

Document Front Sheet

Name and date of meeting: London Sexual Health Commissioning Board, 8 July 2008	
Title of document: Draft Business Case for improved access to LARC across London	Agenda item: 6
	Attachment: E
Aims: The report presents a draft Business case to the LSHCB to increase access to Long Action Reversible Contraception (LARC) across London in line with NICE guidelines (2005).	
Summary: Summary: LARC is proven to be both clinically- and cost-effective in reducing unplanned pregnancy including reducing teenage conceptions and abortions. This paper builds upon the NICE guidelines (2005) to increase access to LARC by 8% which would have major public health and financial impact to the NHS. It outlines the needs in London, the training requirements to increase workforce capacity to deliver LARC, the cost of LARC and potential costs avoided arising from implementing the NICE guidelines across London. In summary, the training costs would be c£152K, the costs of LARCs £1.98m which would avoid costs to PCTs of c£17.5m across London.	
Actions: The LSHCB is asked to discuss this draft business case and endorse the principles and findings in this proposal to London PCTs to prioritise in their PCT funding plans for the DH 08-9 funds to improve access to contraception and their ' 09-10 commissioning intentions.	
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Sexual & Reproductive Healthcare in London: Implementing the NICE Guidance on Long Acting Reversible Contraception

1. Purpose of Document

This paper aims to inform the LSHCB of the findings and potential cost savings/avoidance of implementing the 2005 NICE LARC Guidance. It highlights how this initiative could contribute to a reduction in pregnancy rates, abortions and repeat abortions, including in young people.

London continues to have the highest burden of sexual ill health in the UK with a disproportionate impact on inequalities, public health and the associated financial implications.

1. Background

The NICE Clinical Guideline 30 Long Acting Reversible Contraception (LARC) was published in October 2005. The LARC Methods are progestogen-only injectables, copper intrauterine devices (IUD), the Intrauterine System (IUS) and the Subdermal Implant (SDI). The guideline concluded that LARC methods are both more effective and cost effective than both the oral contraceptive pill and condoms. SDI, IUD and IUS are more cost effective than the injectable contraceptives which require a visit to a healthcare professional every 12 weeks for the latter. Once established on the other methods users do not require regular visits to see a healthcare professional except for complications or removals. SDI are licensed for 3 years, IUS for 5 years and IUDs for 5-10 years.

It is estimated that at least 30% of pregnancies are unplanned. Expert clinical opinion is that LARC methods may have a wider role in preventing unplanned pregnancy and their increased uptake could help to reduce unintended pregnancies. In comparison to other Northern European countries access to and use of LARC is limited and healthcare professionals need increased training to help women make an informed choice. Healthcare providers and commissioners also need a clear understanding of the relative cost effectiveness of LARC compared with other methods of contraception.

Provision of a comprehensive contraceptive service for NHS London would fulfil the requirements of the NICE guidelines for Long-Acting Reversible Contraception (LARC). NHS London locality aims to provide a service for the 31 Primary Care Trusts which collectively make up Pan London, and would ensure that a comprehensive contraceptive service is being offered to all women in the locality.

Contraceptive services are one of the NHSs most cost effective services. For every £1 invested in contraceptive services, including screening, there is a saving of a least £11 on associated costs.

The government has highlighted unplanned pregnancies as key for change in the National Strategy on Sexual Health and HIV and cites unplanned pregnancies and resulting abortions as being indicators of poor sexual health. England has the highest number of teenage conceptions/pregnancies in Europe; three times that of France and six times that of the Netherlands.

There is a strong link between higher index of social deprivation and poor educational attainment and an increased rate of STI, abortions and teenage conceptions. Unintended

pregnancies increase the risk of social and economic health prospects for both mother and child. Girls from the poorest backgrounds are ten times more likely to become teenage mothers than girls from wealthier backgrounds.

1.1 Need in London

The NICE LARC Guideline aims to increase access to LARC through better information for women, choice, increased provision and training and have a significant impact on resource prioritisation:

- * Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods
- * Women should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated
- * Contraceptive service providers who do not provide LARC within their own practice or service should have an agreed mechanism in place for referring women for LARC
- * Healthcare professionals providing intrauterine or sub-dermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods

Total population of London is 7,518,000

Number of women of reproductive age in London

Age	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Total
Number	215,620	274,576	352,677	355,318	331,936	279,302	225,875	2,035,305

Number of legal abortions in London (2006)

Total	Under 18	18-19	20-24	25-29	30-34	35+
51,072	3,173	4,639	14,081	12,869	8,501	7,809

Sexual health is a priority for London with the highest levels of STIs, teenage pregnancy, abortion and HIV in England. Teenage pregnancy rates in NHS London, (45.4 per 1, 000,) are 5% higher than the national average. Appendix 1

In London there has been an 11.1% reduction since the 1998 baseline to 2006, of the 5,680 conceptions 61% led to abortion. There is a large variation in the reduction of teenage conception rates between inner and outer London: Inner London reduction of 16.6% and outer London of 4.9%. There is considerable variation in the reduction rate within the London boroughs Appendix 2. 15% of England's under 18 conceptions in 2005 were in London Appendix 1

The Teenage Pregnancy Local Implementation Grant ends in 2010.

Women currently are unable to access full range of contraception, especially LARC across NHS London

In 2006 29% of women under the age of 25 having an abortion had had a previous abortion and London has the highest level of repeat abortions.

Abortions not paid for by the NHS are higher in London (25%) than the England average (16%) with 60% of PCTs not achieving their LDP trajectories e.g. Abortions carried out within 10 weeks = 60%

Pills and condoms have high failure rates in typical use (5 to 20 per cent per annum), whereas LARC methods are consistently highly effective (less than 1 per cent per annum) and can contribute to the reduction of conception and abortion rates.

Recommendations include the provision of advice on contraception is a Public Health outcome.

Across the 31 London PCTs, there were a total of 51,072 terminations which took place in 2006. At a cost of £497 per abortion⁷, the total cost of abortions to NHS London equates to £25 million.

Sexual Health has been identified as one of the key national priorities for action in the white paper Choosing Health.

2. Objectives

The implementation of the NICE Guideline on Long Acting Reversible Contraception aims to aid PCTs achieve a reduction in unplanned pregnancy, including teenage pregnancy, and abortion. This will be done through:

* Raising the awareness of LARC methods by:

- social marketing approaches with the resident population of London
- training for clinical and non clinical staff of the merits of LARC methods

* Increasing access to LARC methods by:

- Maximizing capacity of current LARC providers, to be informed by The NHS London Service Mapping and Needs Assessment.
- Training for clinicians to provide LARC where additional provision is required. To be informed by the NHS London Sexual Health Training Needs Assessment

It is envisaged that agreement will be required between London PCTs and NHS London in the support of the implementation of the Long-Acting Reversible Contraception Guidelines

3. Benefits

The benefits of the implementation are:

3.1 A reduction in unplanned pregnancy, including teenage pregnancy, as measured indirectly by a reduction in abortion rates.

A shift in contraceptive use to LARC of 8% will be expected to lead to a reduction in unplanned pregnancies from 45,736 to 33,362.

3.2 Avoidance of costs related to unplanned pregnancy.

NICE economic evaluation calculated that each pregnancy averted will avoid £1,575 in expenditure. This is an average weighted cost to include delivery, abortion, ectopic pregnancy and miscarriage as possible outcomes which would otherwise need to be managed across the health economy. For estimated benefits to individual PCTs see Appendix 4.

Cost avoided by prevention of

1 pregnancy Number of pregnancies potentially prevented Total cost avoided

Costs avoided £1575 12,474 £19,646,550

Training costs Provision of additional LARC Total expenditure

Expenditure (£152,376) (£1,983,000) (£2,135,376) Net costs avoided £17,511,174

3.3 Equity in access to contraceptive methods and increased choice for women as recommended by the NICE guidance

4. Overall Risk profile

Three PCTs in NHS London are already the subject of DH National Support Team for teenage conception reviews (2008). By not investing in this intervention, PCTs risks making an core impact on teenage conception rates, abortion and repeat abortions.

5. Cost

Based on the 31 PCTs in London, the LARC NICE guidance implementation tool recommends the appointment of additional staff grade doctors or nurse specialists to increase capacity to provide backfill for other clinics and where required to allow for an intensive period of clinical training.

In some PCTs there will already be adequate numbers of skilled doctors and nurses to allow increased provision and training. This will require additional resource to enable them to commit more clinical time to LARC provision and to cover pharmacy, equipment and support costs of increased provision. would need to be analysed on a one to one basis, therefore the costs here will vary across London. Appendix 5.

Cost to provide contraception are attached in Appendix 4

6. Timescale

This draft Business Case will be presented to the LSHCB and the London Sexual Health Commissioning Network meeting in July 08. This will be supported by information from the London training needs assessment of Reproductive Sexual Health skills in Primary Care which PCTs have been asked to support for June 08. The findings from the training needs assessment with the London Sexual Health Service Mapping, carried out by MedFASH, will help inform commissioning priorities for the DH funding to PCTs and SHAs to improve access to Contraception and PCTs' 2009-10 commissioning intentions.

7. Evaluation

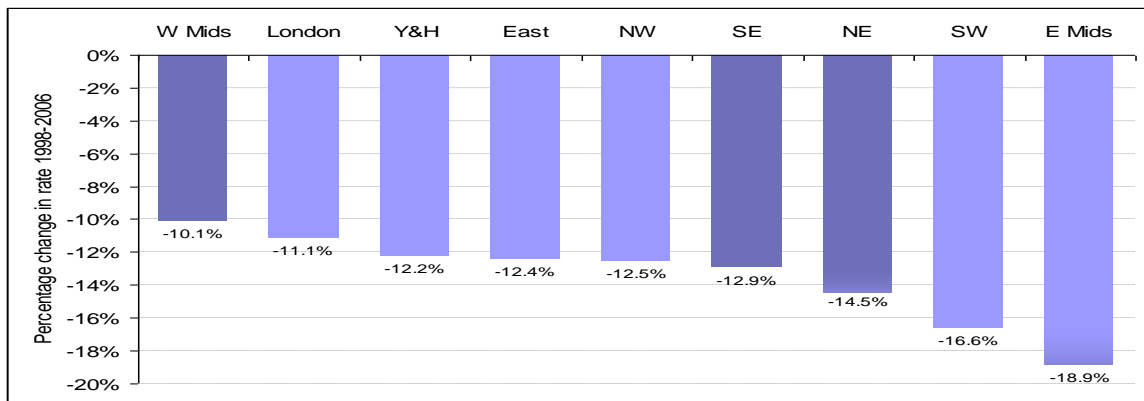
Evaluation of this programme will be through the following:

- * Patient satisfaction survey
- * Increase in the number of staff qualified to train
- * Increase the number of trained staff
- * Increase the initiation of LARCs, including, after abortion
- * Reduction of abortion rates.

It is anticipated that the long term outcome will contribute to the reduction of teenage conceptions; however this may be difficult to contribute to LARC provision alone.

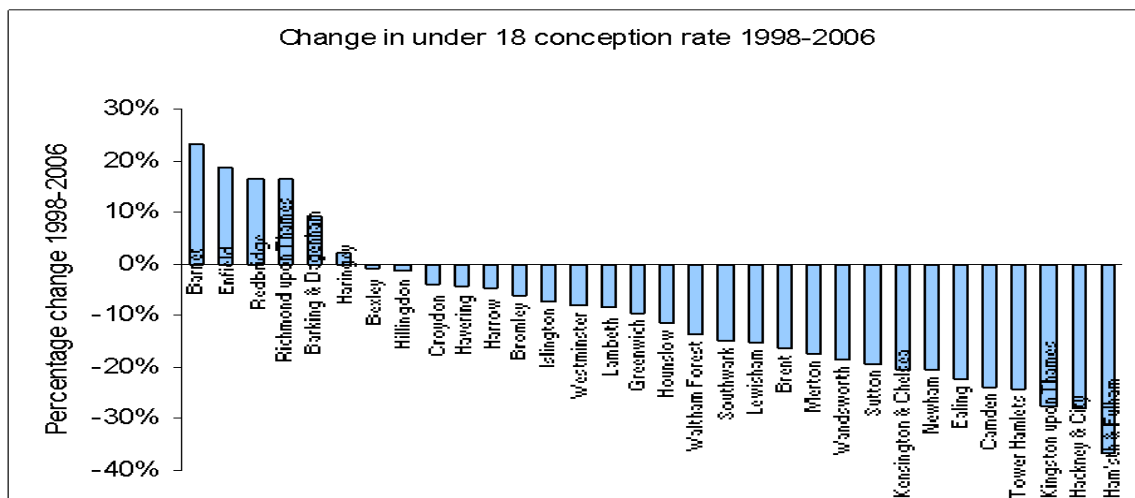
Appendix 1

Teen conception rate in London with regional comparators, 2006



Appendix 2

The 32 London boroughs have achieved varying success, however these figures need to be interpreted knowing that relative small changes in numbers can greatly alter these data.



Appendix 3

Costs over 2 years, costs averted

	National population Standard assumptions	Local population Standard assumptions	Local population Local assumptions
Population: Women aged 15-49	11,966,465	2,035,305	2,035,305
	£000s	£000s	£000s
Current average annual cost to provide contraception	323,091	57,539	57,539
Estimated average annual cost to provide contraception	335,795	59,522	59,522
Additional cost to provide contraception	12,704	1,983	1,983
Current cost of contraception failures	403,933	72,041	72,041
Estimated cost of contraception failures	288,971	52,392	52,392
Increased saving through reduced failures	- 114,962	- 19,649	- 19,649
NET SAVING	- 102,258	- 17,666	- 17,666

Appendix 4

Projected costs averted, NHS London by PCT

	Standard assumptions population of women aged 15-49	Current average annual cost to provide contraception £000s	Estimated average annual cost to provide contraception £000s	Additional Cost to provide contraception £000s	Current Cost of contraceptive failure £000s	Estimated cost of contraceptive failure £000s	Costs averted through reduced failures £000s	Net cost averted £000s
National	11,966,465	323,091	335,795	12,704	403,933	288,971	- 114,962	- 102,258
NHS London	2,035,305	57,539	59,522	1,983	72,041	52,392	- 19,649	- 17,666
Barnet	84,699	2,359	2,443	84	2,949	2,137	- 812	-728
Brent	76,950	2,174	2,251	77	2,723	1,975	- 748	- 671
Camden	69,056	2,151	2,213	62	2,722	1,997	- 725	- 663
Enfield	67,916	1,854	1,925	71	2,315	1,668	- 647	- 576
Haringey	68,493	1,933	2,000	67	2,413	1,758	- 655	- 588
Islington	54,928	1,600	1,650	50	2,000	1,466	- 534	- 484
Barking & Dagenham	42,049	1,177	1,221	44	1,476	1,062	- 414	- 370
Hackney	66,260	1,906	1,971	65	2,386	1,736	- 647	- 582
Havering	54,461	1,427	1,485	58	1,774	1,270	- 504	-446
Newham	72,121	2,107	2,188	79	2,664	1,922	- 724	-663
Redbridge	56,848	1,554	1,613	59	1,942	1,399	- 543	-484
Tower Hamlets	59,957	1,897	1,957	60	2,415	1,767	- 648	-588
Waltham Forest	61,825	1,722	1,783	61	2,144	1,559	- 585	- 524
Harrow	49,282	1,327	1,378	51	1,654	1,189	- 464	- 414
Hammersmith & Fulham	53,106	1,579	1,625	46	1,977	1,460	- 517	- 471
Hillingdon	61,275	1,690	1,754	64	2,115	1,522	- 593	- 529
Hounslow	59,008	1,644	1,703	59	2,051	1,490	- 561	- 502
Kensington & Chelsea	55,431	1,593	1,641	48	1,985	1,462	- 523	-475
Westminster	66,427	2,039	2,098	59	2,574	1,892	- 682	- 623
Ealing	86,238	2,424	2,509	85	3,029	2,205	- 824	- 739
Bexley	50,073	1,322	1,375	53	1,643	1,180	- 463	- 410
Bromley	71,725	1,875	1,947	72	2,319	1,671	- 648	- 576
Greenwich	63,629	1,801	1,865	64	2,252	1,635	- 617	- 553
Lambeth	83,463	2,419	2,493	74	3,023	2,227	- 796	- 722
Lewisham	70,837	1,956	2,024	68	2,434	1,770	- 664	- 596
Southwark	68,514	1,932	1,96	64	2,408	1,756	- 652	- 588
Croydon	87,692	2,356	2,445	89	2,931	2,119	- 812	- 723
Kingston	43,538	1,217	1,260	43	1,520	1,101	- 419	- 376
Richmond & Twickenham	48,355	1,301	1,345	44	1,607	1,173	- 434	- 390
Wandsworth	85,160	2,571	2,641	70	3,220	2,391	- 829	- 759
Sutton & Merton	95,987	2,633	2,725	92	3,275	2,388	- 887	-795

Appendix 5

Ratio of Staff WTE	IUD/IUS	Implants
Change in numbers fitted	67,504	72,879
Average fitting time (mins)	17.2	25.9
Additional WTE required	16.13	26.22
Additional staff to be trained	65	105
Additional staff to be split		
Medical	48.7%	48.7%
Nursing	51.3%	52.3%
Additional numbers requiring training		
Medical	32	51
Nursing	33	54
Unit cost of training one doctor	795	795
Unit cost of training one nurse	993	993
Total cost of training		
Medical staff	25,440	40,545
Nursing Staff	32,769	53,622
TOTAL	58,209	94,167