

LARC

Increased access to long acting methods of contraception

100 or more females per 1000 females of reproductive age per year are prescribed intrauterine, implantable or injectable contraceptives by the end of 2011-2012.

Rationale

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 in Europe; three times that of France and six times that of the Netherlands. Although overall London teenage conception rate is not the highest in England, there are London boroughs with highest teenage conception rate in England, hence highest rate in Europe. In 2008, NHS London recorded by far the highest abortion rate in England, 27 instances per 1000 women aged 15-44 compared with an average for the country of 18.3. Of this, 31% of women under 25 had undergone at least one previous termination. Not all unintended pregnancies end in abortion. It has been suggested that as many as 30% of pregnancies which end in childbirth are unplanned when they are conceived.

Review of evidence on interventions shows that increasing the uptake of LARC methods will reduce the number of unintended pregnancies. The Long Acting Reversible Contraceptive (LARC) methods are progestogen-only injectables, copper intrauterine devices (IUD), the Intrauterine System (IUS) and the Subdermal Implant (SDI). The 2005 NICE 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. 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.

The National Institute for Health and Clinical Excellence (NICE) developed LARC Guideline which aims to increase access to LARC through better information for women, choice, increased provision and training and have a significant impact on resource prioritization. The implementation of NICE LARC guideline should form part of the service development plans for each local health community in London.

Metrics

Units:

- LARC uptake rate for women 15-49 per 1,000 population
- LARC removal rate for women as a percentage of all LARC uptake

Data Definitions:

- Overall LARC uptake can be calculated using aggregated SHRAD (Sexual and Reproductive Health Activity Dataset) and Primary Care activity data from LARC Locally Enhanced Service (LES) and Nationally Enhanced Service (NES) contracts and/or prescription data
- Number of LARC removals performed during the year

Data Quality

1. Establishing baseline is essential.
2. Ensure that all relevant contracts (e.g. Sexual Reproductive Health services, GP enhanced services for LARC, Termination of Pregnancy services with post-abortion contraception provision) specify monthly/quarterly data reporting on the numbers of intrauterine and implant devices fitted and numbers removed as a minimum data requirement.

Organisations' Delivery Setup and Commissioning

1. There should be a lead Board Executive who is responsible for commissioning sexual health service delivery and improvement.
2. Establish a local implementation plan for improvement of access to LARC methods through a range of outlets, including provision of LARC post-abortion.
3. Establish the routes for reporting the results of the implementation plan internally and monitoring progress. The PCT sexual health lead should monitor progress of the plan and report regularly to the PCT Board as a standing item. Reporting should be quarterly

	<p>at a minimum and should be linked to reporting on Teenage Conceptions vital sign (VSB08).</p> <ol style="list-style-type: none"> 4. There should be clear escalation routes in place to identify the action to be taken and by whom when programme milestones are missed. 5. PCT commissioners should carry out a demand mapping/needs assessment exercise and have reflected this in their local service agreements/contractual arrangements. 6. Develop service and capacity mapping of LARC providers to ensure there is sufficient capacity to meet needs. Ensure access to LARC through a range of outlets, including provision of LARC post-abortion. Consider capacity and workforce development for provision of LARC by addressing local LARC training needs and developing Patient Group Directions (PGDs) for nurse prescribers. 7. Increase awareness of LARC methods and competence of local Health Care Providers to raise and discuss their use appropriately. Ensure local General Practices (GPs) discussed LARC methods during all contraceptive consultations. 8. Implement local referral pathways for GPs not offering LARC provision in their own practices. Enable practices to provide LARC through Locally Enhanced Service (LES) and Nationally Enhanced Service (NES) agreements; use Primary Care LARC guide and standard LARC LES and NES templates developed by London Sexual Health Programme. 9. Establish NICE LARC audit group to monitor and evaluate: <ol style="list-style-type: none"> a. Percentage of practices providing contraceptive care who do not provide DMPA b. Percentage of practices providing IU LARC method fitting and number of women aged 15-49 registered with a) these practices and b) those practices not providing IU LARC fittings c. Percentage of practices providing Implant fitting/removal and number of women aged 15-49 registered with a) these practices and b) those practices not providing Implant fitting/removal d. Percentage of practices/services with written protocol for referral for LARC if not provided in-house e. Percentage of LARC referrals (as an outcome) by healthcare professionals who do not provide LARC within their own practice/service of total contraceptive consultations provided by the healthcare professionals f. Percentage of healthcare professionals providing intrauterine or subdermal contraceptives of total healthcare professionals in the area. 10. Increase awareness of LARC methods locally to all women and to all health care service providers. Incorporate promotion of LARC with other sexual health provision, e.g. include LARC discussions within the service specification of Emergency Hormonal Contraception (EHC) pharmacies schemes, LARC leaflets distributed within Chlamydia Screening kits, discussion of LARC during C-Card Condom distribution registration.
Evidence of Effective NHS Intervention	<p>For information on LARC recommendations go to: http://www.nice.org.uk/usingguidance/optimalpracticereviewrecommendationreminders/optimal_practice_review_recommendation_reminders_detail.jsp?o=5</p>
Top Tips	<ol style="list-style-type: none"> 1. Implement LARC care pathway (Appendix 1 below) across primary care and all community services including young people sexual health services 2. PCT Primary Care LARC uptake within baseline can be established using the London sexual health needs assessment and service mapping reports, published by MedFASH (Nov 2008). http://www.medfash.org.uk/publications/documents/London_sexual_health_indicators_PUBLISHED_ONLINE.pdf Data set can be downloaded from London Health Observatory website: http://www.lho.org.uk/HIL/Lifestyle_And_Behaviour/SexualHealth_NeedsAssessment.aspx
References	<ol style="list-style-type: none"> 1. Abortion statistics, England and Wales: 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisti

calpublichealth/index.htm

2. NICE guideline. Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception (2005).
3. Under 18 conception statistics, DCSF Every Child Matters.
<http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00200/>

Appendix 1: Care Pathway LARC

(Source: NICE Clinical Guidelines 30: LARC. Oct 2005)

