PRIMARY CARE
WOMEN'S HEALTH FORUM

Primary Care Women's Health Forum
LARC Fitter Survey Results

pcwhf.co.uk

About this survey

- The Primary Care Women's Health Forum is increasingly concerned about the viability of LARC fitting (implant and IUS/D) in primary care and the implications for women's health and contraceptive care in the future if this is not addressed and prioritised
- We therefore asked our members to share and complete a short survey, so we could understand the current issues about payment, contracting and training for LARC in primary care
- The online survey was open on the PCWHF website during February and March 2020
- Around 650 primary care professionals (GPs and practice nurses) completed the survey

Key findings (1/2)

Our findings demonstrated *significant concerns in the profession around the sustainability of LARC services* in England:

Funding for LARC services

- The main reason professionals are stopping fitting LARC is inadequate reimbursement making the service unviable
- There is considerable variation in fees paid to practices for fitting and removing LARC
- Many professionals were unaware of fitting fees in their area, which may indicate that clinical staff are not being as involved in decision making processes as they should be. Looking at different LARC methods:
    - 20% of professionals were unsure if the implant fitting fee is adequate; 20% felt is it inadequate; 22% felt it is sufficient
    - 62% of professionals were unsure if the IUS fitting fee for contraception is inadequate; 32% felt it is inadequate; only 6% felt it is sufficient
    - 90% of professionals were unsure if the IUS fitting fee for gynaecological purposes is inadequate; 8% felt it is inadequate; only 2% felt it is sufficient
- Fees for fitting LARC have not kept pace with the cost of delivering services. In the past three years:
    - Only 1% of respondents had seen an increase in fee for fitting implants; 35% have stayed the same and 10% have seen a decrease
    - Only 2% of respondents had seen an increase in fee for fitting IUS for contraception; 17% had stayed the same and 5% had seen a decrease

Key findings (2/2)

The fragmented referral pathway

- A third of practices (34%) are only funded for fitting LARC for contraception and not for HMB or menopause, despite this requiring the same skills and removing a burden from secondary care services
- Only 20% of practices have developed a service to accept referrals from local GP practices. This is despite commitments of the NHS Long Term Plan to expand network working between practices, so that patients are supported to access a wider, and more convenient, range of specialist services[1]

Accessing training and maintaining skills

- There are problems with the accessibility and cost of training and maintaining recertification standards
    - More than a third (38%) of respondents said that training provision had reduced in their area
    - Only 7% reported that training in their area has improved over the last five years
- As a result of these difficulties, professionals are concerned that the LARC fitting workforce is becoming deskilled. Looking to the future, this is putting women's access to these highly trained clinicians at risk

Professionals have concerns over the impact that loss of LARC services are having – and will continue to have – on women's health. As Primary Care Networks (PCNs) become established, women's health must be prioritised and developed across localities to ensure all women have access to these vital services going forward, beyond COVID-19.

1. NHS England, The NHS Long Term Plan, January 2019

Recommended actions (1/2)

Funding for LARC services

1. A national review of fitting fees should be considered, to develop a consensus view of what a fair fee should look like
2. Local commissioners should review the fees paid to GPs for providing LARC and increase them where needed to ensure they cover the cost of the time, staffing, implant / IUS, and disposables
3. GPs should be adequately reimbursed for LARC fitting and removal, including funding for IUS for both contraceptive and non-contraceptive purposes

The fragmented referral pathway

4. Local commissioners should review LARC services currently available to ensure they meet the needs of their local population and that all women can easily access this essential services – this is especially important in rural / remote areas.
5. The development of PCNs should be utilised to implement referrals of patients between both general practices and community clinics. New models of care, such as Women's Health Hubs, could be utilised to better streamline referral pathways

Recommended actions (2/2)

The fragmented referral pathway (continued)

6. Commissioners should track and make publicly accessible:
    1. A list of the general practices in their area providing LARC, and whether they are providing implants, IUS or both, and whether for contraception and/or gynaecological purposes
    2. A list of community sexual health clinics providing LARC, and whether they are providing implants, IUS or both, and whether for contraception and/or gynaecological purposes
    3. The waiting times in the local area for implant and IUS fits

    This information should be easily accessible to women through local women's health networks, to support patient access and choice

Accessing training and maintaining skills

7. Commissioners should work with training providers to improve accessibility and affordability of training
8. Local commissioners should utilise network collaboration and referral pathways to expose fitters to more opportunities to fit LARCs and therefore maintain their competencies

PRIMARY CARE
WOMEN'S HEALTH FORUM

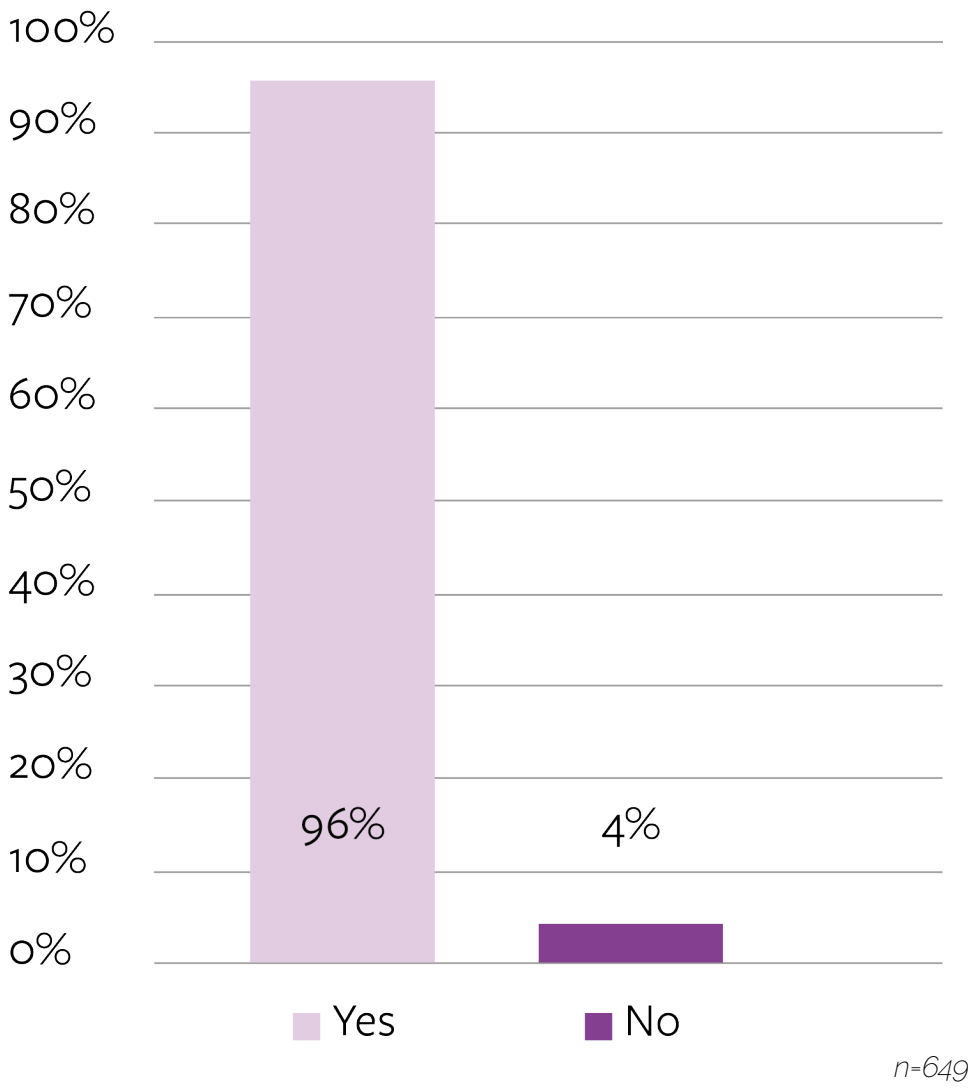
Survey findings

pcwhf.co.uk

PRIMARY CARE
WOMEN'S HEALTH FORUM

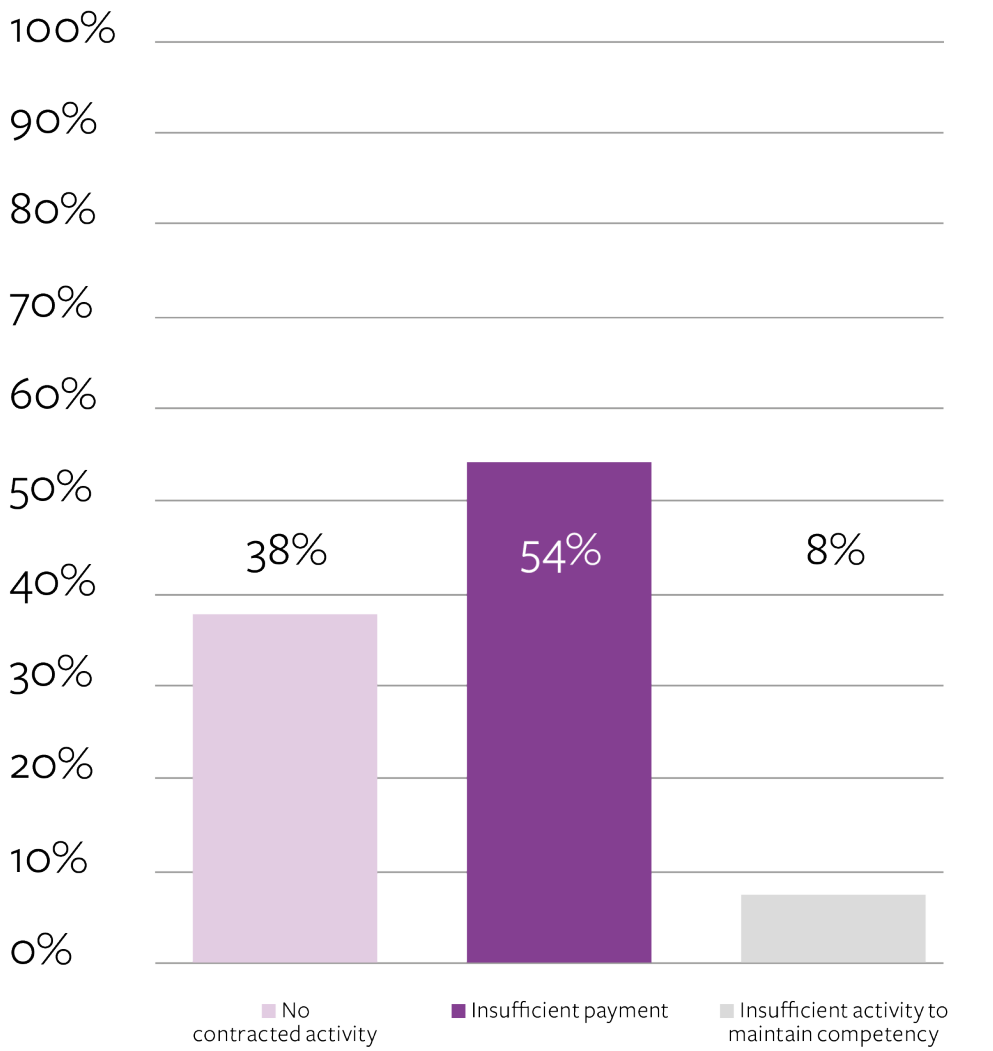
Loss of fitters

Are you currently a LARC fitter in primary care?



n=649

Previous LARC fitters ceased activity because:



n=24

In their own words:

"The payment LARC insertions / removals attract in primary care hasn't changed in the last 10 years. In fact we no longer are paid for IUS checks. Meanwhile local family planning clinics are closing with no increased access for these women. Fittings are cost neutral or even done at a loss now when factoring in GP and equipment time. It is no longer worthwhile training GPs to do the work and yet LARC requirement goes up. This is disgraceful."

"I really enjoyed fitting LARC for our patients and was sad to stop providing a service which was really appreciated by our patients. The re-imbursement was woefully inadequate."

"I plan to stop fitting coils as it is not financially viable. My colleague who fits implants is also stopping. As a practice we will stop fitting any coils or implants because the money makes it not worth our while. Family planning clinics and gynae outpatients had better brace themselves."

"We always have a long waiting list for LARC fittings. If we were paid more for fittings it would be more financially viable for my practice to offer more clinics and appointments."

"I recently retired but if I could have stayed on the Performers List just to do women's medicine I would have done. I am still a GP Appraiser and have raised this at appraisal training meetings. I feel my skills have been wasted - I was fitting up to 30 / year ."

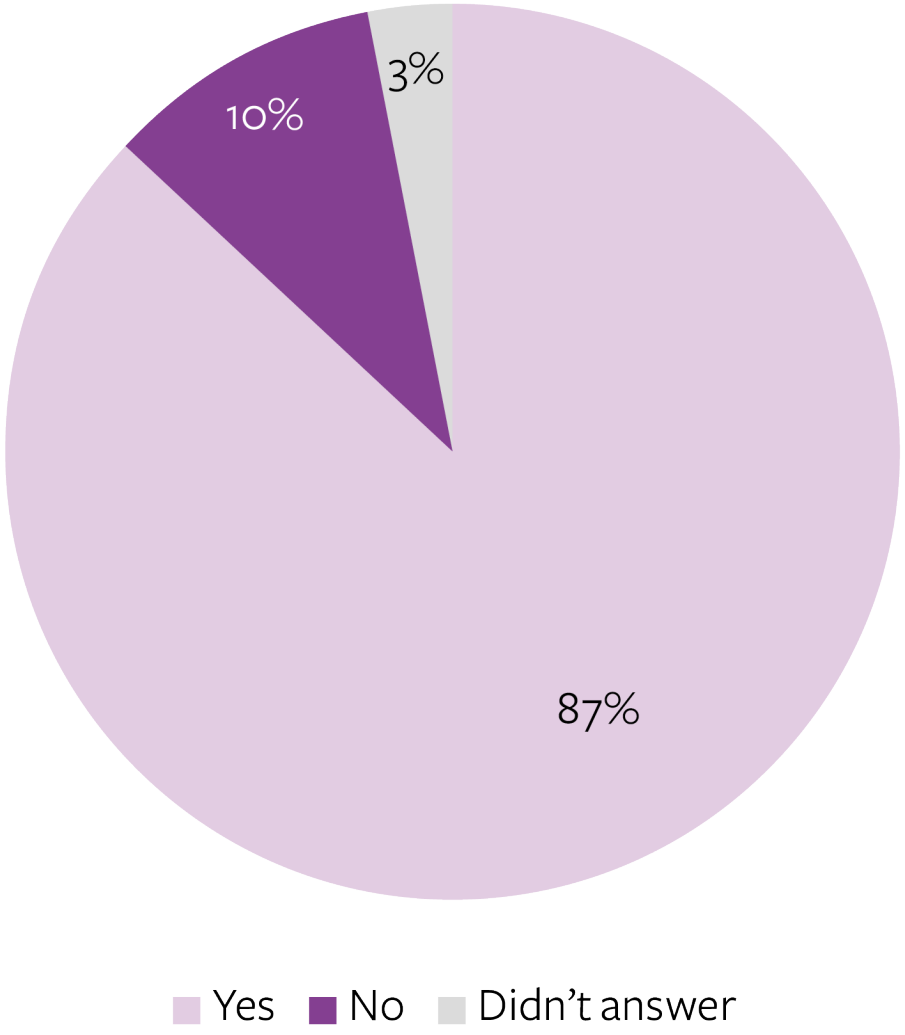
"I would personally have been delighted to continue with doing Nexplanon fitting but we were essentially advised that we would be running at a loss to continue to provide this service to our population. So, we stopped."

"I feel the closure of the Family Planning Clinics has led to a lack of training facilities to train coil fitters. These clinics also offered evening appointments for young women working full time, with the focus. They offered a fantastic sexual health service, including cervical screening, STD screening and contraception at places and times that suited women - this has now all been lost and I fear we have a skill timebomb about to happen as my generation of LARC fitters retire."

PRIMARY CARE
WOMEN'S HEALTH FORUM

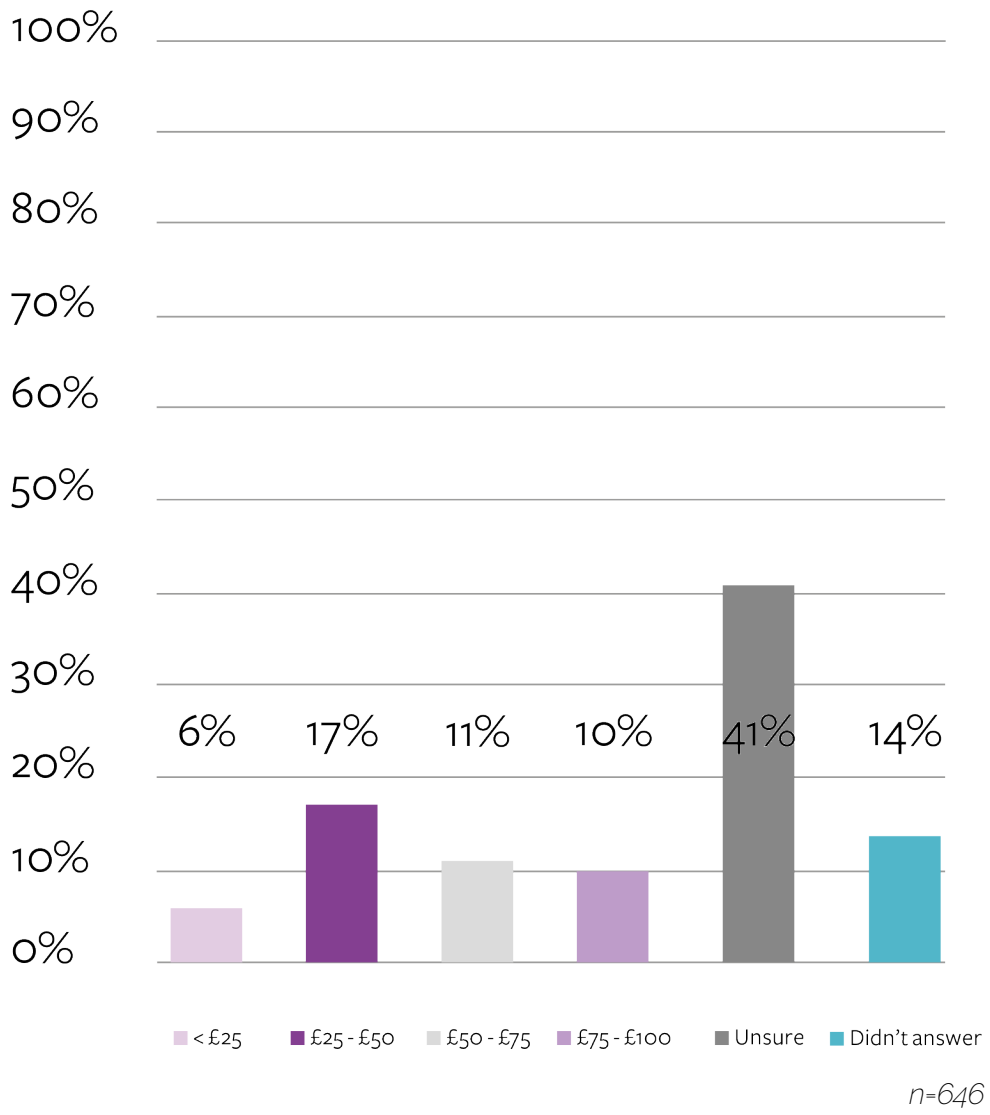
Implants

Do you insert Nexplanon?



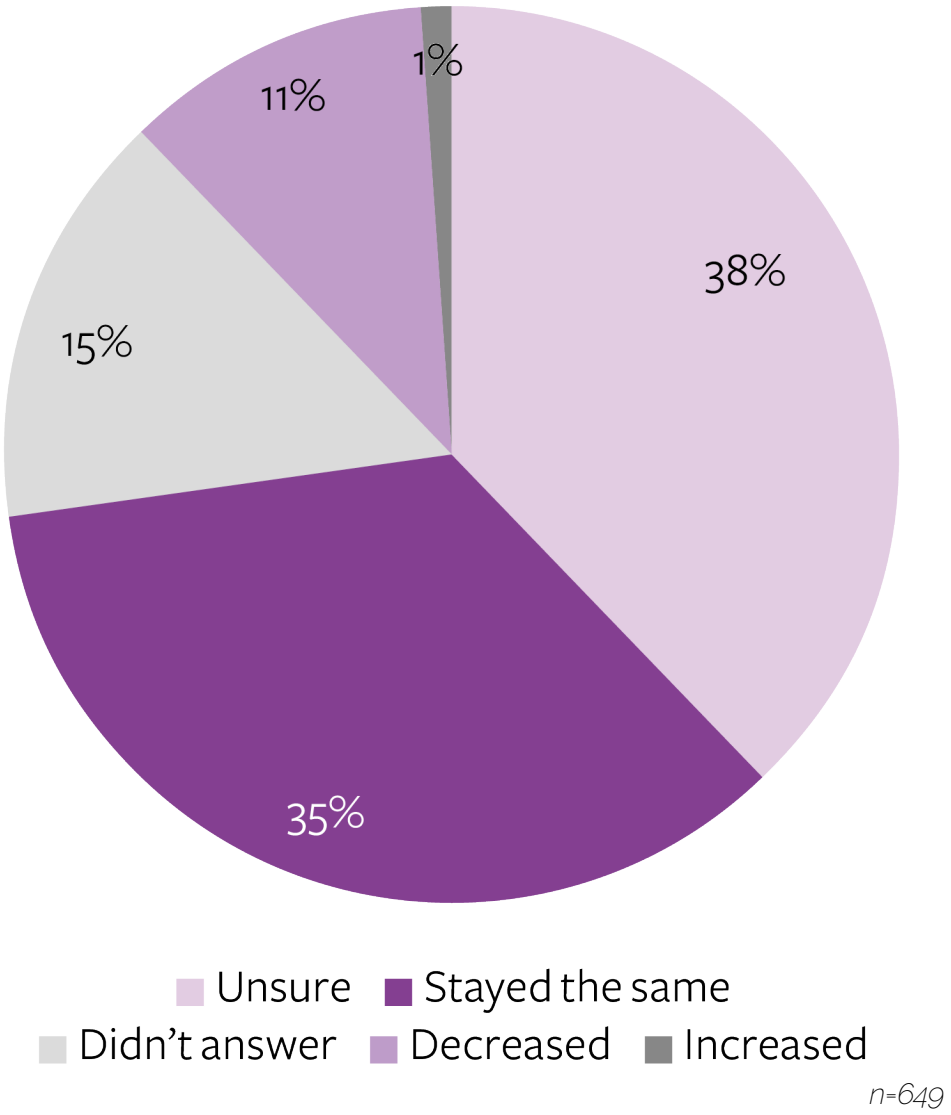
n=649

How much are you paid for Nexplanon insertions?



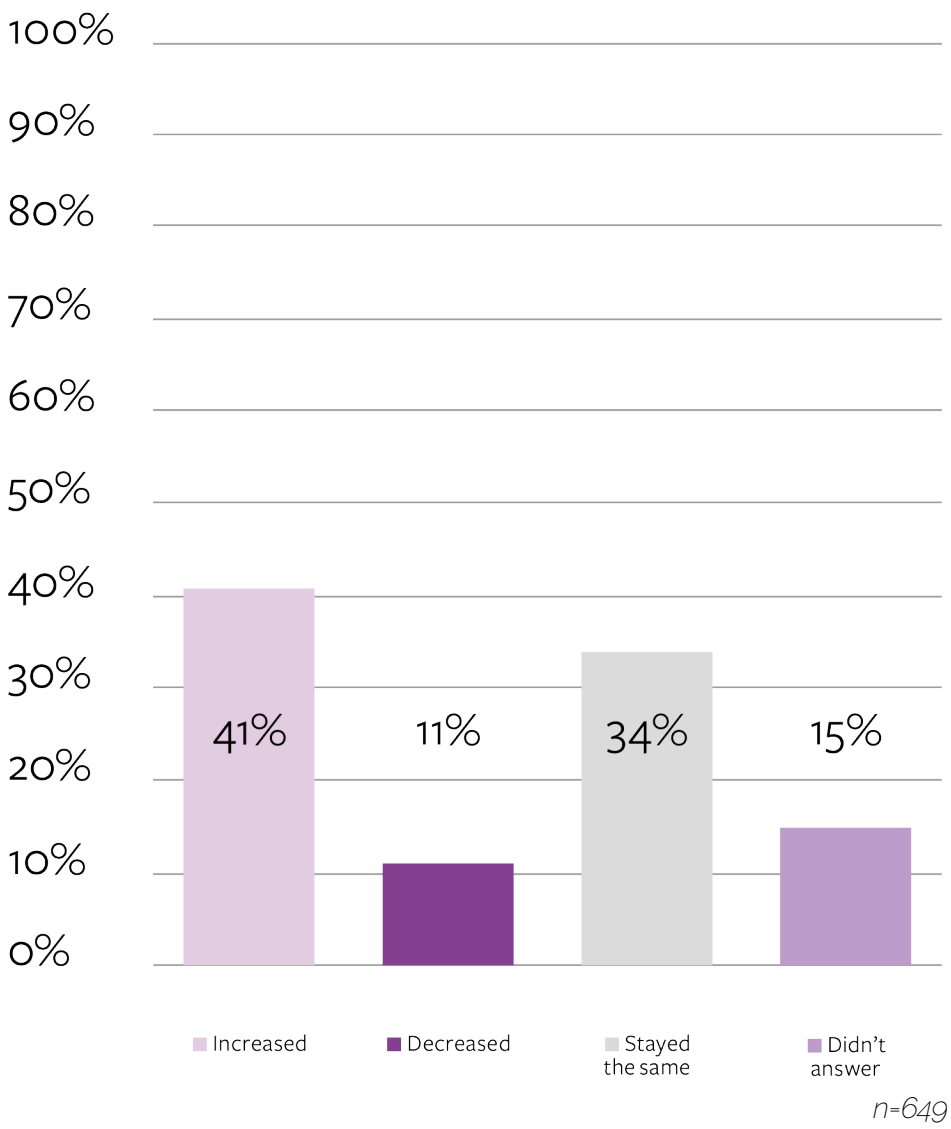
n=646

Has your payment changed over the last three years?

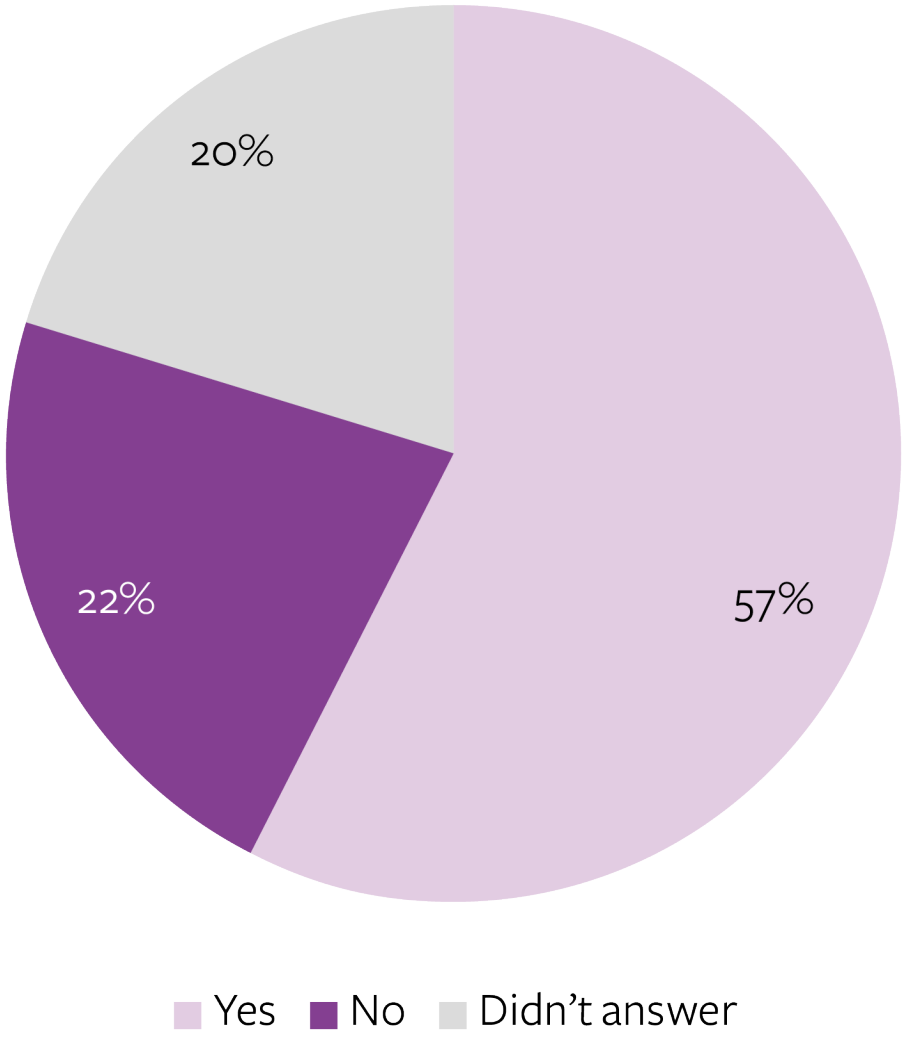


n=649

Has your Nexplanon insertion activity changed over the last 3 years?



Do you think the fee is adequate for this activity?



n=649

In their own words:

"Being paid £25 for an implant fit makes this an un-viable service. On average I do 75 implant procedures a year and due to losing money on each procedure due to staff costs and consumables I am having to discontinue at my surgery."

"The fee for both Implant and IUS/IUD insertions hasn't changed for years."

"We intend to stop fitting implants as there is no payment for this service and no reimbursement of the prescription."

"Only able to claim removal fee for Nexplanon if inserted!."

"The variability in payments over the country - and even locally from county to city is not fair."

"My provision of a Nexplanon/IUCD/IUS service actually costs the practice in terms of my time. We do it so at least our patients have some kind of service."

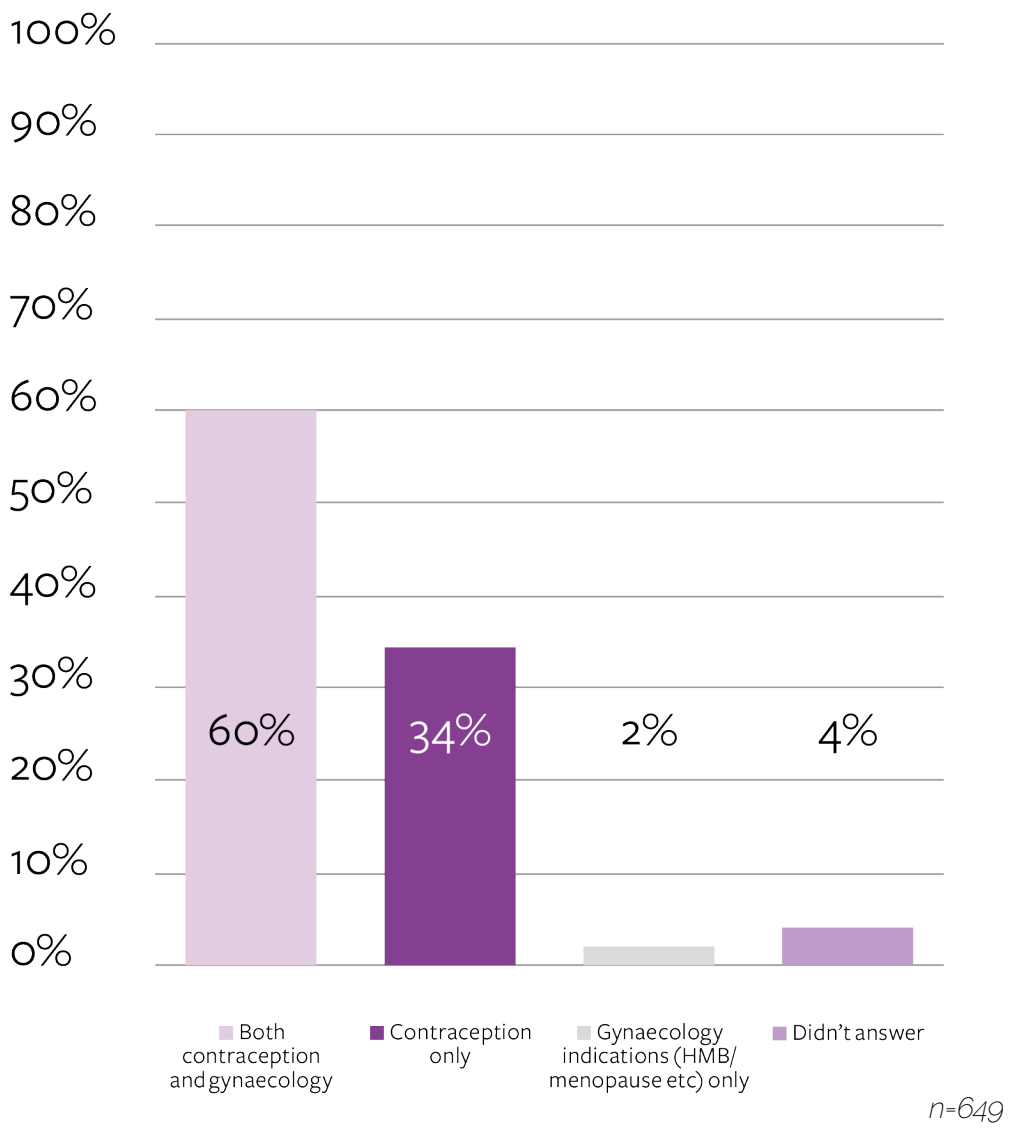
"In Wales I don't think we are paid anything for Nexplanon insertion, only paid for removal!"

"Fees for removing Nexplanon are not enough. It takes similar time and more expertise than fitting one but is paid at half the amount. I really don't know why???."

PRIMARY CARE
WOMEN'S HEALTH FORUM

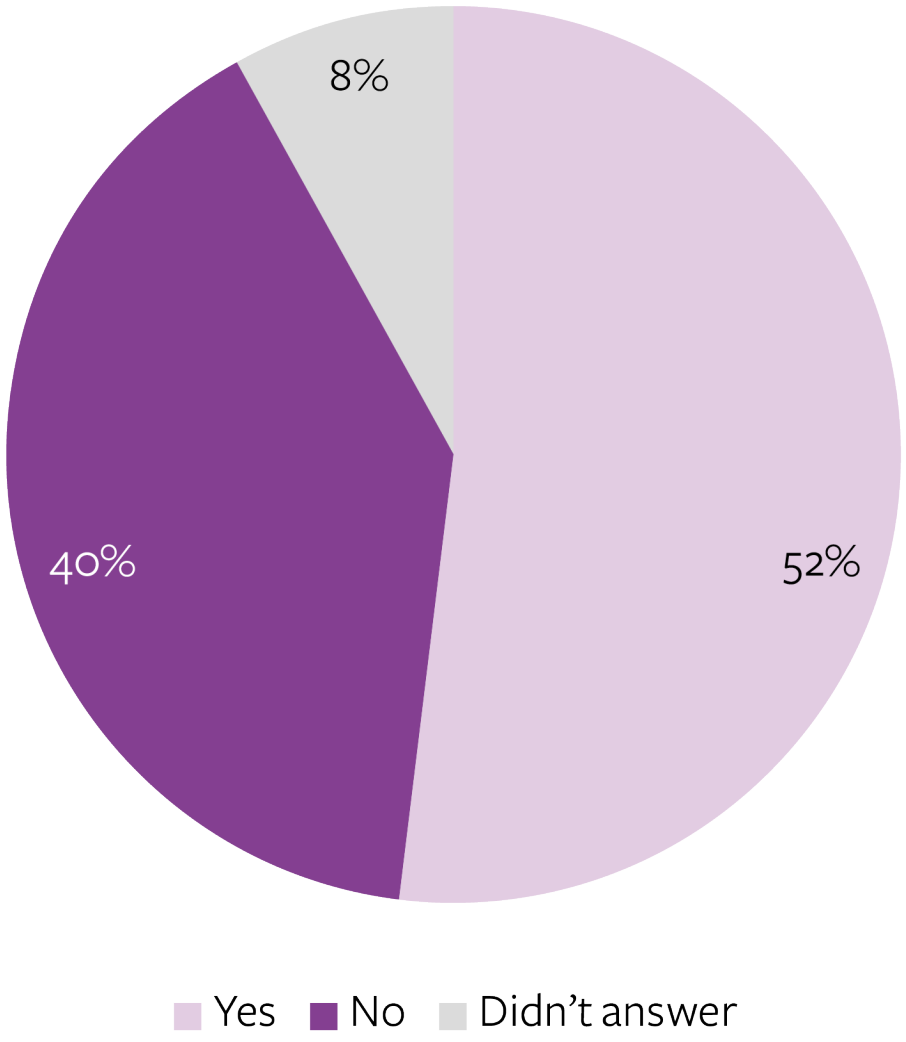
IUS

Practices are funded for IUS insertion for…



n=649

Do you get paid different rates for IUS insertion for contraception and for gynaecology purposes?



n=649

In their own words:

"There is no incentive to fit for HMB/HRT which is bigger demand than contraception and would be a direct saving to health economy a not an outpatient appointment."

"We can claim for IUS insertions for menorrhagia when contraception is not needed but we can't claim for IUS insertions for HRT (unless we pretend they also have menorrhagia)."

"IUS funding comes from [a] different source depending on whether for contraception or gynaecology. Our sexual health service will not see difficult IUS insertions for gynaecology reasons so have to refer to hospital now."

"I think the fee for fitting should be for all indications, not just contraception, as [it] involves [the] same procedure."

"We are funded for contraception and HMB but not as adjunct to HRT. I would like to see this changed."

"I think we should be funded for gynae fitting, especially re HRT."

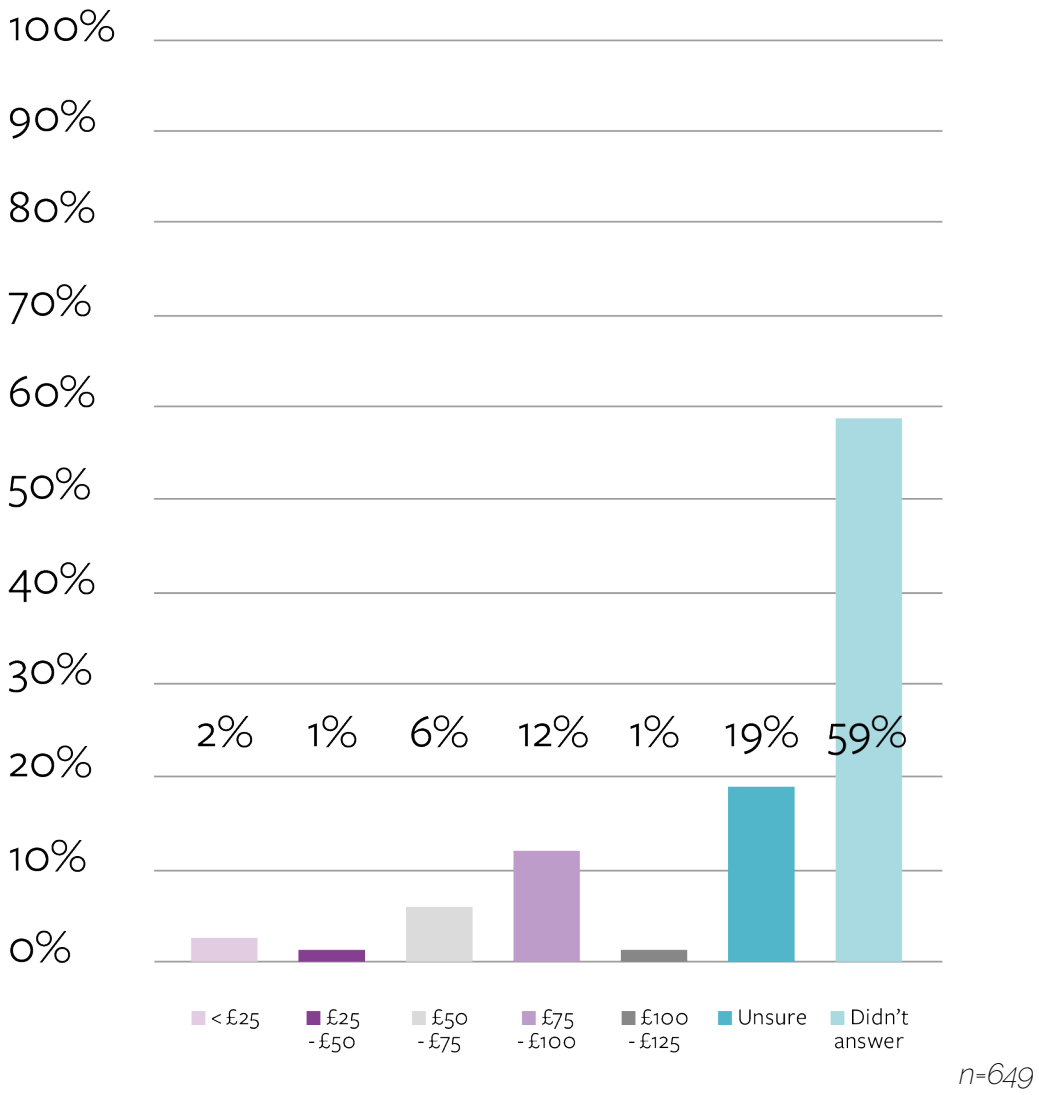
"Patients have to be referred to gynaecology for an IUS for menorrhagia or HRT. That is time consuming for the GP and patient and unnecessary when a GP coil fitter could do it for them at the surgery."

"Some GP practices have stopped their fitters offering the service because it takes up too much time and is not well enough remunerated (especially since IUS fitted for endometrial protection and menorrhagia is not remunerated at all) and women have no access to first line emergency contraception - the IUD."

"Public health in our area pays for coil or IUS insertion done for contraception. I am not paid for insertion of IUS for menorrhagia or for HRT purpose as that funding come from CCG budget. I think it is unfair. Hospitals are charging more money for same work."

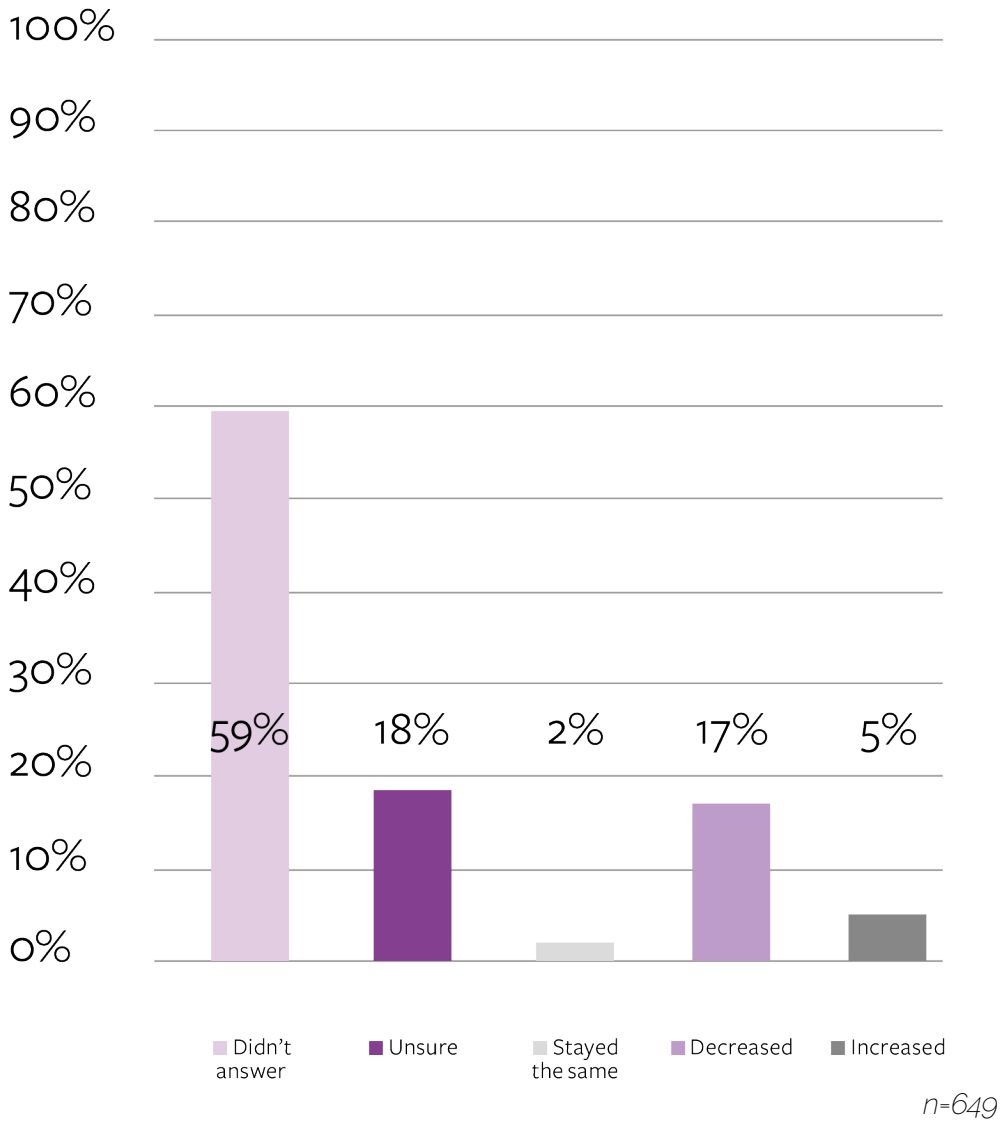
"There is no payment for GPs to fit IUS in women who do not need it for contraception where I work."

How much are you paid for IUS insertion activity for contraception?



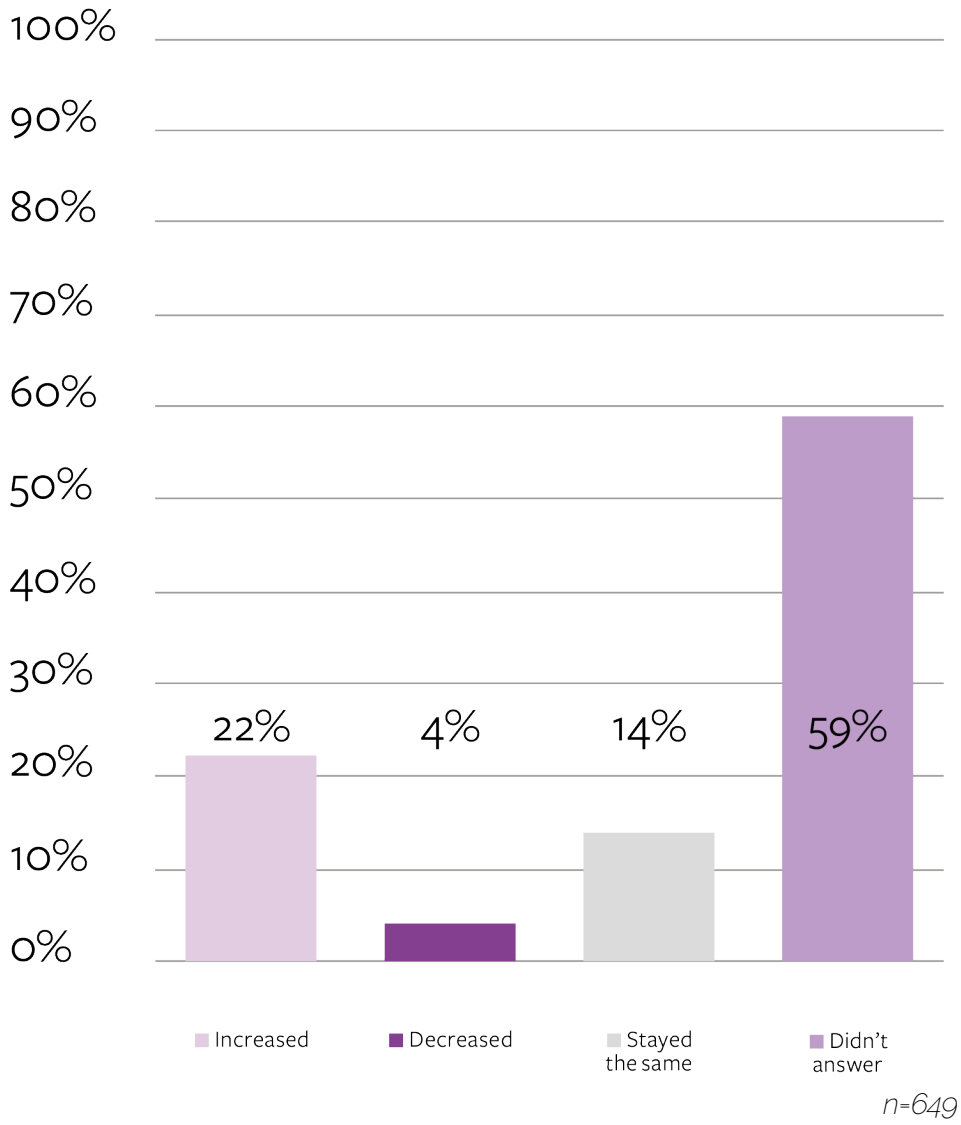
n=649

Has your payment for IUS insertion for contraception changed over the last 3 years?

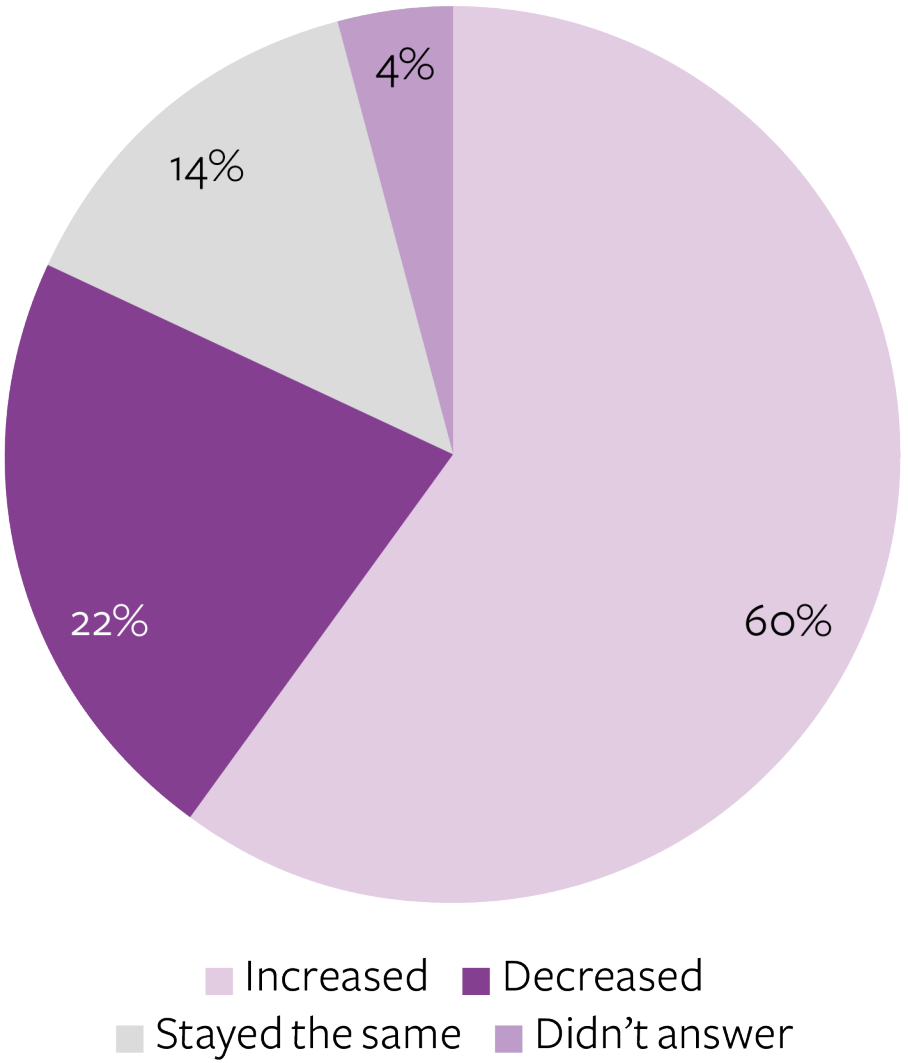


n=649

Has your IUS insertion activity for contraception changed over the last 3 years?

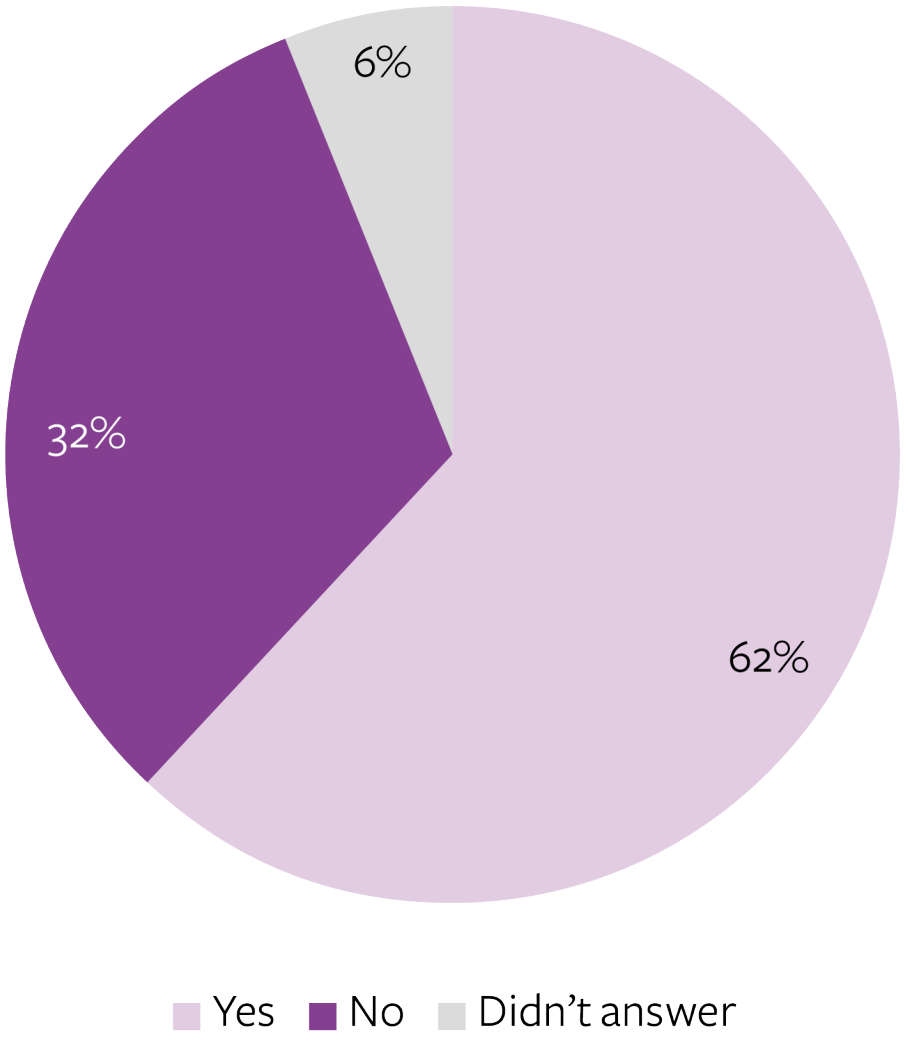


Has your IUS insertion activity for contraception changed over the last 3 years?



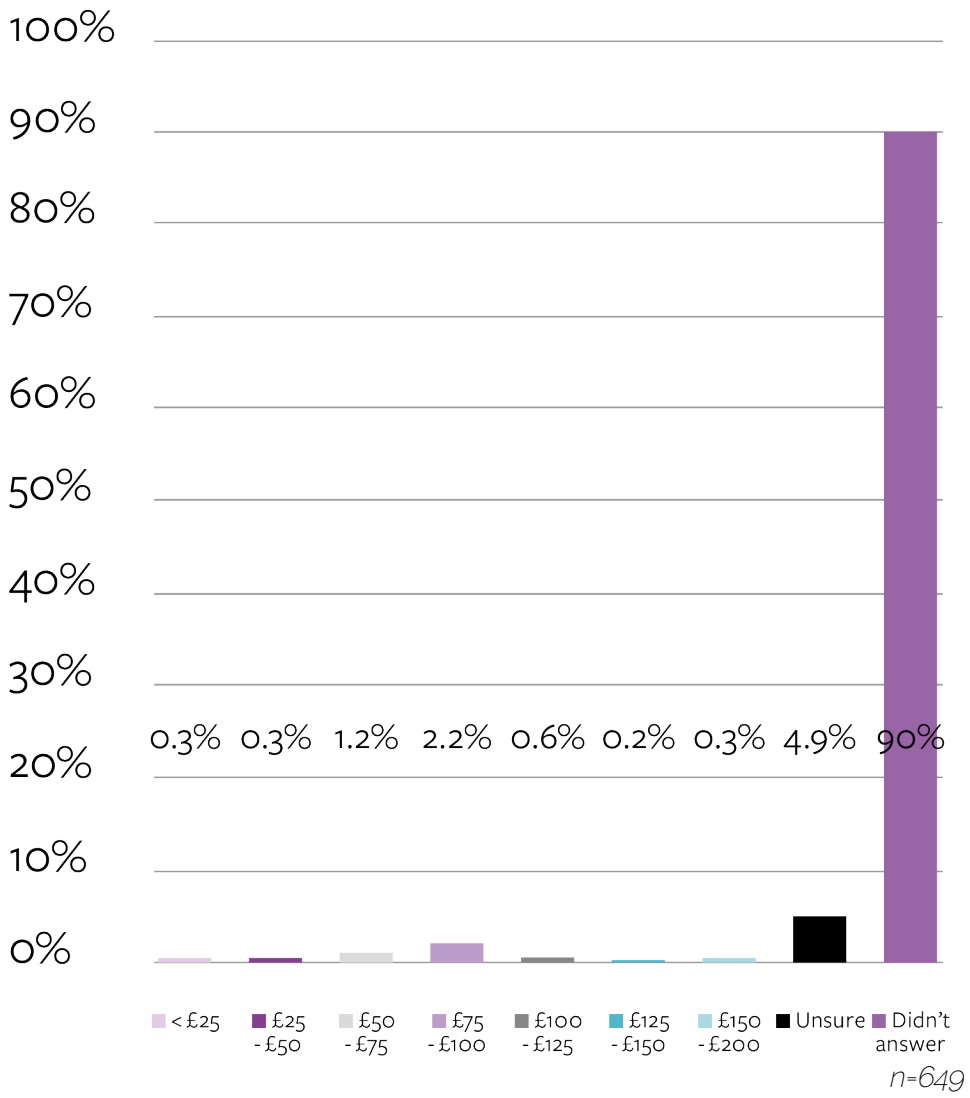
n=649
n=649

Do you think the fee is adequate for the activity?

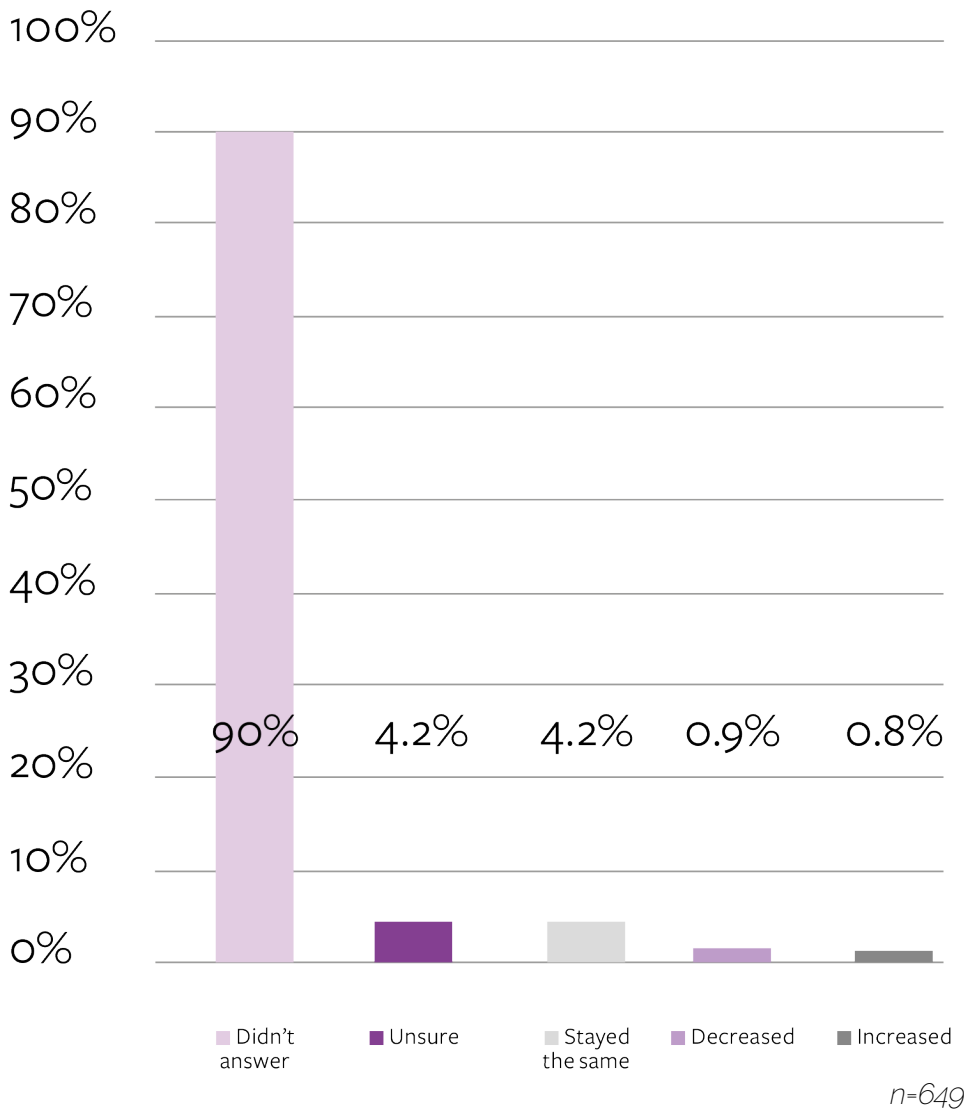


n=649

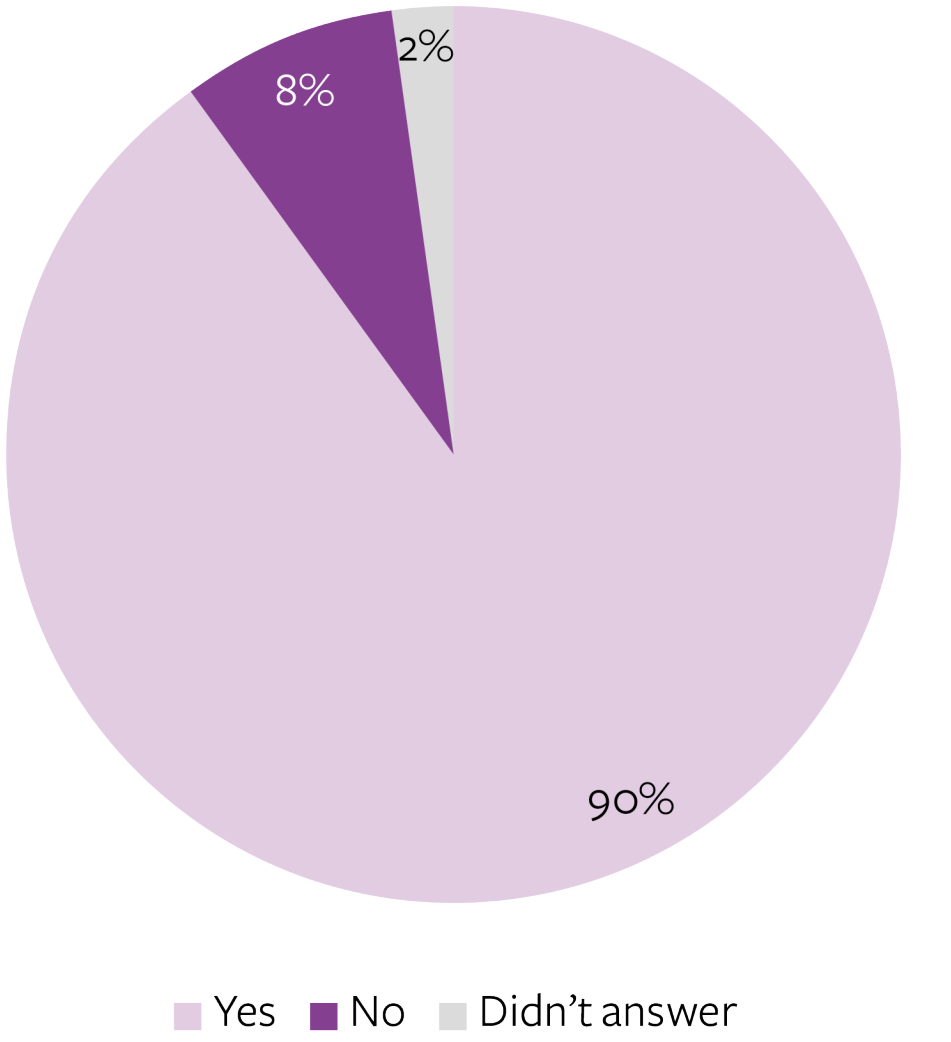
How much are you paid for IUS insertion activity for gynaecology indications?



Has your payment for IUS insertion for gynaecology purposes changed over the last 3 years?

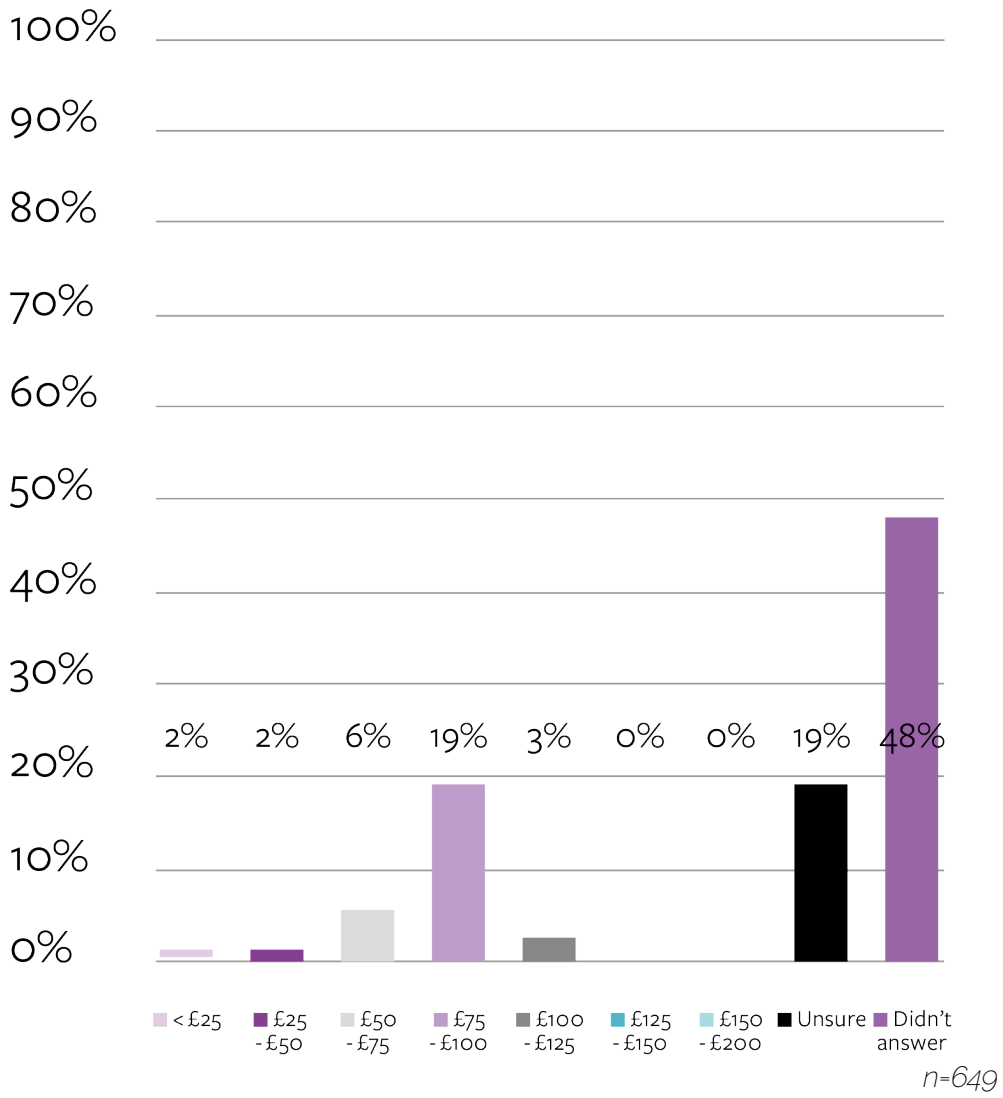


Do you think the fee for inserting IUS for gynaecology purposes is adequate for this activity?

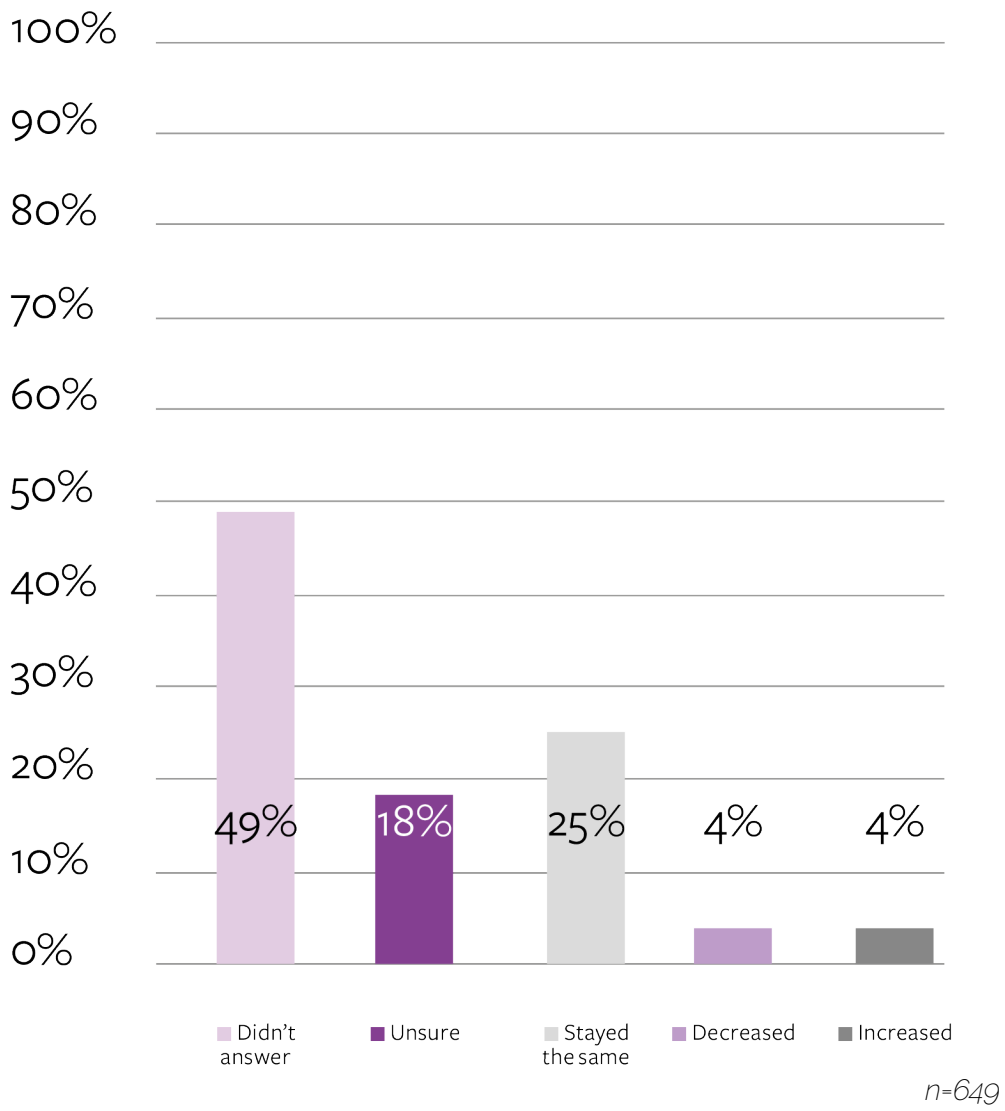


n=649

How much are you paid for IUS insertion activity for both contraception and gynaecology indications?

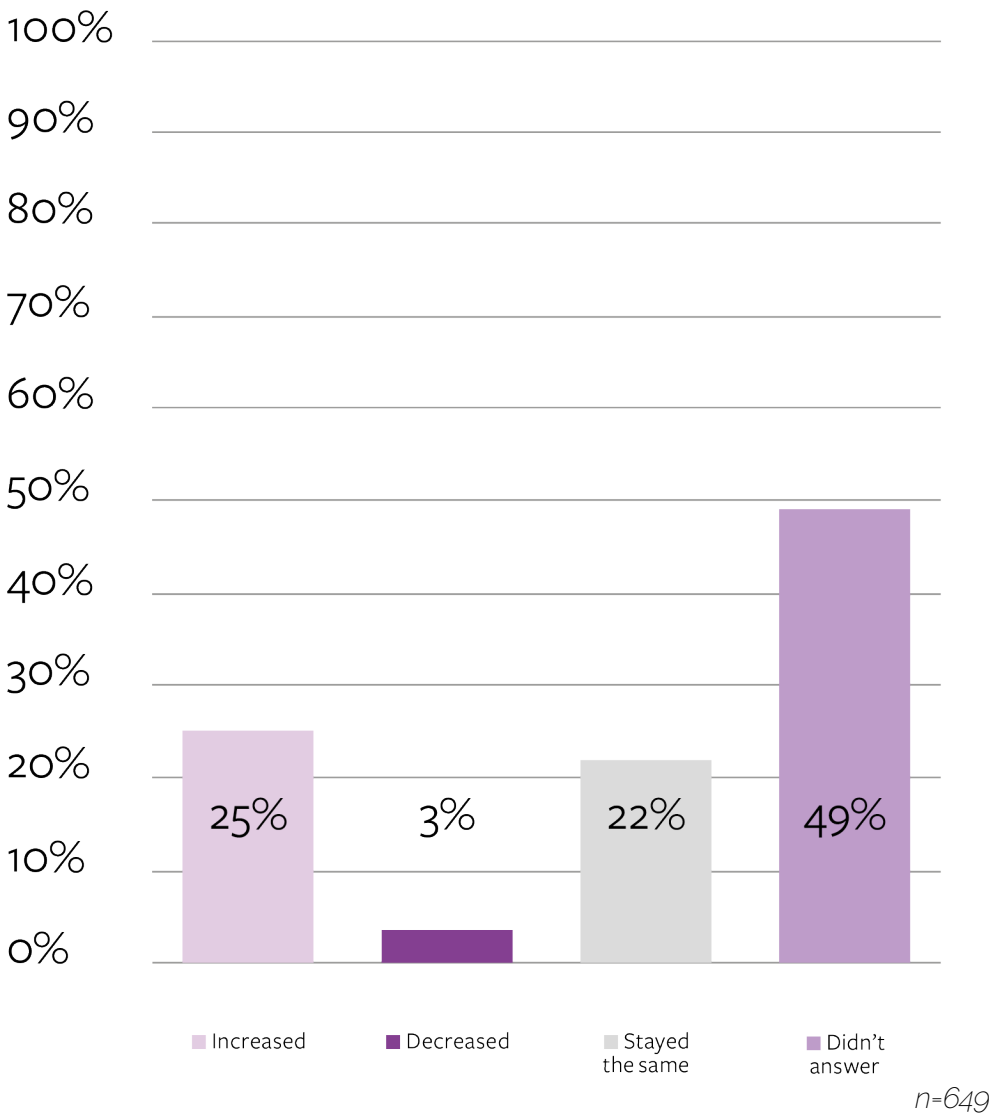


Has your payment for IUS insertion for contraception and gynaecology purposes changed over the last 3 years?



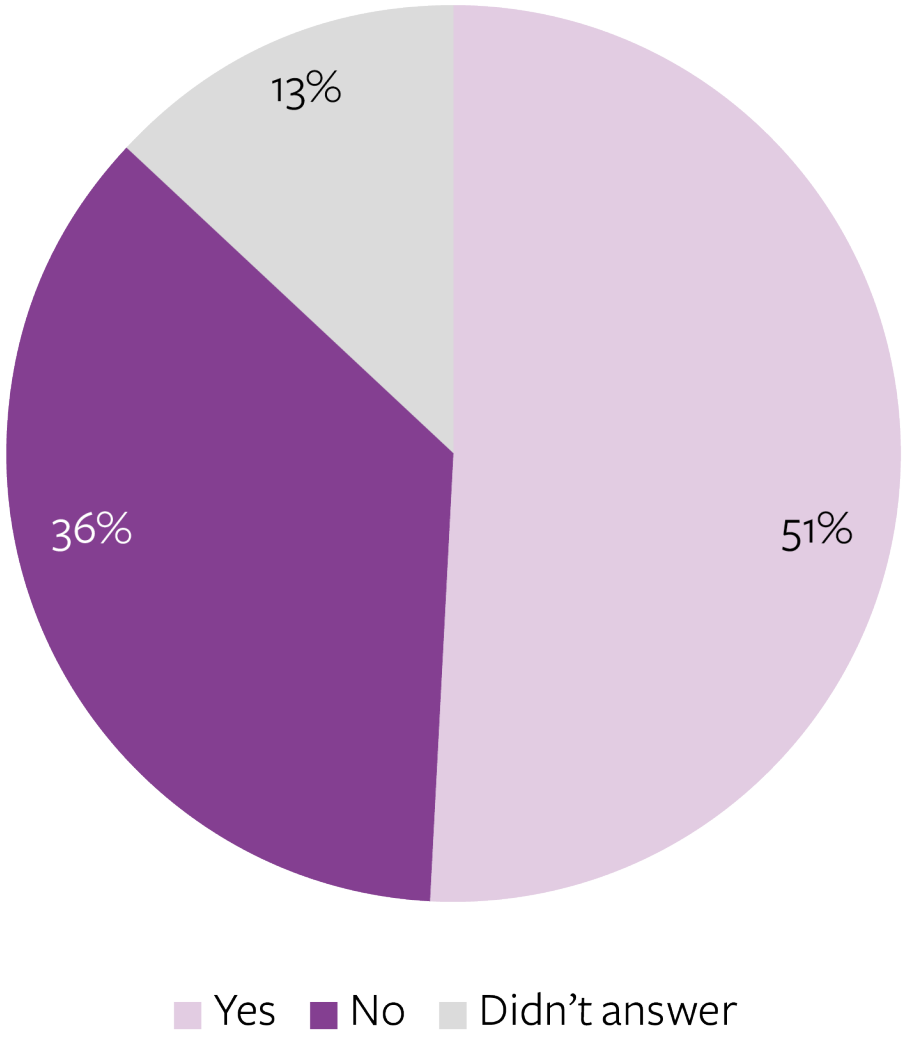
n=649

Has your IUS insertion activity for contraception and gynaecology purposes changed over the last 3 years?



n=649

Do you think the fee for IUS insertions for both contraception and gynaecology purposes is adequate for this activity?

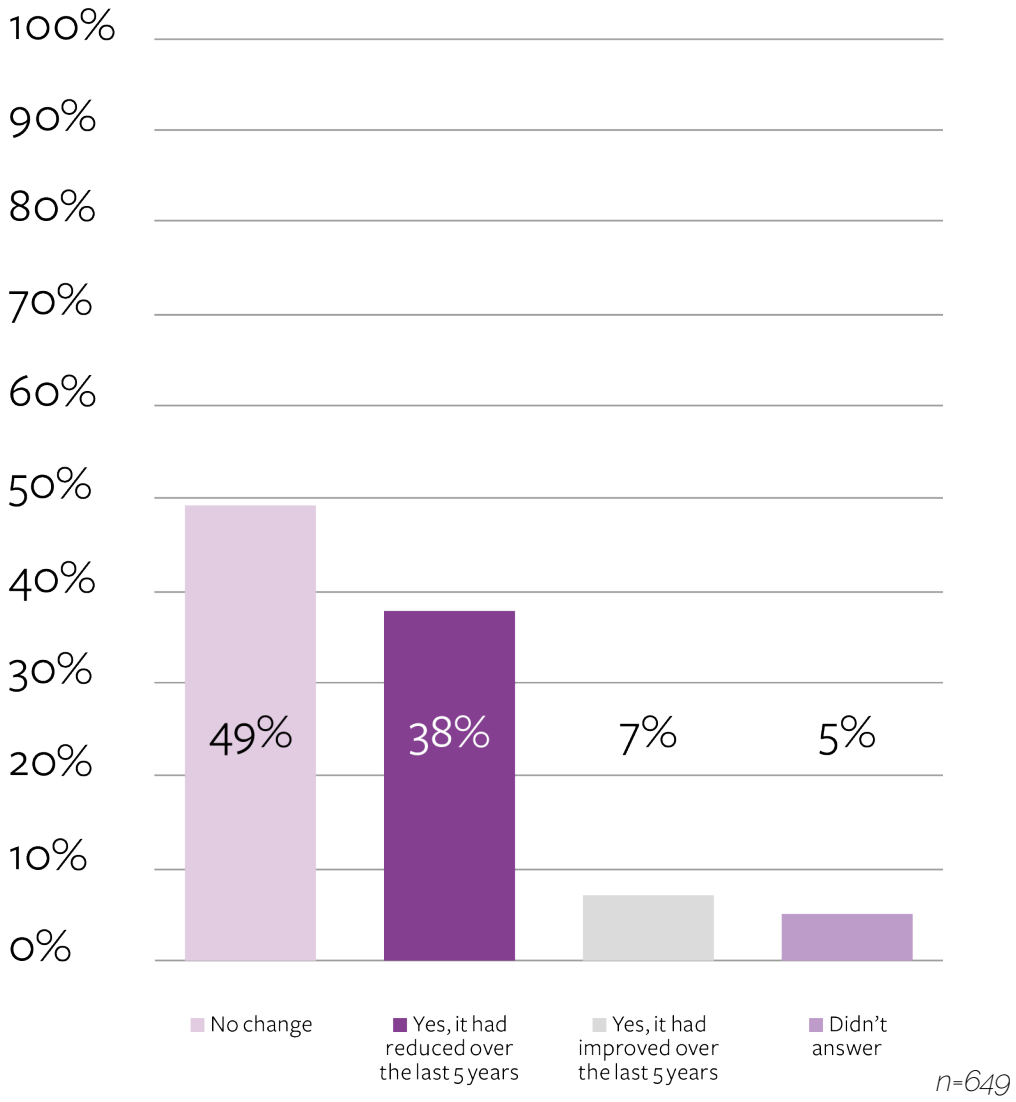


n=649

PRIMARY CARE
WOMEN'S HEALTH FORUM

Training

Have there been any changes to your local arrangements for training new clinicians to provide LARC?



In their own words:

"Training has reduced - I was previously registered with the RCN and an accredited trainer for subdermal implants and coil fitting. However, since moving registration to FRSH I would have to restart my training from scratch to enable me to then become an accredited trainer which seems overly onerous and unnecessary."

"Recertification is important but time consuming and expensive. We are now questioning whether or not we should continue to offer to our patients."

"We've always accepted IUS/IUCD referrals from other practices, we have not advertised. There was no other provision in our town. Implants have been trickier. We ask the patient to attend with a prescribed device for this if [they are] not registered with our practice."

"We need more places for training new professionals and we also need more update courses for existent fitters."

"Training is increasingly difficult to provide and obtain."

"Training made so difficult to achieve required numbers with no payments for training expenses mean impossible to continue."

"I have been trying to get Nexplanon fitting training for over a year. One obstacle after another. Need to be very very committed to not give up. I am finally planning to train [at] end of March unless that gets cancelled too. Meanwhile patients [are] having to wait 4 weeks for local contraception service fitting. Not good enough!"

"Charges for reaccreditation (£100 per Annum FSRH membership) and time consuming nature of accreditation has effectively stifled new entries into training."

"I feel the closure of the Family Planning Clinics has led to a lack of training facilities to train coil fitters."

In their own words:

"We have now employed a nurse to do our LARCs, my worry is I will now be deskilled and less able to support her."

"There seems to be some reluctance locally to train newer members of staff, we are trying to train an IUS/ IUD fitter as our current one retires this year."

"As a Practice Nurse in Primary Care, I have found it increasingly difficult to keep up my numbers. Competing with GP colleagues in an increasingly busy atmosphere plus having to re-apply for my LOC had made me decide to not continue. I will not be reapplying."

"GPs are also getting de-skilled in LARCs provision and new GP trainees are put off by the difficulty in accessing training. The College appears to have done little so far in addressing the issue."

"I have only managed one IUS insertion in 12m and no implants as my current practice is very close to the local sexual health clinic. I feel my 10yrs + experience is being wasted."

"We have trained up our ANP to do the implant work as the remuneration is too low for a GP to do it, hence the reason why my insertions have decreased and I probably won't renew the LOC SDI next year."

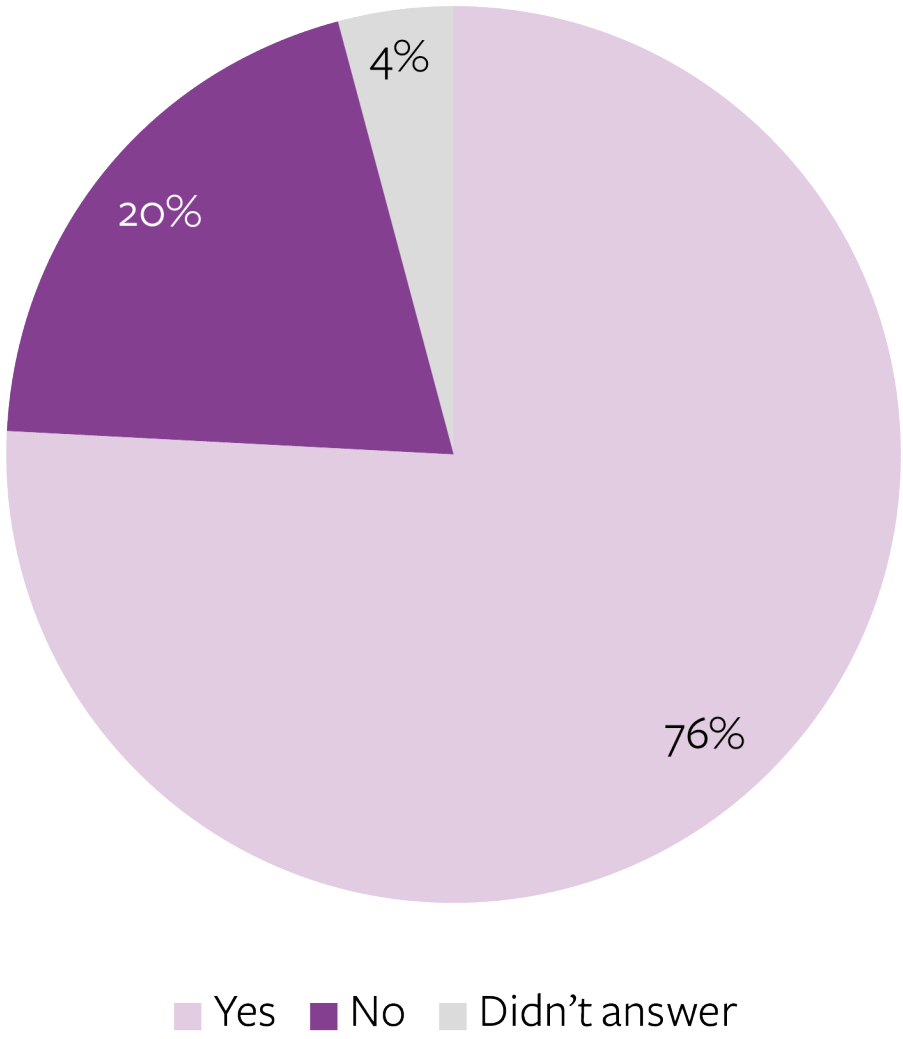
"We have adequate numbers of people trained to fit coils in our practice but all our coil fitters are over 50 years [old]."

"I have now decided to let my IMPLANT fitting certificate go as I would have to set up specific clinics do catch up with numbers, [the] same might happen with coils in due course."

PRIMARY CARE
WOMEN'S HEALTH FORUM

Referrals

Have you developed an IUS insertion service to accept referrals from local GP practices?



n=649

In their own words:

"We have been trying to set up an interpractice referral system but have been struggling."

"We did trial accepting from other practices but the uptake was very poor. If the clinician doesn't understand the benefits of LARC they are unlikely to refer into other services."

"We've always accepted IUS/IUCD referrals from other practices, we have not advertised. There was no other provision in our town. Implants have been trickier. We ask the patient to attend with a prescribed device for this if [they are] not registered with our practice."

"We have reduced our clinics and are not now accepting referrals from other practices."

"Although we have developed a format for referrals most GP practices don't use the service."

"We need to all do the same around the country. There is work to develop hub models for LARC and 'community gynae' happening."

"I feel if we start taking on referrals from other practices that we need the referrers to be adhering to our consent process and also for us to be able to access EMiS to ensure safety."

"Biggest bug bear - strings left too short by secondary care leading to having to re-refer for removal after doing an IUS to confirm its presence. And patients being seen in secondary care and then sent to general practice to fit the coil."

"Locally, sexual health clinic will not fit LARCS in anyone over age 25 unless complex or vulnerable patient. The latter will not be accepted without a GP referral letter."

PRIMARY CARE
WOMEN'S HEALTH FORUM

Prioritisation

In their own words:

"Not considered a priority by local CCG."

"Need more support from local CCG."

"We feel devalued by the reduction in payments. Our CCG wants all fitters to be nurses only who have no Gynae experience like our in house GPs. It is very sad. Our patients want their LARCs fitted in their own practice by people they know."

"Our local family planning services have been decimated over the past few years."

"I have been trying to arrange a clinic as a provider for neighbouring GP practices but my CCG is dragging its feet."

"The local Council refuses to see that the fee offered makes the provision of a LARCs service by the GP Practice financially unviable."

"Understandably the provision of sexual health services is not a high priority for the local council. They have multiple other demands...."

"I tried to suggest developing a service where we pooled all our local LARC fitters in GP to offer a service via the Extended Access service (6.30-8.30pm Mon-Fri and Saturday and Sunday Mornings), which could be funded using a small fraction of the money that covered the old SHC. The LA rejected this."

PRIMARY CARE
WOMEN'S HEALTH FORUM

Impact for women

In their own words:

"Several local sexual health clinics were closed down last June. Our local clinic has a 6 week wait for coil fittings and despite having that clinic our practice still struggled to provide enough appointments (I am the only fitter). We now only have 3 SHC in our locality, however our patients that do not drive can only reach one. The clinic times are unsatisfactory for many working women."

"Our geography is isolated and our patients prefer to have contraception services provided locally and by clinicians they are familiar with. In line with the reduced funding we have reduced our service provision as we cannot continue to function at a loss."

"Funding has reduced to such an extent that it is non viable to us to provide this, I feel, essential service to our patients who are now forced to endure unacceptable waits to be seen in primary, or even more costly secondary care."

"I feel we are moving backward and I am not surprised that based on recent figures 25% of pregnancies end in abortion (this is a real shame and is avoidable). Women are being let down."

"As we are under so much pressure in primary care we had to stop fitting coils for a while earlier this year. We did not have enough GPs to do everything which causes a huge backlog. Part of this was for financial reasons."

"Local contraceptive services dramatically reduced to closure outreach clinics to just 3 hubs. Young women/girls are having to travel long distances to access LARC services which is scary with increased pregnancy and STI's a possibility."

"Women will have to go to family planning clinics which have very long waits and are hard to access due to their appointment options being reduced. It is such a shame for women and will lead to higher unwanted pregnancies and more terminations."

"We signposted our women to the local sexual health clinic. However, this means appointments are on Thursday mornings only. We used to provide Nexplanon fittings potentially 4-5 days of the week. I fear that women will have lost out on the provision."