PRIMARY CARE
WOMEN'S HEALTH FORUM

On the brink

The reality of Long-Acting Reversible Contraception (LARC) provision in primary care

Why urgent action is needed to protect and improve continued access to primary care provision of LARC

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> **“This is a timely survey. We are seriously looking at stopping accepting patients from other practices as the only income they generate for us is the item of service fee. This does not cover the cost of staff and consumables.**
>
> Anonymous
>
> **”**

ABOUT THE AUTHORS

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Executive Summary

LARC fitters in primary care

- >85% indicated the fitting fee for IUS/D for all indications was inadequate.
- >60% did not know how much they were paid to fit LARC.
- 49% stated there had been no change to the training for new clinicians.
- 43% indicated that training had reduced.
- 80% have not developed an IUS/D insertion service to accept referrals from local GP practices.

For non-fitters or never-fitters, 89% were interested in training to fit LARC but:

- 25% cannot access training.
- 24% reported there is not enough time to train.
- 23% said there is no practice support for training to fit.
- 18% felt the training is too costly.

(Please see **appendices** for full graphs/tables of above).

The Primary Care Women's Health Forum (PCWHF) is increasingly concerned about the viability of long-acting reversible contraception (LARC) fitting (implant and IUS/IUD) in primary care and the implications for wider women's health and contraceptive care in the future if this is not addressed and prioritised.

Based on first-hand evidence from healthcare professionals in primary care, this report provides an up-to-date overview of LARC fitting in the UK, comparing where we are in 2023 with data from 2020. As well as providing an overview, this report includes conclusions and offers recommendations.

The report draws on newly collected quantitative and qualitative data from two surveys conducted in Spring 2023. A total of 1152 UK healthcare professionals responded, comprising 687 LARC fitters, 213 lapsed fitters and 252 never/non-fitters. It compares results with the PCWHF's survey conducted in 2020 (which received responses from a total of 650 UK healthcare professionals). The 2023 survey called upon fitters both past and present, as well as non-fitters and never-fitters to understand the current environment of LARC provision in primary care.

The PCWHF has used these responses to shape this report and ensure it reflects the voices of primary care clinicians delivering women's health care across the country.

> **"Fitting costs for all LARC has not changed in over a decade yet the cost to the practice has substantially increased (disposables etc).**
>
> At the moment we have no provision for getting financial recompense for gynaecological/HRT insertion (noncontraceptive purposes). Yet, we know that we can do this locally which is much more timely, cost-effective and better for the patient.
>
> Despite the move to ICB provision, our 'place' gives nearly 50% less financial recompense for inserting implants than the next adjacent 'place' and 25% less for inserting IUS/D.
>
> Numbers of GPs, who are able and willing to insert is dwindling. We are heading for a crisis. We need to be properly renumerated for this to encourage new fitters.
>
> Anonymous"

> **The fees are not high enough and it is ridiculous that we are not paid for [LARC as] HRT.**
>
> Anonymous

Funding

In the majority of areas, fees for fitting of LARC are still perceived to be inadequate, with respondents flagging this as a major issue, making the continued provision of fitting LARC unviable. A common theme mentioned by respondents flagged that the service was costing them money and they, in turn, were incurring a loss to deliver. This was in line with 2020 results and is not indicated to be because of the pandemic.

The results of the study in 2020 and again in 2023 reflect that the problem is ongoing and multi-faceted, with inconsistent funding (for all indications) resulting in practices stopping provision, limited access to training, and limited training options. However, the demand for LARC has remained the same, or increased.

There remains a major variation in reimbursement for fitting of LARC for both insertion and removal and this has not changed since 2020. The variation in fees for fitting implants and IUS/D for all indications ranged between £25 to £200 with an average implant fitting between £25 and £75 and the average for an IUS/D procedure being £80.

The results highlight a need for future commissioners and providers to prioritise and address the provision of LARC for all indications by working together at a national and local level to address these issues.

Training/workforce

Training remains an issue with respondents saying it takes too long and is too expensive. Provision and access to LARC training continues to decline. Three years on, access to training and the cost of training/recertifying is still reported as a major issue.

A further consideration is GPs moving to roles where they are unable to fit LARC, leaving gaps in provision. It is harder to continue to maintain competency working as a salaried GP or a locum compared to being a partner. Nurses are being trained to replace GPs to deliver LARC, which is seen as an efficiency but is resulting in further skill loss. Nurses can be reluctant to take this work on following training if they feel exposed and sometimes vulnerable.

Increasing demand, access to services and sustainability

Healthcare professionals have major concerns about the impact that the loss of LARC services is having and will continue to have on women's health. This includes waiting lists, and a de-skilled workforce in primary care, along with an increase in the demand for access to LNG-IUS licenced for wider indications such as treatment of heavy periods and menopause. A number of practices reported continuing to perform services at a loss to support their patients and local communities, however this is unsustainable in the long-term.

Conclusions and recommendations

The report provides a comprehensive and detailed analysis of the current issues surrounding LARC in primary care.

Initial recommendations based on the findings from both surveys include:

- Tackle inequalities and remove the current postcode lottery of care by mandating adequate provision of LARC in primary care across the UK.
- Introduce a national minimum 'fair' fitting fee that covers the cost of sustainable LARC provision in primary care.
- Ensure LARC funding includes fitting for all indications (contraception and gynaecology).
- Address training issues to support workforce and capacity.
- Review models of service and improve a patient's journey whilst also making savings.
- Advise community-based models of Women's Health Hubs in line with the Women's Health Strategy and explore access to, and effective spending of, the assigned £25 million.

On the brink – The reality of LARC services in primary care

I. BACKGROUND

The PCWHF is increasingly concerned about the viability of long-acting reversible contraception (LARC) fitting (implant and IUS/IUD) in primary care and the implications for wider women's health and contraceptive care in the future if this is not addressed and prioritised.

There is well researched evidence confirming the superior efficacy of LARC over the shorter acting methods of contraception[1] and NICE guidance[2] encourages the use of these methods. Not only are they more efficacious, but they are cost–effective ways of controlling fertility[3].

Some LARC methods are also cost effective and recommended for the treatment of heavy menstrual bleeding[4] and in the management of menopause[5]. The importance of proper training, reimbursement and access to the service is therefore key to a woman's health, her wellbeing and health equity, as well as the wider health and social care system.

However, in 2020[6] when the PCWHF surveyed over 600 primary care healthcare professionals, it was clear that LARC provision was underfunded, undertrained and access to provision was difficult. Reported obstacles to LARC provision included inadequate funding and the loss of LARC-trained doctors and nurses. Sustainability of workforce was a key issue highlighted as was women's access to LARC including pathways, counselling, and women's perception.

So, three years on, what has changed? In 2023, the PCWHF ran another survey to see how things faired post-pandemic regarding funding issues and training among GPs and practice nurses. In addition, a separate survey targeted lapsed fitters and non/never-fitters to determine why they stopped or never undertook training to fit.

II. METHODOLOGY

In 2023, the PCWHF surveyed its members using two surveys. Survey one targeted LARC fitters and survey two targeted lapsed fitters or those who had never fit. The first survey was sent out in early February and the second at the end of the same month.

The surveys were sent to the PCWHF subscriber database and shared on the PCWHF private clinical Facebook Group; the respondents were all NHS primary care clinicians. Key themes from the survey came from both the quantitative and qualitative responses. The PCWHF analysed the data using Excel to identify and compare common themes and trends from the feedback received.

> **"Massive increase in demand for IUS insertions as part of HRT purposes.**
>
> **Very challenging to continue LARC provision alongside other huge pressures GPs are under.**
>
> **Also young GP trainees are not interested in developing LARC fitting as it is not seen as a valuable skill/money spinner for practices.**
>
> Anonymous"

III. FINDINGS

LARC fitters

Data collected February/March 2023
687 respondents

KEY TAKEAWAYS

Funding

- Fees for fitting of LARC are still perceived to be inadequate with respondents flagging this as a major issue.
- There remains a significant and concerning variation in the amount of reimbursement for fitting across England.

Training

- The provision of, and access to, LARC training continues to decline and when it is accessed, the training takes too long and is too expensive.

Demand

- The demand for LARC is high and increasing for all indications, but there is not enough support or prioritisation to deliver this as a holistic service.

Access/closures

- Some respondents reported closing or considering stopping provision of LARC fitting in practice due to the above factors.

Non-fitters/lapsed fitters

Data collected February/March 2023
465 respondents

KEY TAKEAWAYS

- 54% of respondents were previously a LARC fitter but had now stopped.
- 35% stopped fitting due to a practice decision
- 12% were unable to fund their FSRH membership
- 11% found the payment for the work insufficient.
- 46% had never fitted any form of LARC.

Training

For non-fitters/never-fitters

- 89% were interested in training to fit LARC but
  - 25% cannot access it.
  - 24% report there is not enough time to train.
  - 23% say there is no practice support.
  - 18% say the training is too costly.

Key themes

FUNDING

One of the main reasons clinicians reported they were struggling to fit LARC was due to inadequate funding. A substantial proportion of respondents mentioned the service was costing them money and they were incurring a loss to deliver it. This has not changed since the 2020 survey.

The lack of payment for fitting LARC for non-contraceptive benefits i.e. heavy menstrual bleeding or as part of menopause treatment was also documented as a cause for financial concern. With the recent increase in demand for HRT, the demand for LNG-IUS has dramatically increased and continues to do so.

There is considerable variation in fees paid to practices for fitting and removing LARC – this has not changed since 2020. Some of the respondents reported being paid for different aspects such as the fitting but not the removal or reimbursement for 'no show' patients.

Fitting fees for implants and IUS/D for all indications range between approximately £25 to £200, with the average for implant fitting ranging between £25 and £75. The average cost for an IUS/D fit is around £80.

The majority of respondents cited that reimbursement had not changed for 10 years (15 years in some areas), however the cost of providing insertion and removal to the surgery was increasing year on year – resulting in practices being out of pocket to provide the service.

> "We offer LARC services to our registered patients at a loss. We continue to offer it because we enjoy it and believe it is an important service for our patients – despite not making business sense.
>
> Anonymous"

Of those that expressed an opinion

Table 1: Percentage of respondents who felt the fitting fee was adequate for LARC indications

	YES	NO
IUS/D contraception	11% (29)	89% (227)
IUS gynaecology	16% (10)	84% (53)
IUS both	17% (54)	84% (279)
Subdermal implant	21% (113)	79% (426)

Table 2: LARC funding for fitting and trends in payments

	DECREASED	STAYED THE SAME	INCREASED	UNSURE OF PAYMENT AMOUNT	% FUNDED TO FIT IUS/D
IUS/D contraception	6% (17)	48% (134)	4% (11)	42% (119)	34% (225)
IUS gynaecology	7% (5)	36% (26)	10% (7)	47% (34)	2% (11)
LNG IUS both	4% (14)	51% (183)	7% (24)	38% (136)	64% (419)
Subdermal implant	5% (28)	50% (291)	2% (11)	43% (253)	N.A.

TRAINING

Three years on, training accessibility and the cost of training/recertifying is still a major issue. 49% of respondents thought there had been no change to the training for new clinicians, whereas 43% said that, in their opinion, training had reduced (this figure has increased since 2020 [40%]). Only 8% felt they had seen an increase in training. Interestingly, most respondents who saw an increase were practicing in Scotland.

A number of those surveyed mentioned that they were retiring in the next year or two or have recently retired, expressing concern for their local communities.

The opinion of some LARC fitters is that younger GPs and nurses do not take on the lengthy training process as there is not as much monetary benefit to them or the practice where they work compared with other, shorter courses.

Numerous professionals reported that accessing training is far too difficult, with too many hoops to jump through, as well as it being too costly – all reasons not to undertake training.

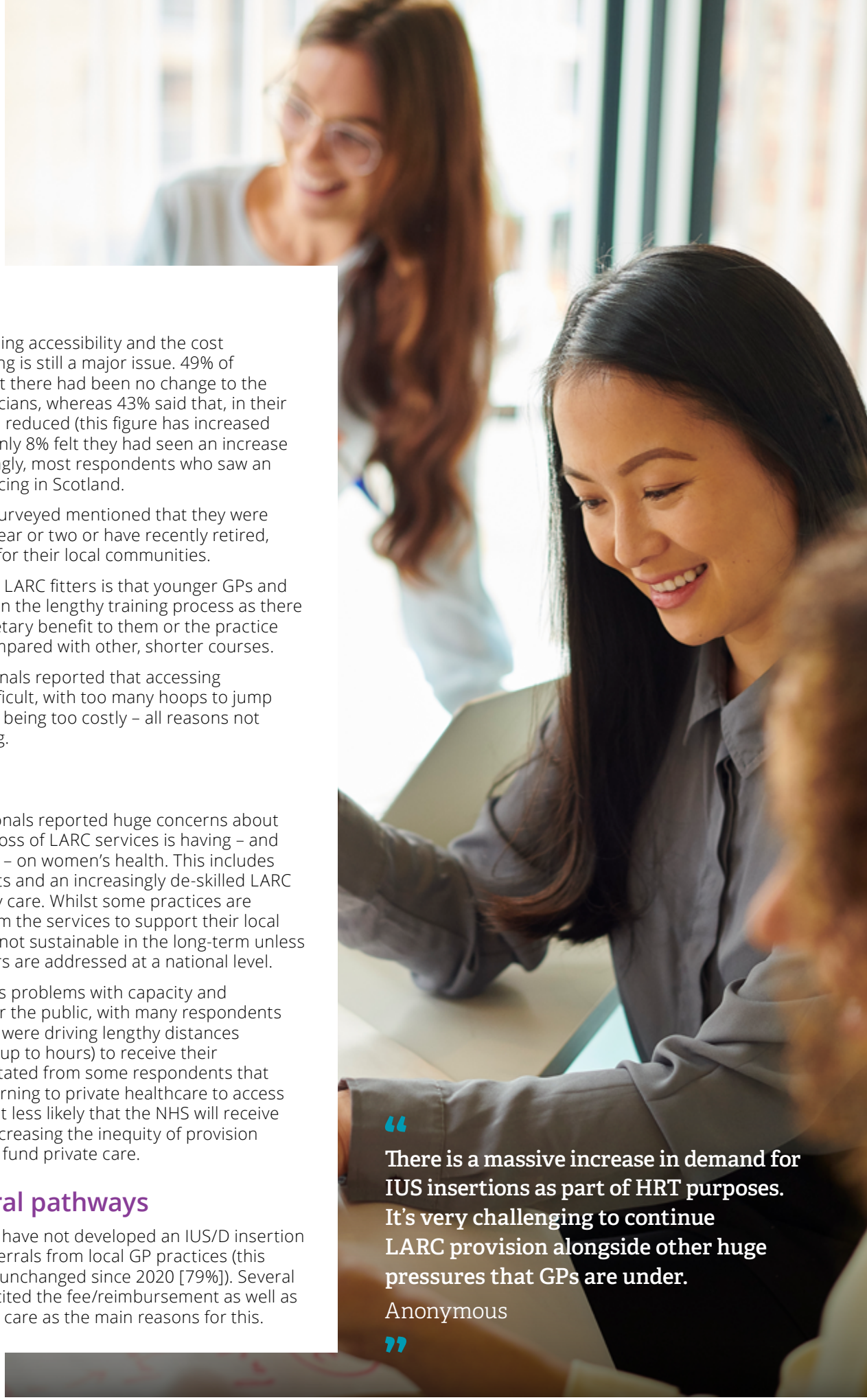
Demand

Healthcare professionals reported huge concerns about the impact that the loss of LARC services is having – and will continue to have – on women's health. This includes increased waiting lists and an increasingly de-skilled LARC workforce in primary care. Whilst some practices are continuing to perform the services to support their local communities, this is not sustainable in the long-term unless the identified barriers are addressed at a national level.

There are continuous problems with capacity and access to services for the public, with many respondents stating that patients were driving lengthy distances (one practice stated up to hours) to receive their LARC fitting. It was stated from some respondents that more patients are turning to private healthcare to access this service, making it less likely that the NHS will receive more funding and increasing the inequity of provision with many unable to fund private care.

Access/referral pathways

80% of respondents have not developed an IUS/D insertion service to accept referrals from local GP practices (this percentage remains unchanged since 2020 [79%]). Several of the respondents cited the fee/reimbursement as well as pressure on primary care as the main reasons for this.



> "There is a massive increase in demand for IUS insertions as part of HRT purposes. It's very challenging to continue LARC provision alongside other huge pressures that GPs are under."
>
> Anonymous

LARC fitting pre & post-pandemic – a comparison

In 2020[6], when the PCWHF originally ran the survey, 650 healthcare professionals responded. The subsequent report concluded that LARC provision was underfunded, undertrained and access to services was difficult[6].

2020 survey key takeaways

The main reason primary care professionals were stopping fitting LARC was inadequate reimbursement making the services unviable. There was considerable variation in fees paid to practices for fitting and removing LARC.

Most professionals thought the fees paid for LARC fitting (implant and IUS/D) were inadequate. Of those that expressed an opinion:

- 72% felt the implant fitting fee was inadequate; only 28% felt it was sufficient.
- 85% thought the IUS/D fitting fee for contraception was inadequate; only 15% felt it was sufficient.
- 84% thought the IUS fitting fee for gynaecological purposes was inadequate; only 16% agreed that the fee was sufficient.

A third of practitioners (34%) were 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.

It also found that fees for fitting LARC were not keeping pace with the cost of delivering services. In the previous three years:

- Only 1% of respondents had seen an increase in fees for fitting implants; 35% stayed the same and 10% had seen a decrease, The rest of the respondents did not know what the payment was.
- Only 2% of respondents had seen an increase in fees for fitting IUS for contraception; 17% had stayed the same and 5% had seen a decrease.

There were also problems with accessibility and cost of both training and recertifying with more than a third (38%) of respondents saying that training provision had been reduced in their area.

2020 to 2023

Drawing direct comparisons of perceptions between 2020 and 2023 surveys to determine the landscape of LARC fitting found that:

- 48% of respondents felt that contraceptive subdermal implant activity has stayed the same – but almost a third felt it had increased in the past three years.
- IUS/D insertion for contraception was believed to have increased (46%) or stayed the same (37%).
- IUS insertion for gynaecological indications was believed to have increased (45%) or stayed the same (45%).
- IUS insertion for contraception and gynaecological indications (for those paid for both) was believed to have increased to 52%.
- Many respondents noted that there has been a significant demand for LARC fitting linked with HRT and menopause.
- Waiting lists are often capped at 6 months and professionals are reporting that many women are unable to get an appointment due to long waiting times. Reasons include a lack of trained professionals and a reduced number of practices (due to inadequate fees) being able to offer this.

> **“I love offering the service, but it is probably a loss-maker, and in general practice the funding is so tight that there is little room for flexibility.**
>
> Anonymous
>
> **”**

Conclusions

The results of the 2023 survey identify that very little has improved and, in many cases, the situation with LARC provision in primary care is as bad as it was in 2020 if not in fact declining.

Although some healthcare professionals cited COVID-19 as a reason for discontinuing their fitting services, it was not a substantial number, and it was not an overarching theme in the report results.

Analysis of the responses in both studies suggests that healthcare professionals continue to be increasingly frustrated by the lack of remuneration for LARC fittings and access to training, both of which have led fitters to stop their practice, not re-accredit, or prevented them from taking up training. This was also the case for many years prior to the pandemic.

Many respondents noted that there has been a significant demand for LNG-IUS fitting linked with HRT and menopause.

Waiting lists are often capped at 6 months and professionals are reporting that many women are unable to get an appointment due to the long waiting times. Reasons include a lack of trained professionals and a reduced number of practices (due to inadequate fees) being able to offer this.

From the responses, it is obvious that the current women's health system is not designed or equipped to meet women's day-to-day needs, failing them through a non-adopted life course approach which was recommended in The Better for Women Report[7] published in 2019 and is reiterated in the 10-year Women's Health Strategy[8] launched in 2022.

Professor Dame Lesley Regan mentioned in her foreword for the Women's Health Strategy for England[8] that contraception is frequently used as a first-line treatment for menstrual problems, but many women meet barriers to accessing the method of their choice due to siloed commissioning.

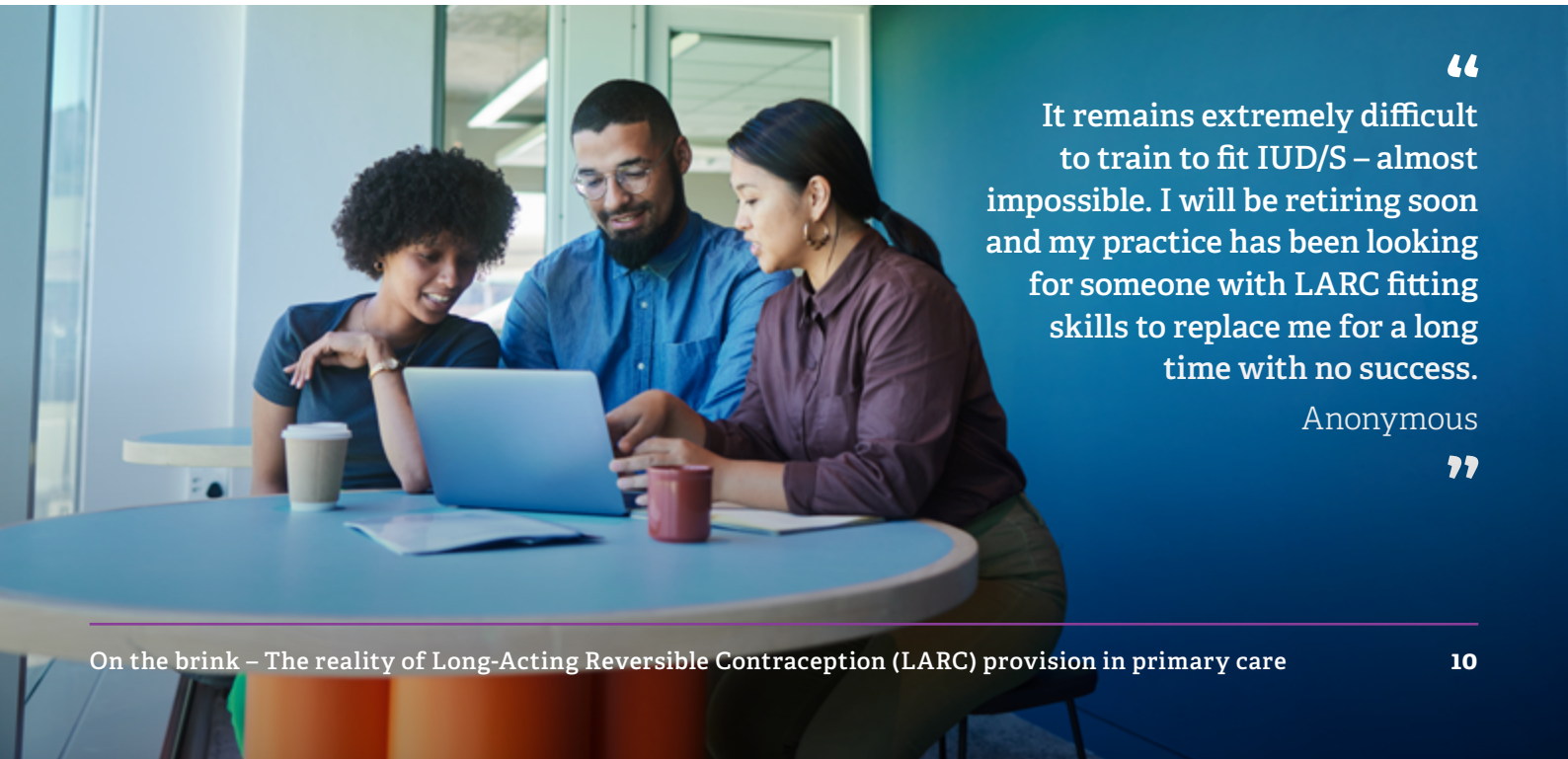
This is clearly echoed by clinicians through this survey. This needs to be addressed immediately to see change for the better for women's access to long-acting reversible contraception.

Celebrating success

Liverpool is a good example of how Women's Health Hubs can assist and increase positive activity across Primary Care Networks[11]. In Liverpool, a pilot commenced in 2019 with 7 of the 9 PCNs involved developing 11 hubs. After creating these local hubs some PCNs saw over 150% increase on pre-pandemic data for LARC prescribing bucking the national trend.

An increase in the uptake of cervical screening was recorded in some PCNs. James Woolgar, Sexual and Reproductive Health Commissioning Lead of Liverpool City, said Liverpool has created: "A fast-growing women's health hub model that sees budgets more effectively combined between the NHS and local authority that is viable for PCNs to deliver. We have made sure there is good easy access to the hubs, planning carefully where they are situated with particular emphasis on the most deprived communities."

It is recommended that this example be shared and widely replicated for commissioners, providers, and patients to benefit from the positive impact of community-based models.



> "It remains extremely difficult to train to fit IUD/S – almost impossible. I will be retiring soon and my practice has been looking for someone with LARC fitting skills to replace me for a long time with no success."
>
> Anonymous

Recommendations

Inequalities must be addressed, and the current postcode lottery of care removed, by mandating adequate provision of LARC in primary care across the UK.

Drawing on the results of both surveys, the Primary Care Women's Health Forum proposes several recommendations:

- There is a need for the introduction of a national minimum 'fair' fitting fee that covers the cost of sustainable LARC provision viable for primary care.
- Funding for LARC fitting must include all indications (contraception and gynaecology).
- Work must be completed to address training issues to support the workforce and capacity – to ensure access for women who want LARC services, service sustainability and also to reduce impact on secondary care.
- Models of service must be reviewed, and the patient journey improved whilst also making savings.
- Women's Health Hubs[9] must be developed in line with the Women's Health Strategy[8] as they have the potential to support the provision of LARC services. With £25 million assigned by the Department of Health and Social Care[10], this funding could be used effectively to improve access through this model.

> **"Given current gynae waiting lists are over a year, I really think the funding disparity needs to be addressed as a matter of urgency"**
>
> Anonymous

References

1 Winner B, et al. N Engl J Med 2012; 366: 1998–2007

2 NICE LARC 2005 guidance www.nice.org.uk/guidance/cg30

3 Peipert JF, et al. Obstet Gynecol 2012;120:1291–97

4 www.nice.org.uk/guidance/ng88

5 www.nice.org.uk/guidance/ng23

6 www.pcwhf.co.uk/resources/larc-fitting-in-primary-care-survey-results

7 www.rcog.org.uk/better-for-women

8 www.gov.uk/government/publications/womens-health-strategy-for-england

9 www.whh.pcwhf.co.uk

10 www.gov.uk/government/news/25-million-for-womens-health-hub-expansion

11 www.whh.pcwhf.co.uk/resources/an-example-of-success-from-liverpool

Appendices

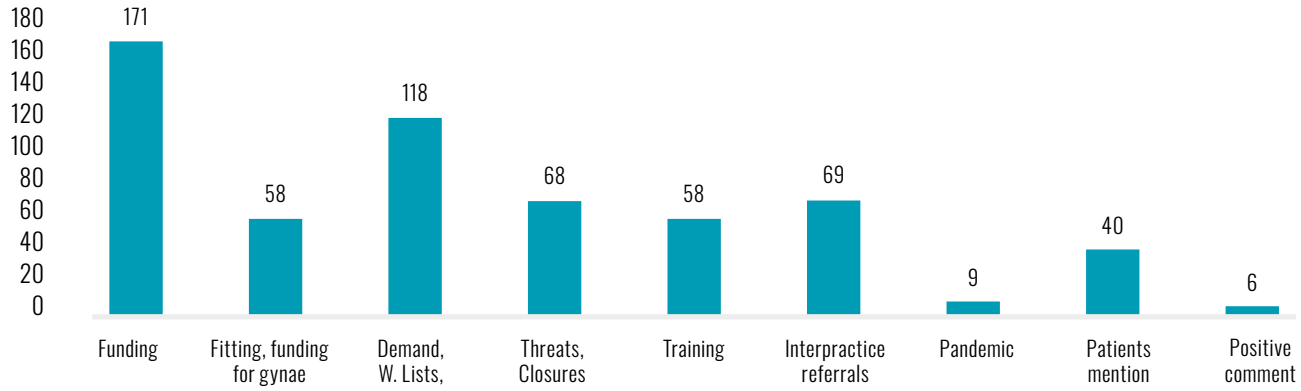
The report draws on newly collected quantitative and qualitative data from two surveys conducted in Spring 2023. In total 1152 UK healthcare professionals responded, comprising of 687 LARC fitters and 465 lapsed or non/never fitters of LARC.

LARC FITTER SURVEY

291 comments received (out of 687 replies)

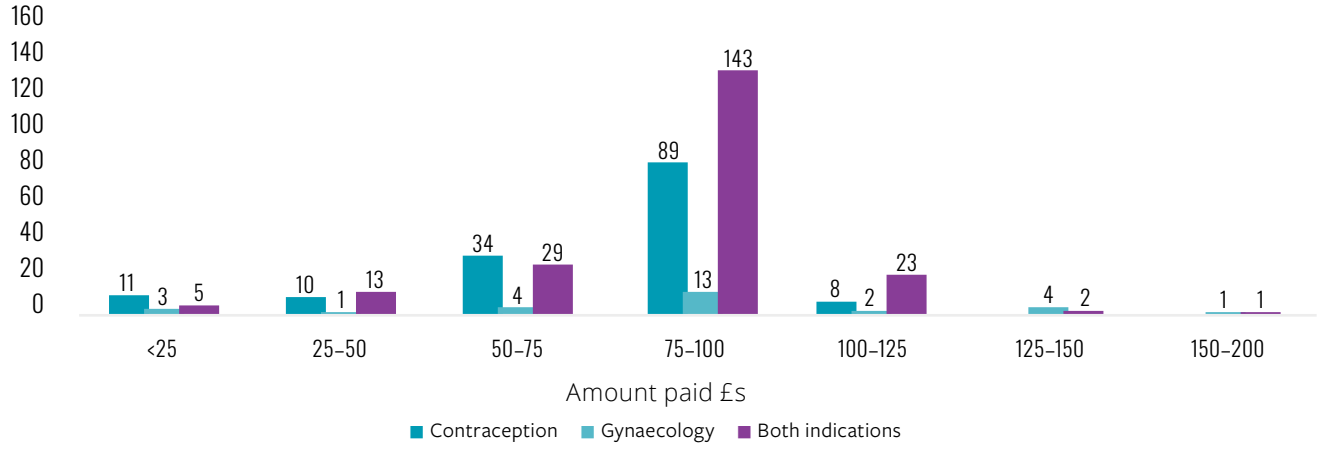
COMMON THEMES

Common themes of key concerns around LARC provision in primary care as perceived by LARC fitters (some comments included more than one common theme)



When asked how much they were paid to fit intrauterine methods the fitting fees ranged from under £25 up to £200 as indicated below:

VARIATION IN FITTING FEES PAID FOR LNG-IUS ACROSS UK

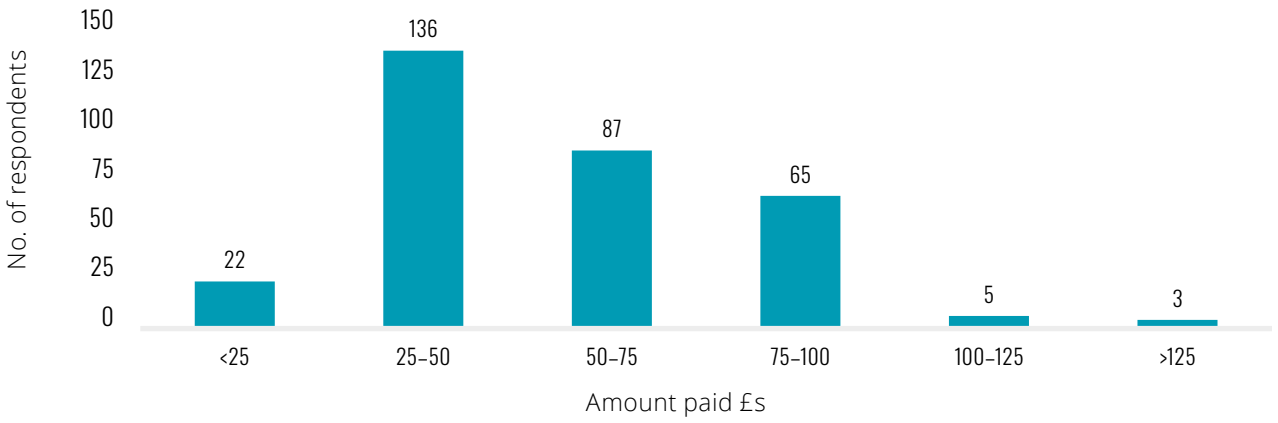


However, out of the 687 responses a high proportion of the healthcare professionals admitted they were unsure of the fees paid to their practice for fitting of intra-uterine methods, or did not respond to the questions:

RESPONSE	CONTRACEPTION	GYNAECOLOGY	BOTH INDICATIONS
Unsure	130	44	141
No response	405	615	330

When asked how much they were paid to fit subdermal implants for contraception the fitting fees ranged from under £25 up to £200 as indicated below:

VARIATION IN FITTING FEES PAID FOR SUBDERMAL IMPLANTS ACROSS UK



However, out of the 687 responses a high proportion of the healthcare professionals admitted they were unsure of the fees paid to their practice for fitting of subdermal implants, or did not respond to the questions.

FEES PAID	CONTRACEPTION
Unsure	266
No response	103

Funding of LARC in primary care

TREND IN LARC FITTING PAYMENTS	CONTRACEPTION	STAYED THE SAME	INCREASED	UNSURE OF PAYMENT	FUNDED TO FIT
IUS contraception	6% (17)	48% (134)	4% (11)	42% (119)	34% (225)
IUS gynaecology	7% (5)	36% (26)	10% (7)	47% (34)	2% (11)
IUS both	4% (14)	51% (183)	7% (24)	38% (136)	64% (419)
Subdermal implant	5% (28)	50% (291)	2% (11)	43% (253)	N. A.

DO YOU THINK THE FITTING FEE IS ADEQUATE?	YES	NO
IUS contraception	11% (29)	89% (227)
IUS gynaecology	16% (10)	84% (53)
IUS both	17% (54)	84% (279)
Subdermal implant	21% (113)	79% (426)

TRAINING

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

CHANGES IN ACCESS TO TRAINING	RESPONSE
Improved	8% (51)
Reduced	43% (278)
No change	49% (312)

PROVISION OF LARC IN PRIMARY CARE

ACTIVITY – FITTING OF LARC	DECREASED	STAYED THE SAME	INCREASED
IUS contraception	18% (49)	37% (102)	46% (128)*
IUS gynaecology	7% (5)	36% (26)	45% (32)
IUS both	4% (14)	51% (183)	52% (187)*
Subdermal implant	5% (28)	50% (291)	32% (187)*

*perceived increase in provision could be due to post pandemic return to fitting.

REFERRAL PATHWAYS (BETWEEN PRACTICE REFERRALS)

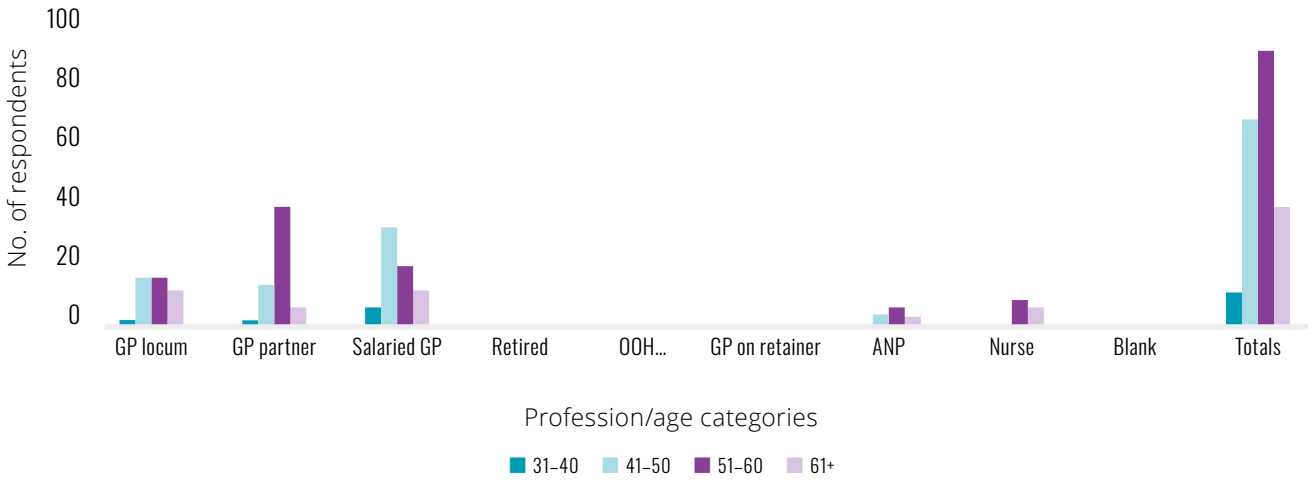
Have you developed an IUS insertion service to accept referrals from local GP practices?

ACCEPTS INTERPRACTICE REFERRALS?	RESPONSE
Yes	20% (132)
No	80% (528)

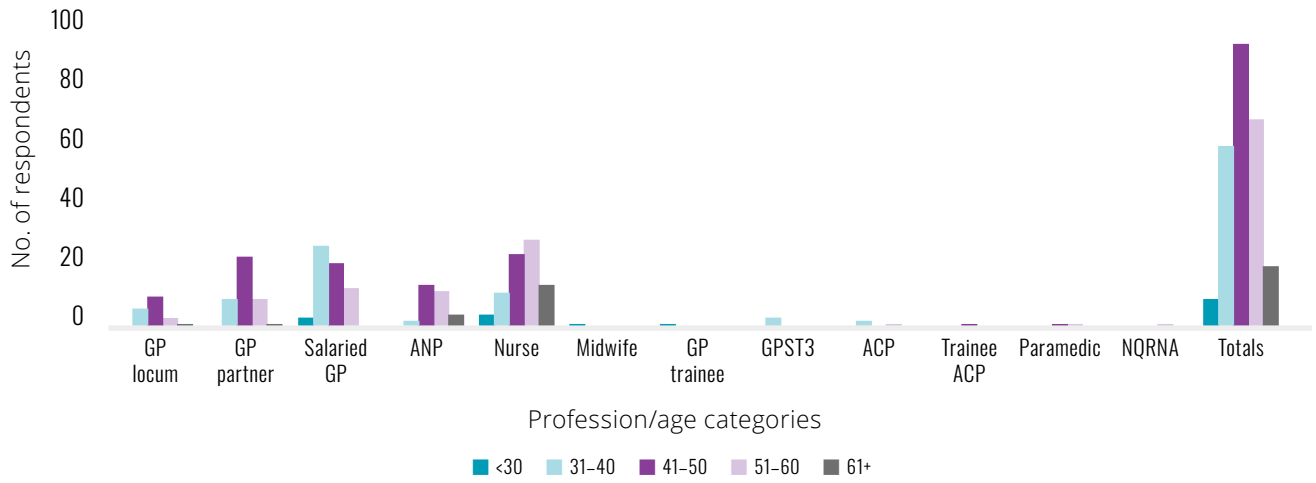
LAPSED & NON/NEVER FITTER LARC SURVEY

(465 members responded)

LAPSED FITTERS BY AGE AND PROFESSION

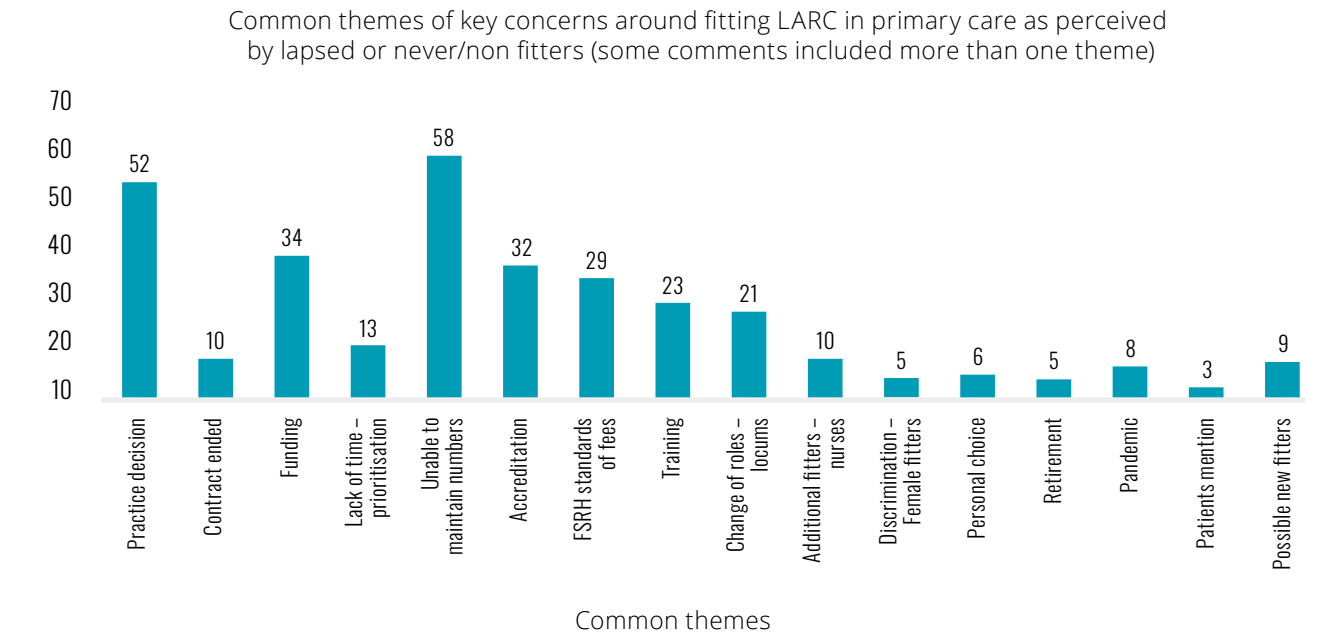


NON/NEVER LARC FITTERS BY AGE AND PROFESSION



228 comments received (out of 465 replies)

COMMON THEMES OF KEY ISSUES AROUND FITTING LARC IN PRIMARY CARE



NEVER/NON LARC FITTERS: WHY HAVE THEY NOT DONE THE TRAINING?