don't get any funding from the CCG at all. If it was a very difficult coil that a GP tried to fit and failed and it was for heavy bleeding or menorrhagia or whatever then we wouldn't obviously turn that patient away, but we have to be very mindful of that...that we're not opening the floodgates as it were. So we might do a very small handful of these on a yearly basis but it's minimal. Purely because we don't get that additional funding so they would normally be referred to gynae."* (***CaSH manager***)

*When asked about claiming fits for non-contraceptive purposes: "They could because we don't ask them to say whether they are for contraception or not. So yes, I imagine they do."* (***CaSH manager***).

*"CIC have never queried whether our Mirenas are fitted for contraception or HMB. They've always just paid for all of them."* (***GP fitter***)

### 2. Drivers and obstacles for LARC provision

Healthcare providers who offer LARC fittings are motivated by a personal dedication to ensuring women have access to holistic contraceptive services. However, they can be challenged by other members of the practice, particularly partners, to demonstrate financial viability. Many providers we spoke with emphasised that offering LARC services was a priority despite the costs.

*"Over the years I've had a lot of pressure from partners and managers asking "How are you going to make this more cost-effective?""* (***GP fitter***)

*"At the end of the day in primary care it's about funding. Because if you're a partner...and you're negotiating where your priorities are going to be, and the big opportunities are with running a diabetic clinic...some of the other partners were specialists in cardiovascular disease, one was in diabetes, one in dermatology and one was in minor surgery and all of those brought in more money. So if you were thinking, well... which specialties are we going to explore more and you're always going to make more doing the diabetes, cardiovascular, musculoskeletal clinics than you were doing women's health. That was the debate...general practice is a business."* (***GP fitter***)

*Partner "struggled to see the relevance of sexual health and contraceptive services and thought what's the point if CIC service is in town and commissioned to provide contraceptive services, what's the point of having primary care doing it?"* (***GP fitter***)

*"Often what we find is LARCs are becoming not very important. People don't see them as very important because they don't bring in much money for what they are and there are priorities. It's often quite a battle to say "Actually this is a priority.""* (***GP fitter***)

> "Many providers emphasised that offering LARC services was a priority despite the costs"

## 3. Staffing and training

**Staffing is becoming a problem in the area, as trained providers, particularly nurses, are retiring and new providers are reluctant to get trained for LARC fittings.**

*"They (providers) want to understand women's health but they seem to be reluctant...though there is access to training there isn't this confidence... some of it is down to the fact that it requires face-to-face and pelvic examinations, and they all get anxious about that...getting anybody to do coils was really hard."* (***GP fitter***)

*"Staffing is the main one. I think staffing and skills and the training because we're not doing too badly now but I have been madly training for the past year or so. So we're not doing too badly for coil and implant fitters. But what's really important once they're trained is to have a clinic because it's about getting the clinics up and running so that people can get the experience. What we really need is more nurses trained but there's just a lack of nurses. We've got two amazing CaSH nurses who do most of the work, but they would freely admit that they are well into their 50s. You know we need to be training some younger nurses to make sure when they retire, we've still got some highly trained staff."* (***GP fitter***)

## 4. Accessibility: do women know where to go?

**There is a need for more clarity on where women can access contraceptive services and more education around what is available in the area. Services need to be easily accessible so that at-risk populations can easily travel to them. COVID restrictions have closed down many LARC clinics in general practice, making it difficult for teenagers to access contraception.**

*"I think in [the local authority], because it's a big diverse geographical area it's easier to go to the GP if the GP fits because it's local. Whereas you often have to travel to a sexual health clinic which is okay if you are mobile, but it isn't okay for everybody."* (***GP fitter***)

*"It's about opportunistic discussions... contracept[ion] and women's health [are] always on my mind as a GP and there aren't many under 20-year-olds that will leave my room, or I'll end a telephone discussion with [them] where I don't ask them what contraception they are using and whether they have had a chlamydia test recently."* (***GP fitter***)

*"Need clarity around what our offer is – I live in [local authority] but I wouldn't know where I would go (and I work in the area) to find out how to access this service, particularly if I didn't want to go to my GP as a starting point. And what we find with some of our communities is they don't want to go to their GP who may be a family friend and they may be doing something that is considered not appropriate by their communities. We need some mapping of where our resources are placed to make sure they are accessible, but to do that we need to talk together and we're not doing that at the moment, so we need to improve our communication across people who commission and deliver sexual health services."* (***CaSH business manager***)

> "There is a need for more clarity on where women can access contraceptive services"

## PROMINENT THEMES FROM INTERVIEWS – RURAL AREA

### 1. Commissioning Structure

**LOCAL AUTHORITY CONTRACTED THE HEALTHCARE TRUST TO MANAGE THE:**

- Contraception and Sexual Health service contract
- General Practice contracts to deliver LARC.

No additional funding at present from CCG to support HMB or menopause fits – practices fit for all indications agreed with LA. CaSH services do not fit for non-contraceptive purposes.

*"...If I'm honest, provision is patchy [and] not consistent across the area...we had seen an increase and uptake in LARCs early 2013...now stabilised but remained constant across the last 3 years...recently given LARC budget for GPs to ISH (Integrated Sexual Health)"* (***Commissioner***)

*"Patients get lost in the system, for instance the HMB patients, patients wanting smears, fitting a coil but not allowed to do smear so have to go back to GP and go through that again. All sorts of things we used to be able to do in sexual health we have to send them all back to the GPs now and quite often the GPs have less experience than we have and they have often sent them to us in the first place. Sometimes they end up having to go to secondary care because we are not commissioned to treat them and that costs a huge amount more money. The other thing is now because we're not commissioned to do certain things, the people who have experience in the service of offering things such as genital dermatology or simple gynaecological aspects of sexual health are getting deskilled and those skills aren't deemed necessary so they are not employing people with that experience... in our sexual health service now, as doctors retire they are not replacing them [and] it is becoming a nurse-led service, and nurses don't have the gynaecological experience, broad trainings, dermatology, menopause etc. knowledge to be able to offer this service to women. At the moment it's not necessary as were not commissioned to do that but then it's not a good service for the women because they get stuck in the system."* (***Former GP, current sexual health provider***)

### 2. Drivers and obstacles for LARC provision

Most providers in this area believe that offering LARCs comes down to the providers' personal interest.

*"A passion for it. A feeling that it is an appropriate service for women. I think particularly where we are-we are further away from mainstream services... It's a good close to home service so it's about my passion, my interest but also providing a good service for women. We don't honestly make money out of it."* (***GP fitter***)

*"Unless you've got someone who champions the cause of women's health or women's contraception, it's difficult to see [the value in] it because sometimes it's the training element, or has someone got the time or the interest as well, and then afterwards its making sure your clinics run smoothly."* (***GP fitter***)

*"Partners not really interested in adding coils to the service. They don't think they have a good number of patients interested in it."* (***GP non-fitter***)

Adequate LARC provision in the area is at risk as trained providers are retiring and others are facing challenges with maintaining their LARC insertion skills. Some practices do not appear to have sufficient patients interested in LARC methods, particularly IUDs and IUSs, for providers to continue competently and confidently to fit.

> “Without LARCs in local practices, many women will not be able to get their preferred method”

*“There aren’t many GPs wanting to get trained these days, there is no incentive for GPs to do it. When I started in general practice it was very much as a female partner if you didn’t have your Diploma and couldn’t offer contraception to the patient you wouldn’t stand a chance of getting a job. Now there doesn’t seem to be the incentive for practices wanting to offer that for patients and certainly training in LoCs is just something else for them to worry about. They are getting more and more overwhelmed from things being passed back out from secondary care to primary care to manage and it’s not at the top of the priority list unfortunately. Unless GPs are really passionate about it and got a real interest there is not a lot of incentive for them to do it at the moment.”* (**Former GP, current sexual health provider**)

*“Crisis is looming in [rural area] as people retire, those who have been fitting fewer than the national average, or having had a significant gap not fitting any during the first lockdown in particular will probably cease to go on or start rather.”* (**Sexual health lead clinician**)

*“I never was in a practice or a place where I’d get enough coil numbers to actually feel that I was keeping my competence levels up.” GP explaining why she no longer fits and does not have the skills to continue to fit.* (**GP non-fitter**)

*“Struggled to get number in per year to keep letter of competence because we were a small practice with limited number of patients. If not doing that many in a year then you don’t gain experience and makes you less confident doing it. Is it worth it? I will just send them to the sexual health clinic, not always easily accessible for patients, [it] varies a lot from one area to another.”* (**Former GP, current sexual health provider**)

## 3. Accessibility: distance and limited options

**This is a rural area with large distances to travel to access care. Without LARCs in local practices, many women will not be able to get their preferred method. Some providers believe that even if distance were not an issue, practices without the ability to provide LARCs may not be promoting the methods as a suitable option. They wonder if providers are only promoting methods they have on hand.**

*“Sheer distance sometimes. To ask a young girl to travel somehow without mum knowing 40 miles to get an emergency coil in the evening is a bit much.”* (**Sexual Health Lead Clinician**)

*“There’s the local CaSH centre which is in (rural area) which is about 45 miles away so it’s quite a distance. I guess it’s fine for people who’ve got transport but it’s not easily accessible on public transport either.”* (**GP non-fitter**)

*“Problem is rurality of where they live, especially young people who just don’t have the transport. Furthest surgery from the nearest clinic is 15 miles, then some patients live in the hills another 5 miles out.” Provider continues to describe another problem some women may face when getting LARCs: “Access really. I think if it was more accessible in practice, I guess if something is available it gets used more, doesn’t it?”* (**Former GP, current sexual health provider**)

*“I try to promote the coil. I know sometimes when people come back to me about the pill again and they’ve never gone ahead and asked about the coil. So maybe if it was going to be done here, they would have gone ahead but because the practice phoned somebody else they’ve not followed that through.”* (**Nurse practitioner**)

## PROMINENT THEMES FROM INTERVIEWS – CITY

### 1. Commissioning Structure

**LOCAL AUTHORITY CONTRACT:**

- Contraception and Sexual Health service
- General Practice contracts to deliver LARC

CCG contract/fund GP Federation to deliver a community gynaecology service delivered from general practice premises by GPSI and Consultant Gynaecologists. All general practices and CaSH services with contract to fit IUS are paid for all indications agreed with LA.

*"We have a KPI for LARC fitting but only for integrated service. I would like this to change but problem we have since 2013 Locally Commissioned Service (LCS) contracting side of things continued to stay with CCG through bureaucracy and fact they do all of these other LCS with them. Public Health have had to fall in behind what CCG is doing and whenever we have wanted to modernise get caught out with CCGs who don't want to do this at the moment. COVID has given us a catalyst to start these conversations and start doing it. Previously when we've tried to talk to GPs about modernising LCS [we've been] met with resistance down to, in my mind funding, concern about what's going to change funding wise." (**Public health commissioner**)*

*"Trying to do [postpartum contraception] but as far as CCG concerned no money for that anymore. All money gone for COVID stuff. Hoping to get that sorted this year. [We've] got a pilot within one Trust with integrated care service doing it with CCG funding but wanted to widen out to Trusts across sector...CCG lead maternity commissioner can't commit to any of that at the moment." (**Public health commissioner**)*

*"The biggest issue I think from the barrier to going back to more holistic women's health is the split in commissioning. The whole local authority CCG thing has been a complete headache for us."(**Sexual health consultant**)*

### 2. Drivers and obstacles for LARC provision

Fitting providers listed financial viability, inadequate fitting fees, and difficulty of training as potential hurdles for non-fitting practices to offer LARC services. Those who do fit, do so out of personal interest and a passion for women's health.

*"I think if practices were offered a little more money for the fitting that would be more appealing for partners and practice managers. I set up my clinic in 2016 and had to come up with a business plan on costs and what payments would be and it kind of broke even which was okay. If offered more money that would be an incentive, similarly for people wanting to train if it was less expensive - cost is a significant thing." (**GP fitter**)*

*"Gynae isn't my favourite topic by any means but as a female GP I do see a lot of it and I think that it's due diligence to be trained in doing it as it comes up a lot during my day...the training, trying to get it I had a bit of an issue I contacted local trainers, and trainers didn't have any spaces or capacity [with] trainers off due to COVID...contact them again in a month or so prioritising local staff GUM and family planning trainees over GPs and then local GPs so I think there is a bit of a barrier to trying to get training as well." (**GP non-fitter**)*

*"We do need the ability to train more fitters... having said that there's only a point in training people if they're then going to maintain their skills. I don't think it's in anybody's interest to have trained people who are then going to fit 3 to 4 devices per year. I think it's better to have people who fit quite a few." (**Consultant in sexual health**)*

## 3. Accessibility: It is a postcode lottery

**Access in the area is not equal and depends on postcode, according to the providers interviewed. Being able to offer and fit LARCs influences whether providers actually counsel patients on them.**

*"It's not fair at the moment because you've got practices that do coils and you've got practices that don't do coils so it's not a fair distribution for patients actually. It's not equal. We need to think of something that is a bit fairer for distribution... There are some GPs who don't do any LARCs... and so if they aren't comfortable talking about it they're not going to explain it properly."* (***GP fitter***)

*"First thing is for the patient to know where to go because I think again the non-uniformity of where you go to get your contraception can be terribly confusing...I think a lot of people don't know where to start."* (***Consultant in sexual health***)

*"GPs which are the shrinking [workforce] are doing the most fantastic job for nothing and having to defend their services from their colleagues and it is just a complete Cinderella story that makes me sad. [It] needs some serious money and let's just innovate and do a good service in partnership with contraception specialists and local GPs who are interested and let's do something that is no longer postcode because it's purely postcode at the moment."* (***Sexual health lead***)

**Appointments are not immediately available and so patients may lose interest and not follow-up.**

*"Patients' access to appointments, especially at the moment, they might look at something else in the interim like the pill or something else and they might not get round to getting the LARC fitting might just give up. Some of our patients don't want to be seen face-to-face at the moment, COVID aside having to wait for appointments, having to wait a couple of months you might have got pregnant or taken a different method that they might just stick to."* (***GP fitter***)

*"[Providers need to] change what you say because of what's available to your patient...[It's easy to say] our old friend the pill [as the] first response. They like it and come back for more...so [it's] different when you engage and talk, [but you] can't do it without the ability to offer the actual fitting - more lay enthusiast role in there with great ways of illustrating to women how much more effective LARCs are, and safe."* (***Sexual health lead***)

## PROMINENT THEMES FROM INTERVIEWS – CITY

### 1. Commissioning Structure

**LOCAL AUTHORITY CONTRACT:**

- Contraception and Sexual Health service
- GP contracts via GP federation to deliver LARC

No additional funding at present from CCG to support HMB or menopause fits – practices and CaSH fit LARC for all indications agreed with LA. Local authority has had low LARC provision in primary care. CaSH services predominantly provide contraception, particularly LARCs. The 2019 contract with the GP federation aims to improve LARC uptake across the locality through primary care.

*"In primary care need to commission and be very clear what the level of service is rather than 'any willing provider' which is not working -some primary care will come forward and be very keen and champion and others for lots of reasons don't might be space, preference of clinicians – need to commission for population need rather than whoever fancies does this. (**Director of Public Health**)*

In addition, a pilot 'gynae hub' was set up within one of the primary care networks to explore whether such a model will improve the patient experience (includes offering LARC for HMB and menopause as well as contraception) in primary care.

The purpose of the hub is to improve the patient journey, seeing the right person in the right place at the right time, reducing unnecessary referrals, while providing an opportunity for GPs to be upskilled in provision of LARC fitting for all indications and low risk gynaecology counselling and treatments.

*"CCG wants to reduce referrals but one of the aims of the project is to reduce difference in the quality of referrals and also to recognize that there's probably a minimum rate of referral, that is optimum. … I hope the rates will go up in practice, because hopefully, they'll become more aware of the service, and then they'll start referring people in, and it will be a gradual process where they'll be kind of socialized into the fact that actually, there are some women out there that actually need some help." (**Consultant in gynae and sexual health**)*

### 2. Drivers and obstacles for LARC provision

Well over half of general practices don't provide any form of LARC fitting service. LARC provision in this local authority is predominantly situated in Contraception and Sexual Health services. The new contract introduced in 2019 specifies that in time all practices will provide a LARC service (and have put an incentive in place to encourage this). However, currently primary care providers offering LARCs do so out of personal interest. While sexual health services offer appointments with a relatively short wait time, providers believe their patients would like to be able to get their intrauterine methods and implants at their local GPs.

*"Not as many practices fitting LARCs as we would like." (**Director of Public Health**)*

*"Historically, I used to always say just go to your sexual health centre. But I think that can be a big barrier for people. That basically means it can't be dealt with then and there. They have to go away and potentially find a phone number, phone somebody, find a time for an appointment…So I think if you're streamlining the process [and] keeping it in-house, it kind of keeps the momentum rather than [allowing women to drop off] the radar." (**GP, non-fitter**)*

*"GPs who have been through a Women's Health service or have a letter of competence are more likely to drive it forward. [They've] really got to want to do it. As a partner, [you're in a] better position to bring the practice along. As a financial offer it doesn't pay, [you] have to override that and have the spirit to do it…Training is difficult but if you really want to do it you probably could pay for training, probably could maintain your competencies but it would have to be one of your driving aims and given the pressures in general practice at the moment I think fewer and fewer people have got the energy to do that. Practice saying it's not really viable, why would you [do it], apart from doing a good thing." (**Consultant in gynae and sexual health**)*

"Providers believe their patients would like to be able to get their intrauterine methods and implants at their local GPs"

*"Where you've got GPs who are very keen on fitting LARC it can work very well, it's a question of where you haven't you can do all sorts of things, offer to pay for training, offer to pay for backfill – sometimes it works and sometimes it doesn't. The inequity of uptake and service provision is just really stark in sexual health, some women have great access and some women don't and the characteristic is often about the service offer and whether they have good inter practice referral or any inter practice referral, whether they've got a champion; it doesn't have to be a GP it can be a nurse champion." (**Director of Public Health**)*

**Training is expensive, time consuming and hard to find. GP providers are already thinly stretched and and can't afford to leave their practices for long periods of time to do the hands-on training. Finding training opportunities is one of the main barriers in this local authority, according to the providers.**

*"[It] doesn't work just to give people the training, [you] have to embed it. [For example] trying to train midwives in hospital to give contraception [and] they've been enthusiastic and lovely, [have] taken it on [and] trained in implants but they haven't fitted a single implant. [They are] not confident enough, don't think about it. Training with a presence, constant discussion and a reminder is the way you make things change - you have to hold people's hands, [be] a bit more persuasive." (**Consultant in gynae and sexual health**)*

*"Training issue, you can pay for the training, you can agree to backfill and sometimes that works and if you don't agree to pay for the training and don't agree to backfill that acts as a barrier for some but ultimately you need a trained workforce." (**LA Commissioner**)*

*"Getting the training and getting someone to sign you off isn't easy and it's quite expensive...I had to actively seek it out a lot and had to find someone who would do it and it took a lot of effort. In day-to-day life if you're really busy, unless you really want it, [it's too difficult]." (**GP fitter**)*

*"Hard to find training. The academic side of it is probably quite easy to access but its the placements that are quite difficult. I filled in a form for training long before COVID and haven't heard anything back." (**Practice nurse, non-fitter**)*

## 3. Accessibility

**Currently, providers at fitting practices are catching up with the backlog created by COVID. Waiting times can stretch weeks and with sexual health services offering appointments at earlier times, it may be easier to refer patients there. However, providers recognise that many patients would rather wait and see their GP than seek appointments elsewhere.**

*"One of the problems with delivering LARC in primary care is ease of access - we are able to offer a LARC appointment 5 days a week morning and afternoon. In primary care by definition, you don't know how many people you are going to get in and trying to lump things into a list doesn't necessarily work people might not be able to have a fitter available on the day". (**CaSH consultant**)*

*"[It can be the] make up of practices, some are just male GPs who don't really know about women's health, don't therefore ask the questions, therefore women don't get offered things. Interestingly the practices that don't have any female GPs also don't refer to gynaecology. Just not seeing or not hearing the issues that are going on [makes it] much more difficult for women to access services." (**Consultant in gynae and sexual health**)*

*"The outcome that everybody wants and that I've been passionate about for some time is that all women have access to good quality contraception at a place that they wish to choose from and primary care has a role in identifying women who may want to change their method or may want to look at other methods and the fitting of it is actually secondary. It might be at the practice but it depends on the clinician as to how skilled they are in the discussions, but once you've prepped somebody ready for LARC then that's the point you want to make sure it's easy as possible to access but actually there's quite a lot of work that needs to be done before that rather than just I'm going to refer you to LARC clinic for a fitting, if you haven't spoken about options, myth buster not LARC ready, get a lot of DNAs." (**LA Commissioner**)*

*"It's frustrating for me and the female GP at the moment who is fitting coils...we want to be able to offer this service. Sometimes it's not good enough that we aren't able to give appointments as soon as women want them." (**Practice nurse, non-fitter**)*

# APPENDIX 3: LONG ACTING REVERSIBLE CONTRACEPTION (LARC) PROJECT INTERVIEW GUIDE/QUESTIONS

## Purpose:

- Is General Practice at risk of losing/ seeing a dramatic decline in LARC service provision?
- What is the challenge to maintaining services (sustainability)?
- What would keep LARC services going/expand?
- What information/resources would help primary care HCPs understand funding and training opportunities?

## Commissioner questions

**HOW IS LARC FITTING ORGANISED WITHIN THE LOCAL AUTHORITY?**

1. How are funding and contracts organised?
2. What are the accountability mechanisms for provision of LARCs?
3. What are the main barriers?
4. How could this be improved?

## Provider questions

1. Tell me about your practice with a particular focus on LARC provision? (Your role, type, size, population served, PCN)
2. What sort of things make healthcare professionals choose to fit or not in general practice?
3. Tell me about the practice policy in relation to LARC fitting? (Is it supportive?)
4. What makes it difficult for a practice to offer a LARC fitting service?
5. How could it be made easier for the practice to offer LARC fitting/get LARC fitted for patients?
6. Tell me about how and where women can access LARC in the area?
7. How could access to LARCs be improved?
8. What do you think prevents women from getting fittings?

## Participants

1. **Commissioners** – Local Authority (LA)/Clinical Commissioning Group
2. **Providers** – Primary care and Contraception and Sexual Health Service (CaSH) providers including practices that fit LARCs and those who don't. Ensure that both nurses and doctors are sampled, and practice decision makers versus other staff.

## Interviewer

1. Confirm current role and thank participant.
2. Outline project purpose and obtain consent to record the interview
3. Confirm definition of LARC - subdermal implant and intrauterine methods

PRIMARY CARE
WOMEN'S HEALTH FORUM

# Championing Women's Health

The Primary Care Women's Health Forum is a membership organisation for primary care clinicians interested in women's health. It promotes the highest standards of healthcare and strives for quality care for all women.

**► Find out more: www.pcwhf.co.uk**

twitter.com/pcwhf facebook.com/PCWHF

TO PROGRESS STANDARDS ACROSS GOVERNMENT, HEALTHCARE AND INDUSTRY, WE:

- Lobby Government on women's health policy
- Advise commissioners
- Shape the future of services
- Promote high standards
- Support women to make informed choices
- Involve women in future models of care

FOR CLINICIANS, WE PROMOTE BEST PRACTICE THROUGH CLINICALLY LED WOMEN'S HEALTH EDUCATION, INFORMATION AND EVENTS.

- Free resources
- CPD events and masterclasses
- eLearning
- *Her Life Her Health*, our quarterly publication
- Rock My Menopause, our public-facing menopause campaign