

A Baseline Needs Assessment for the Development of a London LARC Network: Consultation with Key Stakeholders

August 2010

Contact:

Kevin Miles, Head of Options UK
Options Consultancy Services Ltd
20-23 Greville Street
London EC1N 8SS
020 7430 1900
www.options.co.uk/UK

TABLE OF CONTENTS

Executive Summary	3
1 Background and Methodology.....	5
1.1 What is Options UK?.....	5
1.2 Research Governance.....	5
2 Key Barriers to Increasing LARC Uptake.....	6
2.1 Lack of Knowledge.....	6
2.2 Training of Health Care Staff	7
2.3 Access to Services.....	9
2.4 Commissioning of Services	10
2.4.1 Services that received no specific funding to provide LARC services	11
2.4.2 Services that are funded but have capped or restricted budgets	11
2.4.3 Multiple and complex commissioning pathways, particularly in general practice	12
2.4.4 Inequality of commissioning pathways	13
2.5 Data	13
3 Overcoming Barriers	14
3.1 Equitable and Evidence Informed Commissioning.....	14
3.2 More Efficient Training Pathways	15
3.3 Better Awareness and Knowledge	16
3.4 Clear Referral Pathways	17
4 How Would a London LARC Network Look and Function?	18
5 What Can a London LARC Network Reasonably Achieve in the Next 12 Months?.....	19

EXECUTIVE SUMMARY

The London LARC Network (LLN) is a new initiative commissioned by the London Sexual Health Programme. The LLN commenced in April 2010 and in the first instance will run for a 12 month period. In this time the LLN hopes to achieve a range of outputs that will assist providers and commissioners to increase the level of LARC uptake across London.

In order to define the objectives and structure of the LLN, consultation took place with 39 key stakeholders from across London, representing contraception and sexual health services, general practice, abortion providers and commissioners. The results, as summarised below, will lead to the development of a strategic framework of priority outputs that can be realistically achieved by the LLN in the forthcoming year.

What Are The Main Barriers To Increasing LARC Uptake?

Lack of Knowledge & Awareness

- Lack of general public knowledge of LARC methods and how to access them
- Cultural beliefs and other myths
- Lack of correct information provided by health staff

Training

- Challenges completing practical elements of training
- Lack of training funds
- Accreditation requirements for doctors
- Maintaining competence
- High accreditation fees for nurses
- Restrictions on nurses being able to fit IUS/IUDs
- Willingness of staff to be trained

Access

- Flexibility and access to LARC services
- Inflexible GP appointment systems
- Some services unaware of local LARC provider referral pathways

Commissioning

- Specific funds for LARC not always available
- Capped budgets
- Multiple & complex commissioning pathways in general practice
- Inequality of commissioning pathways

Data

- Incomplete and inconsistent data to inform service direction
- Poor removal data

Overcoming Barriers

Equitable & Evidence Informed Commissioning Pathways

- Sharing of good commissioning practice and contract templates
- Joint procurement of LARC
- Educate and lobby commissioners about benefits of LARC and good practice models
- Equitable commissioning particularly for abortion providers

Efficient Training Pathways

- Clarification of training pre-requisites and accreditation procedures for various providers
- Sharing training resources
- Standardising training and accreditation fees
- More involvement of general practitioners and practice nurses

Better Awareness & Knowledge

- More research on acceptability and user experience

- Better signposting of services
- Better use of NHS Direct as a source of information
- More social marketing of LARC

Clear Referral Pathways

- Local pathways to LARC providers
- Pathways for complex removals

What Could a LARC Network Achieve in the Next 12-Months?

- Mapping where there are trained LARC providers and where there is a big gap, including services that deal with removals and complex issues.
- More detailed data on implant removals and sharing of good practice where removal rates are low (once there is an understanding of why removal rates are higher/lower in some areas but not others).
- Showcasing and sharing successful models of training and assessment.
- Showcasing and sharing successful models of LARC service provision.
- Showcasing and sharing successful models of commissioning practice.
- Develop pan-London or sector level cross-training opportunities.
- A London network of services who can do deep implant removals and clear referral pathways and cross charging mechanisms for these services.
- The development and dissemination of a bimanual training package for nurses.
- Sharing of standardised patient group directions (PGDs) for nurses.
- Clarification on what pre-requisites clinical staff require before undertaking LARC training.
- Lobby for the inclusion of nurses to insert implants and IUS/IUDs (in areas where there is senior management or medical resistance).
- A pan-London standard for assessing competence and accreditation of nurses.
- Lobby for standardisation of training/accreditation fees.
- A consistent set of READ codes for general practice electronic patient record (EPR) systems.
- Guidance on how to develop local pathways of knowledge and expertise.
- Lobby for equitable commissioning for choice of LARC in abortion services that is not postcode or age dependent.
- Educate and lobby commissioners for an evidence informed, client centred choice approach to contraception provision.
- General information sharing and clinical updates on all issues relating to LARC commissioning and service provision.
- Contemporary LARC user experience and acceptability data

1 BACKGROUND AND METHODOLOGY

The **London LARC Network (LLN)** is an initiative commissioned by the London Sexual Health Programme. The LLN commenced in April 2010 and will run for a 12 month period. In this time the LLN hopes to achieve a range of quality outputs that will assist providers and commissioners to increase the level of LARC uptake across London.

In order to define the objectives and structure of the LLN, consultation took place in the form of semi-structured telephone **interviews with 26 key stakeholders** from across London, representing contraception and sexual health services, general practice, abortion providers and commissioners. The interviews were recorded, transcribed and subjected to basic thematic analysis based on the tenets of grounded theory. To ensure an honest and open account of the problems services face, key informants were assured anonymity. As such, no identifiers are reported alongside quotes in this report, although every effort has been made to ensure that the quotes used originate from a range of individuals from the various settings where LARC is commissioned from and provided.

In addition, an email was cascaded via several London sexual health networks and **13 written responses** were received. A table of respondents and PCT representation is located in Appendix 1.

The next step following reporting of these findings to the LLN steering group is to establish an action plan that is specific, measurable, achievable, realistic and time-framed over the forthcoming year.

1.1 WHAT IS OPTIONS UK?

Options UK is the UK programme of Options Consultancy Services Ltd, a leading provider of technical assistance, consultancy and management services in health and the social sectors. Options Consultancy Services has worked for over 18 years providing technical expertise in sexual and reproductive health services internationally.

With expertise in sexual health, adolescent health, service design, monitoring and evaluation, policy and practice and service user engagement, the multidisciplinary Options UK team provide fresh, innovative and practical solutions to service providers, policy makers and commissioners in the UK. We have a strong track record in conducting needs assessments nationally and consider ourselves the leading provider of sexual health needs assessments in England. For more information go to www.options.co.uk/UK

1.2 RESEARCH GOVERNANCE

The Technical Lead at Options UK was responsible for ensuring that appropriate governance procedures were followed throughout this consultation. The consultation was regarded as opinion gathering exercise, rather than primary research, with the results being primarily to inform future commissioning and provider strategies. As such, ethics committee approval was neither required nor sought. However, Options UK followed the general principles of research governance in terms of key informant confidentiality and data protection. Verbal consent was sought following an explanation of the consultation purpose and assurance of anonymity. Audio recordings and electronic transcripts were stored on a secure server, only accessible to Options UK staff. These will be destroyed six months after reporting is complete.

2 KEY BARRIERS TO INCREASING LARC UPTAKE

2.1 LACK OF KNOWLEDGE

A number of key informants talked about the general public's lack of knowledge and awareness of LARC methods as being a barrier to increasing LARC use.

...there hasn't been perhaps enough publicity out there about LARCs... So we have to, obviously, proactively bring it into contraceptive choices whereas everybody's heard of the pill and when they come in and ask for contraception they're kind of expecting the pill, I suppose.

Whilst some providers commented positively about the recent Department of Health Contraception Campaign, with local evidence of increased demand for services, others felt that the campaign had little effect on service demand. Other key informants felt that more needed to be done locally to market LARC methods to the public.

I'll give you an example, when I was last up in Sunderland there are loads of posters around the tube station, bus stations, around the city for young people about different forms of LARC. Whereas in London I've never seen that.

For some communities, cultural or religious beliefs were seen to be a barrier to accessing LARC.

There are preconceived ideas like especially for IUD/IUS for the ethnic minority population; a device going inside them is a problem. And if you extend that cultural issue, the irregular bleeding related to all the traditional methods like the Depo, IUS and the implant and the possible Mirena that is another barrier, which is unacceptable to them culturally. And the most of them believe that when they are bleeding they cannot pray and fast, the Muslims. But, actually because if there's not a normal menses they cannot pray and fast if even they bleed, but the majority just believe that any bleeding is menstruation and so they think that they should not pray and fast. But, the cultural issue, the knowledge base, the preconceived ideas that they gather from friends and relatives is a barrier.

The lack of correct information was also felt to be perpetuated by some health care professionals. It was reported that women were still being misinformed particularly around IUDs; the notion that nulliparous women who were not in stable relationships were not eligible to have an IUD fitted.

There's also a very antiquated view that I still see in a number of young women coming to me from Family Planning Services who have been told that they can't have an IUD because they're not in a stable relationship or they haven't had children...In the recent months, I've seen two 19 or 20 years olds who've both been through every single hormonal contraception, thoroughly miserable and basically at risk of unplanned pregnancy and been told by Family Planning Services you can't have a coil.

There was also a lack of awareness of where to access LARC methods. One key informant talked about how the GUM service had been training GPs to insert IUDs and implants, but the GPs had returned to their practices and had not had any requests for LARC. This reiterates the need for local LARC knowledge networks that extend to potential service users.

They don't appreciate that GPs can provide an implant or a LARC method; it's not something they naturally associate with their GP unless they've got an up and running designated family planning clinic within their GP service.

2.2 TRAINING OF HEALTH CARE STAFF

At the heart of most problems that services face is achieving and maintaining competence. Many services have found it difficult for staff to complete the training for IUD/IUS and implants. Getting the theory completed was relatively straight forward, but getting staff signed off on the practical aspect was widely regarded as difficult. Many key informants stated how booked clinics for training had been arranged but due to the high non-attendance in these clinics, staff were finishing the training session with little observation and hands on experience. For GPs and practice nurses, this results in an expensive training process as their time out of general practice is costly. In other services where insertions took place on a walk-in basis, this also had its drawbacks in terms of offering a specific training session and trainers not being able to accommodate this approach.

I go along to a clinic and they're expecting five people who want implants to turn up so that I can train a doctor or a nurse, and I can sit there the whole morning and none of these patients turn up.

I've had one of my colleagues, she passed her diploma in January, she had her certificate; I'm still waiting for her to get her LARC stuff done. It's month five now.

I think, yes, access to training. I'm involved a lot, especially in implant training, and the problem there is it's very easy for me to go along and do the theory module and the model arm training with people but then for the GP or community doctor, whoever it is, we have then for me to demonstrate on a patient, for me to watch them do a couple of patients, then demonstrate a removal as well as an insertion, and then them do a couple of removals. So it's quite a long process and even longer with IUDs because of the number of IUDs doctors have to do before they're passed as competent, which is right, but it's a long training and it's quite a tricky one to set up because you have to get the trainer, the trainee and a certain number of patients who are the right stage in their cycle there for, if it's training about IUDs or implants. So it is that difficulty and also I think for GPs there's all the issues around payment and things, but not being a GP I can't speak for them on that, but it takes time out of their surgery and all that and I don't know whether they find it very cost effective.

One key informant working in general practice had requested to attend the local CaSH clinic for training but was turned down for unknown reasons. Several key informants also commented on the competition for practical training places, with doctors often getting prioritised ahead of nurses, rather than considering who had been waiting longest and who was more likely to use the skills more often.

The provision of specific training funds were reported as an issue, both from those trying to access training but not able to access funding and those providing training and not being paid to do so.

...the PCTs want the GPs to provide the majority of LARC. But what they then expect to happen is for the community contraception services to provide the training. But essentially there doesn't seem to be any mechanism, or funding of community contraception services, to provide that training. And when they're under severe pressure anyway to provide service within a limited budget, finding the resources and the time to provide the LARC training is very difficult.

There was also the issue of GPs who had been fitting IUDs for 10 years or more who were now required to seek a letter of competence to demonstrate a standard of care that commissioners were now seeking. As a result it was reported that some PCTs were moving away from insisting on Faculty membership as a requirement, instead taking a more practical approach and setting their own local standard. For others where commissioners requested Faculty membership and Letter of Competence, the effort to attain this qualification was not worth the effort, therefore some GPs preferred to stop fitting IUDs.

I think one of the other barriers could potentially be the requirements of the faculty in terms of accreditation. My understanding is, that in order to be deemed competent, you need the letter of

competence and you need to fit I think 10 or 12 a year. In some practices, where there might only be one or two, you know with a smaller list size...

What I'm hearing is if we complied with the rigid set of accreditation criteria in terms of the faculty, these people [GPs] actually shouldn't be allowed to do it because they're not registered with them anymore and there was some sort of period way back where the faculty changed... something changed and there was a bit of a period where GPs who previously were accredited could continue being accredited and continue paying their annual subscription. But if they weren't organised and they didn't realise and they didn't get a letter a lot of them actually fell out of the loop at that stage and what the faculty seemed to be getting at was you can't join back in... You've got to do X, Y and Z and they're saying, no, not worth it. I'm not going to do it.

In spite of the challenges for GPs, there were successes in getting more GPs LARC trained. Several respondents commented positively about the Improving Contraception Choices programme where GPs could get trained.

We've been lucky enough to have been recently involved in a programme called Improving Choices. We've managed to get a few GPs trained through that programme. Prior to that it was all around linking up with our local family planning service and there was a very long waiting list and it was very difficult and it often didn't always work out the way it was intended.

However, an issue of accessing data from the Improving Contraception Choices training programme was described. Respondents highlighted that they were having difficulty in obtaining data from the programme as to which of their staff had completed the training.

The issue of accessing LARC training also remains an issue for nurses, particularly given the widespread sessional nature of nurses working in contraception services.

And that's been a little bit of a hurdle, because for other providers like ourselves where the nurses don't work full-time in family planning, it can be difficult to actually access Implanon training, and that doesn't help in gaining access to LARC.

There was widespread resentment regarding the recent hike in accreditation fees (£400 for non-members and £300 for members) being issued from the Royal College of Nursing (RCN), which were considered higher than for medical staff (£35 with the Faculty of Sexual & Reproductive Health).

There's also the issue of nurses; we've got a lot more nurse interest now in the implant training in particular, and therefore we do have a problem looking at (A), the cost of it, because the RCN have now bumped that up to £400 for non-members, and (B), how to accredit people really, whether we absolutely have to go with the RCN, and also, our local trainers are to accredit nurses really. It's a new area for them.

It's not fair. And all they [RCN] are doing is administering it [accreditation]; they're not organising the training or doing anything. It's really naughty.

The recent RCN stuff, I certainly get lots of phone calls about it, is a rip off, and really should be condemned from the highest level: they're trying to make money out of nurses.

As a result of the challenges for training and accrediting nurses, several providers stated that they were now taking a more pragmatic approach and developing their own internal guidance and clinical governance structures; even if this was not exactly in line with the Faculty of Sexual & Reproductive Healthcare (FSRH) guidance.

From an abortion provider point of view, one issue raised was that LARC training has been very geared around doctors and nurses who work in general contraception services. This model is not entirely transferable to abortion services. For instance, abortion services may be commissioned to insert implants and IUDs, but they are rarely commissioned to remove them. However, for a doctor to get a letter of competence signed off, they would need to be observed removing X number of implants for instance. In a service that does not do removals there is no opportunity to perform this procedure and therefore one abortion provider thought it would be useful if “*LARC fitting can be considered in other environments other than just Family Planning, so that you can have a letter of competence appropriate to the service you provide.*”

One provider commented on the willingness of staff to be trained in LARC use. This was particularly an issue for sessional nurses. From a practice nurse point of view, professional confidence was reported to be a potential barrier, with nurses feeling that the skill was beyond their scope of practice. Another commented on the reluctance of some senior staff to ‘allow’ nurses to be trained to fit IUDs and also that nurses should be paid on a consistent banding if they have been trained.

But like a lot of services, most of my – they call themselves Family Planning, but I call them contraception nurses – are of an older age group, and they’re sessional. So the actual investment time and the time it takes to train someone up, and whether they actually want to be trained up; that can be a real barrier.

One provider stated that a barrier to nurses being trained revolved around the issue of the nurses’ competence to administer IV atropine. Following a statement from the Faculty of Sexual & Reproductive Healthcare in 2009,¹ nurse delivered IUD clinics were suspended in one provider service as ‘*the employing trust made a decision that competence could not be achieved due to the rate nature of the emergency*’. This was despite the nurses being willing to access training in this area.

Finally, from a practice nurse point of view, the issue of prescribing implant devices and lidocaine was raised as a potential barrier. Whilst the training was quoted as good, the mechanisms for dealing with the legal prescribing, supply and administration issues were not addressed, leaving her to return to her practice to try and sort something out by herself.

2.3 ACCESS TO SERVICES

Access to services was also seen to be a barrier to increasing LARC use. There is no one size fits all model so services have often had to use trial and error to establish the model the best suits their local population. Offering services, such as IUD/IUS and implants on a walk-in basis, whilst ideal in the sense that woman has maximum flexibility to access the service, hampers busy services even more, as implants and IUS/IUDs take up considerable time in a clinician’s session. Walk-in services are also often oversubscribed, resulting in daily capping, door closures and women being turned away. On the other hand, services offering booked appointments for LARC fitting were often blighted by high rates of non-attendance. Booked services were also regarded as a barrier given that most LARC methods are usually commenced around the start of a woman’s period.

If you only do coils say on a Wednesday morning or something the chance of a woman starting her period somewhere near a Wednesday morning and not being at work and not having the flu and not being on holiday and so on makes it really quite limited; so it does have to be far more flexible than is easy to manage sometimes.

¹ Joint Statement (June 2009) Produced By The Associate Members’ Working Group And The Clinical Standards Committee On The Role Of Nurses In Managing Persistent Bradycardia During Intrauterine Contraceptive Insertion In Sexual Health Services

Their GPs will offer a LARC session once a month in a blue moon, in the middle of the day. So that's a barrier, whereas our [contraception] services are mainly in the evening, and at week-ends. But unfortunately that means they tend to be overrun as this is mainly walk-in, so patients can get turned away, which is unfortunate, and they may feel they've got nowhere else to go.

Although some general practices were commissioned to provide LARC methods, there were concerns raised by one key informant about the inflexibility of the GP appointment system, particularly with regard to the ability to book way in advance or at last moment.

I think that the problem in general practice is that you might only have one or two doctors within a surgery who are able to perform a fitting and many GPs, because of the nature of their appointment systems, which has changed dramatically over the last couple of years, where they have to offer appointments within 48 hours of request. I think what you tend to find is that GPs are less flexible about stretching the rules ... so I often get women turning up in my service where they say, well I was going to go to a GP but they told me to ring when I was on my period and when I rang when I was on my period I couldn't get an appointment.

Several sexual health services who were not able to offer LARC within their own service reported the difficulty in knowing where to refer service users to in their local area.

We are not able to offer IUD insertions, and referral for IUD insertions remains quite an issue, because again, you can't do it opportunistically, they have to be referred to another provider. There are no clear pathways. Normally, although we have two sites where we can normally refer, it normally involves having a couple of telephone conversations, and it's just not a very efficient service.

Another side of the barriers to accessing LARC is that despite having clear referral pathways in place, these do not always work for some individuals.

Sometimes people go in to see their GPs and they ask for a long acting method such an IUD or an implant and nobody in the practice has got any training to give it to them and so then they're told, oh, well, you'll have to go to such-and-such a clinic where there's a doctor or a nurse who's trained to do that. I think once someone's been given a barrier like that, once you've had the kids looked after for half an hour, an hour, and then you're told, no, we can't do it here, you've got to arrange another day to go without them to a clinic, it's difficult and that'll put people off.

One point was raised about the referral pathway for implant removals, which for some women has been noted to be a particular problem in specific areas of London.

I've got a nurse who works for us in our service, who also works for a Family Planning service for a particular PCT, and she said they have women coming in, sobbing, and begging to have their LARC removed, and by and large, their voices aren't heard. They are told to basically, go away and cope for a bit longer, and a bit longer, and a bit longer. She's told me that she's had women threatening to cut out their Implanon themselves...because they can't get appointments to have them removed. If that's how it really is out there, you know, then that's pretty appalling, actually.

2.4 COMMISSIONING OF SERVICES

There were several issues relating to commissioning, including: i) services that received no specific funding to provide LARC services; ii) services that were funded but had capped budgets, particularly in relation to drug budgets; iii) multiple and complex commissioning pathways, particularly in general practice; iv) inequality of commissioning pathways, particularly relating to abortion services. These are all explored further.

2.4.1 SERVICES WHO ARE NOT SPECIFICALLY COMMISSIONED TO PROVIDE LARC

This issue mainly affects GUM services who, working under GUM tariff, are not specifically commissioned to provide general contraception services, and more specifically, LARC services. As a result, the lack of financial incentive leaves many services unable to offer LARC to their service users.

However, due to service user demand and also on principle of providing a holistic service, some GUM services have established LARC services and absorb this extra cost within existing funding arrangements.

Within our own service, I think what took a lot of time was issues surrounding funding, we were never really given a complete yes go and start the implant service. We did it because we just thought you know what this is ridiculous, and sending 15 year olds to another service, I never know whether they get there, and then they come back to me a month later for emergency contraception, this has to stop.

To be honest we're not specifically funded for LARC, but we offer it anyway. And so we have this crazy situation, where LARC is not available in a lot of local community contraception settings. So we have people turning up here to GUM looking for LARC, because they can't find it anywhere else.

2.4.2 SERVICES THAT ARE FUNDED BUT HAVE CAPPED OR RESTRICTED BUDGETS

Several services talked about budgetary restrictions that had resulted in reduced LARC options. For instance, in one PCT increasing use of Mirena had resulted in increasing cost pressures and a reluctance to promote Mirena use.

Our budget is fixed and remains the same as last year. Therefore there is no provision for increasing LARCs. This is despite training additional staff for implants and IUD/IUSs.

Whilst many key informants declared local targets had been set for LARC use, some PCTs showed no interest in increasing LARC. This was thought to be a result of increasing cost pressures.

Well I think that there are PCT or LARC targets, but to be perfectly honest they don't seem to put that as a very high priority. And so there's no pressure to apply LARC, quite the opposite in fact. As I say I think that what the PCT is doing at the moment, is just saying well, there's only so much money we've got for the community contraception services, do what you can. And as far as the GPs are concerned, do what you can as well. But there doesn't seem to be anything particularly co-ordinated around increasing LARC in any way. So I'm sure we're probably at amber or red locally as far LARC is concerned. As much as anything, because the PCT are not really putting any great effort into it.

From an abortion provider point of view, some PCTs were requesting prior approval from the commissioner before the abortion provider could offer LARC. Although rarely declined, it was yet “another hoop for providers to jump through” and a subtle disincentive to offer LARC. If the PCT did not commission the abortion provider, the client would have to be referred back to the community contraception services, which were already at capacity. Therefore the opportunity to provide LARC at abortion was being missed.

In fact we did have a client who phoned up [the abortion provider] and we said, you need to go back to your family planning service and then she phoned me back and said I've been there but they can't see me for six weeks. It's not ideal in any way.

2.4.3 MULTIPLE AND COMPLEX COMMISSIONING PATHWAYS, PARTICULARLY IN GENERAL PRACTICE

A number of key informants working in commissioning positions declared the area of LARC in general practice to be a “minefield” in terms of payments and keeping check on competence.

I'm just tearing my hair out with figures, and I think you'll find the same picture as well, and I'm sure that there are some PCTs that have always had this pretty sorted, but I think just because you have this issue, people in contract and performance aren't clinicians. And also, they haven't always been very clear about mechanisms for maintaining records on accreditation and qualifications, and GPs come and go. We've got practices who are getting paid, who aren't doing any fittings. And likewise, we've got practices doing fittings, who haven't done them for 15 years, but have got a contract, and we've got one or two who are doing fittings, but don't have a contract. So there's quite a lot to sort out, you know, whoa, what's happening there?

For general practice, there appear to be a range of commissioning options in place. For IUD/IUS, these appear to be mostly funded through PMS² contracting using a NES³ specification, whereas implants appear to be mostly funded through LES⁴ specifications. One PCT reported the lack of QOF⁵ points that LARC attracted as a potential barrier to GPs discussing LARC and in another PCT the recent changes from a LIS⁶ to yet another model of funding (unspecified) threatened access. More recent LARC commissioning models involved GP consortia, chambers or clusters in a specific locale having designated practices where GPs could refer their patients. What was clear was that if there was no financial gain from offering LARC, it was not usually offered at all, even if the GP was trained as a provider.

... I think that it's primarily they don't have any local enhanced service for implants. Even if they're trained in implant, which a lot of them are because they've been out and done the training, they don't get any payment for it; so there's an overwhelming feeling of why bother. Also most of the practices locally are what we call PMS practices, so they've had their IUD fitting lumped into their overall PCT negotiated contract, so again there's no real monitoring or maintenance or payment specifically put on a per patient basis for those services.

Another perceived barrier was the logistics of getting coils/implants paid for in general practice. There is a lack of clarity over the extra steps that patients have to take when they request a coil/implant from their GP.

The issue is because the patient has to get a prescription from the GP and because the GP can't buy them in bulk and store them in the service, they have to send the patient with a prescription. The patient then goes down to the pharmacy and brings it back to the GP and some of the problems that I'm hearing associated with that is sometimes the patients never fill the script, but also they might come back to the GP a few days with it and the GP says, I'm busy; I can't fit it.

It's not very satisfactory, partly because it puts another sort of step in the pathway but also because you really ought to have spare coils in the surgery in case you drop one on the floor or something and need a spare. I think this may be something to do with the way GPs are funded and their ability to claim back for things, I really don't know...

² Personal Medical Service agreements are locally negotiated and have the ability to introduce local flexibilities not available under the GMS contract.

³ Enhanced services that have national specifications and benchmark pricing, but are not directed. These include intra-uterine contraceptive device fitting and more specialised sexual health services.

⁴ Enhanced services that are developed locally. The terms and conditions of these will be discussed and agreed locally between the primary care organisation and the practice with, if wished, the involvement of the local medical committee.

⁵ The Quality and Outcomes Framework (QOF) is a voluntary system of financial incentives hosted within the new General Medical Services (nGMS) contract.

⁶ Practice Based Commissioning Local Incentive Scheme

2.4.4 INEQUALITY OF COMMISSIONING PATHWAYS

It was clear that there is a wide variance in commissioning pathways for LARC across London. The area in which this is more pronounced is commissioning of LARC in abortion services. There was one report from a clinician whose local abortion services were not in a position to offer LARC to the women who used this service, purely because the commissioning pathway for LARC was not in place.

I think the abortion services would like to be in a position to deliver the LARC, they've got half the women anaesthetised for goodness sake, and yet they have to send the women out to go through another traumatic procedure because the commissioners aren't giving them the money. The commissioners still have to pay for the LARC elsewhere and yet they're paying for another visit, so how that makes sense?

On speaking with several abortion providers in London, it now appears that all but a few London PCT commissioners are now able to include LARC as part of the commissioned abortion package, but there remains a lack of parity with some PCTs only commissioning LARC for specific age groups, such as under 25s and others only able to offer it within a certain timeframe of the abortion procedure taking place. Whilst these offers were felt to be beneficial, one abortion provider felt that in terms of offering women choice, the wider range of contraception post-abortion should also be available. Again some PCTs were commissioning this choice, but most were not.

I think one of the things that as a service provider, for me, is that I would like it if commissioners thought about all methods of contraception as well. Which indeed they do, but what I would hate is for us to be so target driven that we're recommending LARC, when actually something else may be more appropriate, but as I say, there is a variation with commissioners' approach on that.

The issue of removals was also raised by abortion providers. Whilst women could have, say an implant inserted at the time of abortion, if they wanted or needed to have it removed, they were unable to return to the abortion provider, therefore having to find another service. This of course raises the issue of continuity of care. Given that contraceptive implants can have side-effects that warrant removal within several months of insertion, the lack of a continuous commissioning pathway impacted significantly on the end user. The effect of abortion providers not being commissioned to remove implants also resulted in a negative perception of the abortion provider by other sexual health providers who felt that they have to 'pick up the removals' for which they were not responsible for inserting.

2.5 DATA

Complete and consistent data for uptake of LARC across London is complex. Many contraception services still collect statistics on paper and it is often not disaggregated; e-PACT data does not capture all methods appropriately; GUMCAD coding doesn't disaggregate contraceptive methods; GPs often only collect data if their contract requires them to do so and READ codes for GP electronic patient records are inconsistent. As a result, many PCTs do not have a clear and accurate picture of their local LARC uptake and/or removal rate.

Data from GUM will also be quite difficult to get, because we don't use KT31 or SRHAD codes, so we just have only our P3 codes, and then whatever we take out of the cupboards, so we've got quite reasonably limited data on contraceptive.

I know it's ridiculous that we don't know. I mean, I'm much clearer now and getting my head around it. But I've had to use prescribing data this year to try and set the finance payments...and that prescribing data doesn't exactly match the financial year. But we've got a mixture, and I'm sure that this is common across all PCTs; we've got a mixture of historical data from when contracts

originally were started, and then there have been additions onto those, so a practice will then start doing implants... and there are 51 LESs, DESs and NESs to be looking at, without even starting on IUDs.

A number of key informants also raised the issue of data on removal of implants. Many gave anecdote surrounding perceived high rates of removals, but few services have been able to demonstrate any evidence to substantiate this. As such, many providers and commissioners requested better data collection on removal. This was thought to be one area that a London LARC network could focus on. From a general practice perspective, ensuring the EMIS READ codes are accurate was viewed as important and the ability to differentiate between removals that were at the three year renewal rate and those that were being removed early.

One other thing we do get, which again is very anecdotal, but we do quite often get calls from commissioners saying they've had complaints from people saying that they're having to remove too many Implanons or this sort of thing. But it's always very anecdotal and we can never actually get any firm evidence back about was it one of our clients, what was the reason, was it that they didn't have enough time for them or was it just that they'd changed their mind or they couldn't cope with that method.

In terms of who is currently doing IUD/IUS and implant insertions, there is a paucity of data.

Some services have looked at who's providing LARC methods and it seems to vary a lot; if you do a mapping exercise of who's providing it in an area, when it comes to GPs you get a young GP who can do it and then they move on. It's out of date within six months; something like that's really got to be maintained, it's quite difficult.

3 OVERCOMING BARRIERS

3.1 EQUITABLE AND EVIDENCE INFORMED COMMISSIONING

Whilst many key informants acknowledged that targets and performance indicators had the ability to drive services to increase their access to LARC, there was a concern that these could have a perverse effect on informed choice of contraceptive methods; providers didn't want to be in a position whereby they had to 'push' LARC to hit a target.

I think better commissioning support to support the delivery of LARC, but the Commissioners shouldn't be blinded that it's LARC, everyone's got to have a LARC, remembering though there are clinical indications but that there needs to be adequate support to open LARC services.

There was a widespread call for sharing of good commissioning practice, including sharing of templates for LARC specific service agreements.

So it would be useful... I think I'd like to see how other people are tackling it. It might give ideas about how I could tackle it but very practical things... I think for me I'm reasonably clear on commissioning pathways although, having said that, it's always useful to hear what other people have done because you might think you know everything but actually there are some ideas out there you haven't thought of.

Several key informants indicated that joint procurement of LARCs could drive down unit costs, particularly for Mirena which is one of the LARCs that has contributed to over expenditure.

It would be great to get some economies across London, if we could have better procurement specifically at the Mirena, which is very expensive, and that doesn't seem to have come down year-on-year.

Several key informants suggested that educating and lobbying commissioners about the benefits of LARC could help overcome barriers.

I think, like I said, for commissioners who are more inexperienced, it helps to give them clear guidelines as to what they should be commissioning, like a range of access points, having promotional literature, telling people what it is, trying to raise awareness of availability of LARC and what LARC is...

Finally, from a commissioning point of view the issue of equitable commissioning across the various sectors, including abortion services was considered important in terms of reducing barriers to LARC.

Another thing which I think has been helpful is pushing the line as well as making sure that LARC is commissioned via abortion service as well. I think that is important. There's a lot of disparity and inequity in abortion services commissioned across London, and I think making sure everybody is commissioning contraception service where available from the abortion provider is very important.

3.2 MORE EFFICIENT TRAINING PATHWAYS

Training was at the top of most key informants list of interventions that could help reduce barriers to LARC provision.

It's a pity if it [LLN] is not going to go on for longer than 12 months. I think the biggest single issue that they could help in, is on-going training in LARC, provision of training, because that really does need to be sorted out. Obviously they're going to have to take a strategic view as to whether they think they're going to get funding beyond that or not. If they think they can't get funding beyond that, then it's going to have to be some very short lived projects around, offering training intensively as and when they can, and trying champion the provision of LARC through both advertising, but also applying pressure to the PCT commissioners. I think probably that's all they can do in the short term. But clearly if there is potential for it to be long term, then they can plan more strategically around training.

Along with this came the need to involve more general practitioners and practice nurses and supporting them to set up patient group directions or other means of overcoming the prescribing/supply issues for nurses in general practice.

Perhaps getting, especially GPs, more interested in actually training to do this because, of course, I am talking about an extremely small number of GPs who actually come forward for training. Somehow persuading the others sitting in their surgery that maybe they should be giving a bit of time up towards this for their patients rather than just saying to their patients, oh, I don't know anything about that, I don't do that, go to your local family planning clinic.

However, one key informant stated the importance of incentivising practice nurses to LARC undertake training. Whilst some practice nurses undertake LARC training as a professional development opportunity, it was felt important that these nurses were remunerated appropriately if they were to take on roles previously performed by doctors.

A number of key informants wanted clarification around the qualifications practitioners required before they went on LARC training. This was for both nurses who were or were not sexual health trained and also for medical staff who had been providing LARC for some years but didn't have the FSRH Letter of Competence qualification. Whilst it was recognised that PCTs could develop their own competence and accreditation programme, this would only be useful within that PCT and would not carry across other PCTs. Given that there are many sessional nurses who work across different locales, the concept of a pan-London standard was highlighted by several participants.

I suppose it would be good to have some London-wide agreement. The Faculty are very firm that you should have the diploma and you're left with a competence to fit... but if there was some London-wide agreement that people who had had that qualification, let it slip and maintained practice and updating to an equivalent standard... if there was some London-wide agreement, it would perhaps make it easier in some areas.

Also, what sexual health qualifications must a nurse have in order to be able to have the right basis for going ahead and doing the implant training, because again, there are courses all over the place? Again, what would be the minimum that they would need, and I think that goes for doctors also... we've got a number of clinicians locally who have never had the diploma, because they qualified a long time ago, but who are extremely experienced.

We have someone who used to work in Africa, and who fitted hundreds of coils every month. But yes, they don't have on paper the minimum requirement for the Letter of Competence. So again, what are the transferable skills of someone who is extremely skilled?

Sharing training resources was also considered important, particularly in terms of the ongoing pressure to achieve sector-wide savings and efficiencies.

I would like to see more of a regional approach to training because, like I said, I don't think there's enough capacity. There may be an issue potentially with capacity for bringing clinicians up to competency level. And if the capacity can be shared across London, I'm sure that would help.

Finally, there was a strong call to standardise training and accreditation fees that are realistic, particularly for nurses.

3.3 BETTER AWARENESS AND KNOWLEDGE

There was a call to better understand the current thinking of women with relation to LARC, a contemporary view on the acceptability of LARC, why women refuse LARC at the point of offer and what is the experience of women who encounter side-effects that can lead to LARC (implant) removal.

If there was an opportunity to do any qualitative research into why would a woman refuse a LARC. Because I think we've loaded all of our kind of thinking onto capacity being an issue, lack of awareness being an issue. Is there anything else we need to look at with regard to potential refusal? What about from the client's perspective? What do they think of LARCs? What kind of information would they want to receive on it? I don't know if that work is being done before. I don't recall seeing anything along those lines.

Yes, and also get a better idea what the acceptability is of LARC. That if you provide it, offer it more widely and you can measure the impact, you can be more confident that it's being consistently offered and then can measure the true uptake from a patient perspective.

Something around service users' satisfaction and feedback...

I personally would like to have more qualitative data on women aged 25 to 44. I think in sexual health we've had a big focus on young people, and we have quite a lot of data available to us in terms of people under 25. But for women aged 25 to 44, I'd like to understand their health behaviour patterns more.

Signposting of services who provided LARC was seen to be important for both service users and other practitioners making referrals.

I think there should be clear signposting within the respective Boroughs as to where all the places are you can go to get LARC.

The other thing that I was trying to get onto was communication. So if we all go through this and we're working towards these LARC targets, what are we going to do to communicate the availability and the appropriateness of LARC to patients?

One person mentioned the need for better information and ongoing support for LARC. NHS Direct was one avenue that was considered to be a possible source of information and support.

I think the other thing for LARC, particularly for Implanon, is actually having good support networks for women to access, where they can talk to people. Whether there's some sort of, I don't know, NHS Direct, or I'm really not sure, but somewhere that they could pick up the phone and chat, or talk to somebody about their experience of Implanon.

Finally, there several people called for more social marketing of LARC in order to create a demand for this service.

There's quite a common thought process that some women, particularly young women, are quite worried about using a LARC. It's like it makes you get fat or you continuously bleed, it messes up your cycle, spots, and there was... I don't know if it ever was produced, but there was some discussions a year or two ago about producing a myth-busting fact sheet. I don't know if there's any kind of mileage in that still.

3.4 CLEAR REFERRAL PATHWAYS

Providers who were not able to offer LARC, such as some GUM clinics, wanted clearer referral pathways to local LARC providers. A number of providers also requested better referral pathways for difficult LARC issues, such as deep implant removal.

I think there needs to be clear referral pathways for difficult LARC patients so that, as I said, there is no point in everyone having an ultrasound machine to take out a deep implant, or anything like that, but as long as within your area, your patch, there's clear signposting of where you refer the difficult patients to or the complex patients to where there's more expertise, I think that is acceptable and I think that's very sensible.

4 HOW WOULD A LONDON LARC NETWORK LOOK AND FUNCTION?

Although most key informants recognised the need for a London LARC network, many struggled to envision how this would look. However, on the whole, most supported the notion of a small group that included representation from contraception and sexual health services, general practice, GP and CaSH commissioning and abortion providers. Sector representation was also raised.

For most people, they just wanted to be kept informed of the outcomes of the network, rather than direct involvement through meetings. Email updates were most popular, with the possibility of occasional events where further exchange of information could take place.

I definitely think you're obviously going to need some Commissioners there, whether you like it or not of course, and I think you need people, if you're having clinicians involved, I think you need clinicians both from the sexual health setting and contraceptive settings, and you need people; I think personally you should have clinicians like myself, or other people, who are directly involved with the provision and who understand. I think you need representatives from abortion, from sexual health and from contraceptive.

I personally think GUM clinics are really underappreciated where people with contraceptive needs are attending. We have not been contacted to look at either including any LARC denominators or promoting it, except for the usual stuff.

Obviously, you need the commissioners there so that they know what's going on, the commissioner of sexual health in the area, so they're the people with the money, or people who should have the money. So they need to be on that particular board along with the doctors, the lead clinicians who will deliver the service, or the lead nurses. Then you've got the money, you've got the people who know how to do it, and you need to involve, as I say, in some way, an outreach arm that's going to deliver outreach services so they would be the lead youth involvement person.

I think the important thing is to have none or as few meetings as possible. London's quite a big place and if you try and get everybody together for a meeting, firstly it never works they can't set it up, and secondly there's always somebody who can't actually turn up. Doing it by email is far better.

Email update stuff, it's difficult to attend London networks, and I work part-time; I'm bringing people in on this group who are looking at their watches.

A learning network where you could seek the key recommendations for commissioning etc.

A newsletter's a good idea. I think people have got a lot of meetings. I think people haven't got time to come up to town to yet another meeting paid for by their employer, because money's tight and you can't get local funding

One point raised was how the network would communicate with general practitioners – it was felt that cascading emails wasn't always helpful, whereas communication events that cover a range of issues often draw interest.

It was also felt important for a London LARC Network to interface with existing regional networks (NELNET, SWAGNET and the emerging network in North West London).

5 WHAT CAN A LONDON LARC NETWORK REASONABLY ACHIEVE IN THE NEXT 12 MONTHS?

The following list of suggestions was put forward by key informants. This list is not exhaustive as ongoing development of the London LARC Network will continue to gather evidence of emerging issues and concerns.

- Mapping where there are trained LARC providers and where there is a big gap, including services that deal with removals and complex issues.
- More detailed data on implant removals and sharing of good practice where removal rates are low (once there is an understanding of why removal rates are higher/lower in some areas but not others).
- Showcasing and sharing successful models of training and assessment.
- Showcasing and sharing successful models of LARC service provision.
- Showcasing and sharing successful models of commissioning practice.
- Develop pan-London or sector level cross-training opportunities.
- A London network of services who can do deep implant removals and clear referral pathways and cross charging mechanisms for these services.
- The development and dissemination of a bimanual training package for nurses.
- Sharing of standardised patient group directions (PGDs) for nurses.
- Clarification on what prerequisites clinical staff require before undertaking LARC training.
- Lobby for the inclusion of nurses to insert implants and IUS/IUDs (in areas where there is senior management or medical resistance).
- A pan-London standard for assessing competence and accreditation of nurses.
- Lobby for standardisation of training/accreditation fees.
- A consistent set of READ codes for general practice electronic patient record (EPR) systems.
- Guidance on how to develop local pathways of knowledge and expertise.
- Lobby for equitable commissioning for choice of LARC in abortion services that is not postcode or age dependent.
- Educate and lobby commissioners for an evidence informed, client centred choice approach to contraception provision.
- General information sharing and clinical updates on all issues relating to LARC commissioning and service provision.
- Contemporary LARC user experience and acceptability data.

APPENDIX 1 - Key informant interview (n=26) and email responses (n=13) and PCTs represented during consultation process

Commissioners (Sexual Health & Primary Care)	9
GUM Nurses	3
Contraception Nurses	4
GUM Doctors	6
Contraception Doctors	6
Independent SRH Providers (includes abortion services)	4
GPs/Practice Nurses	3
Public Health, Service Improvement & Network Leads	4

