Services for the provision of IUDs and the IUS for contraception and the management of heavy menstrual bleeding

Commissioning guide
Implementing NICE guidance

January 2008
Services for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

Commissioning a service for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

Benefits

Key clinical issues

National priorities

References

Specifying a service for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

Service components

References

Determining local service levels for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

Benchmarks for a standard population

Further information

Assumptions used in estimating a population benchmark

Activity data – Hospital episode statistics

Current practice

Published research

Expert clinical opinion

Conclusions

References

The commissioning and benchmarking tool

Identify indicative local service requirements

Review current commissioned activity

Identify future change in capacity required

Model future commissioning intentions and associated costs

Ensuring corporate and quality assurance

Local quality assurance

Further information

Topic-specific Advisory Group: intrauterine devices and the intrauterine system
Services for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission effective services for the provision of intrauterine devices (IUDs) and the intrauterine system (IUS; also referred to as levonorgestrel-releasing intrauterine system (LNG-IUS) for long-acting reversible contraception (LARC), and the IUS, which can be used for the care of women with heavy menstrual bleeding (HMB).

This commissioning guide should be read in conjunction with the following NICE guidance:

- **NICE clinical guideline CG30 ‘Long-acting reversible contraception’**
- **NICE clinical guideline CG44 ‘Heavy menstrual bleeding’**.

The clinical guidelines cover clinical and cost effectiveness in detail and underpin the content of this guide.

Those involved in the commissioning of services for the care of women with HMB should also read the commissioning guides on hysterectomy and endometrial ablation.

The guide:

- makes the case for commissioning services for the provision of IUDs and the IUS
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded here. There is no need to register.
We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- **Topic-specific Advisory Group: intrauterine devices and the intrauterine system**

  **January 2008**
Commissioning a service for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

Intrauterine devices (IUDs) and the levonorgestrel intrauterine system (LNG-IUS) are forms of long-acting reversible contraception (LARC), which is a contraceptive method that requires administration less than once per cycle or month. NICE clinical guideline CG30 on long-acting reversible contraception identified that all currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use. IUDs and the IUS are more cost effective than the injectable contraceptives.

In 2007 the Findings of the baseline review of contraceptive services reported that 4 million people (most of whom are women) use contraceptive services each year. Around three-quarters of these people see a GP, with the remainder mainly attending specialist community contraceptive services (family planning clinics). However, there is a large variation in GP prescribing for LARC. The full guideline on long-acting reversible contraception noted that the uptake of IUDs and the IUS is low in Great Britain, at around 5% of women aged 16–49 years in 2003/04 compared with 25% for the oral contraceptive pill and 23% for male condoms.

About 30% of pregnancies are unplanned, and the UK has the highest rate of teenage pregnancy in western Europe. The Omnibus Survey Report Contraception and sexual health 2006/07 found that 64% of women interviewed were defined as being ‘at risk’ of pregnancy, with those in the 20–34-year age group being at greatest risk. It is anticipated that increasing the uptake of LARC methods, including IUDs and the IUS, will reduce the number of unintended pregnancies, which is a key aim of the government’s strategy for sexual health and the teenage pregnancy. The NICE cost impact report for CG30 on long-acting reversible contraception estimated that there are savings to be made from unplanned pregnancies avoided where LARC methods of contraception are used.

The LNG-IUS is a long-term progestogen-only method of contraception that is a first-line option for the management of heavy menstrual bleeding (HMB). HMB, also known as menorrhagia, affects around one in three women. It is defined as excessive menstrual blood loss that interferes with the physical, emotional, social and material quality of a woman’s life. Many women with HMB consult healthcare professionals in primary care and HMB is a common reason for referral to a specialist. Optimal pharmaceutical management improves choice and provides an alternative to surgery, thus reducing referral rates to secondary care.

5
**Benefits**

The potential benefits of robustly commissioning services that effectively provide IUDs and the IUS for LARC, and the IUS for the care of women with HMB, and providing better care for women requiring contraception or with HMB include:

- **Reducing the numbers of unintended pregnancy**, contributing to the Public Sector Agreement target to halve the number of under-18 conception rates by 50% by 2010 as part of a broader strategy to improve sexual health. LARC methods are highly effective because they are not dependent on daily concordance and have lower failure rates (0.05% to 2%) than the combined pill and minipill (8%).[3]

- **Reducing the number of avoidable referrals to acute hospital based gynaecology services** by improving access to IUDs and the IUS.

- **Reducing the number of hysterectomies performed and the cost of HMB to health services** by optimising the pharmaceutical management of HMB and offering less invasive treatment. See also the commissioning guides on hysterectomy and endometrial ablation.

- **Providing patient-centred and effective clinical care** of women with HMB by optimising pharmaceutical management as recommended in NICE clinical guideline CG44 on heavy menstrual bleeding.

- **Reducing inequalities** and improving patient access to services.

- **Increasing patient choice** and patient engagement in decision-making about options for contraception and the management of HMB, both of which should contribute to improving patient experience.

- **Better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways. LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use, and they prevent more unplanned pregnancies than the pill. The NICE cost impact report for CG30 on long-acting reversible contraception estimated that a PCT with a population of 40,000 women aged 15–49 years could save more than £300,000 by implementing the NICE clinical guideline CG30 on long-acting reversible contraception.
Key clinical issues

Key clinical issues for commissioning a service for the provision of IUDs and the IUS are:

- **Accurately identifying women suitable for LARC**
- **Accurately identifying and diagnosing women with HMB** to support clinically appropriate care and optimal pharmaceutical management. Access to ultrasound scan and endometrial assessment (biopsy and hysteroscopy) for the diagnosis of HMB, and microbiology services for the provision of testing for sexually transmitted infections, where appropriate, is required.
- **Ensuring that appropriate referral pathways are in place to support access to IUDs and the IUS** from service providers who do **not** offer LARC, for emergency contraception and for the management of HMB.

National priorities

National priorities and initiatives relevant to commissioning a service for the provision of IUDs and IUS include:

- [National service framework for children, young people and maternity services: core standards](#).
- [Delivering the 18 week patient treatment pathway](#) and the heavy menstrual bleeding pathway.
- [Every child matters](#).
- [Choosing Health: making healthy choices easier](#).
- The [Care closer to home](#) initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.
- ‘[Commissioning framework for health and well-being](#) (published for consultation).
- Considering the impact of [patient choice](#).
- [A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services](#).
- Implementation of NICE clinical guidelines. These are developmental standards, and performance against these standards will be assessed by the [Healthcare Commission](#) in line with [Standards for better health](#).

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.
References


Specifying a service for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

**Service components**

The key components of services providing intrauterine devices (IUDs) and the intrauterine system (IUS) are:

- ensuring appropriate choice of contraception and subsequent access to a service providing IUDs and the IUS
- ensuring appropriate assessment and care of women with heavy menstrual bleeding (HMB)
- developing a high-quality service providing IUDs and the IUS.

**Ensuring appropriate choice of contraception and subsequent access to a service providing IUDs and the IUS**

Enabling women to make an informed choice and addressing women’s preferences is important. The NICE clinical guideline CG30 on long-acting reversible contraception recommends that:

- Women requiring contraception should be given information (both verbal and written) about different methods of contraception, including IUDs and the IUS methods that will enable them to choose a method and use it effectively. See Understanding NICE guidance.
- Healthcare professionals advising women about contraceptive choices should be competent to:
  - help women to consider and compare the risks and benefits of all methods relevant to their individual needs
  - manage common side effects and problems.
- Counselling about contraception should be sensitive to cultural differences and religious beliefs.
- Women with learning and/or physical disabilities should be supported in making their own decisions about contraception.

The NICE cost impact report for CG30 on long-acting reversible contraception states that women currently using contraceptive methods other than LARC or the contraceptive pill who are given better information and access to services may wish to choose a LARC method. The current limited use of LARC
suggests that healthcare professionals may need better guidance and training so that they can help women make an informed choice. Addressing this will take time and planning, and commissioners may wish to ensure that the skills and knowledge of all LARC methods are increased within primary care.

Commissioners also need to consider having agreed mechanisms in place for referring women, for whom IUDs and the IUS are suitable and chosen options, from provider services that do not offer LARC.

**Appropriate care and onward referral for women with HMB**

The use of levonorgestrel-releasing IUS (LNG-IUS) is a first-line treatment option for women with HMB. The diagnosis and general management of HMB is described in detail in *NICE clinical guideline CG44 on heavy menstrual bleeding*. It is clearly important to identify women suitable to use the IUS to ensure delivery of care based on the best available evidence. The clinical guideline recommends:

- LNG-IUS should be considered where no structural or histological abnormality is present, or for fibroids less than 3 cm in diameter which are causing no distortion of the uterine cavity
- the healthcare professional should determine whether hormonal contraception is acceptable to the woman before recommending treatment (for example, she may wish to conceive).

Commissioners need to be aware that examinations and investigations for HMB to determine the suitability of LNG-IUS as a treatment option may be required. These may include physical examination, ultrasound (first-line diagnostic tool for identifying structural abnormalities), biopsy and hysteroscopy as outlined in the *NICE clinical guideline CG44 on heavy menstrual bleeding*. Their provision will need to be considered in local integrated care pathways.

See also the commissioning guides on [hysterectomy](#) and [endometrial ablation](#).

**Developing a high-quality service providing IUDs and the IUS**

Commissioners should be aware that having appropriately trained staff and arrangements for managing sexually transmitted infections (STI) is of key importance.

*NICE clinical guideline CG30 on long-acting reversible contraception* recommends that:

- healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide LARC methods of contraception
• IUDs and the IUS should only be fitted by trained personnel with continuing experience of inserting at least one IUD or one IUS a month

• healthcare professionals helping women to make contraceptive choices should be familiar with nationally agreed guidance on medical eligibility and recommendations for contraceptive use.

Treatment, care and information should be culturally appropriate and in a form that is accessible to people who have additional needs.

Because the risk of uterine perforation is related to the skill of the healthcare professional inserting the IUD or IUS, commissioners will wish to assure themselves that healthcare professionals, both existing and newly involved in this service provision, are competent. Community contraceptive services are reported by the Findings of the baseline review of contraceptive services to be the main providers of training to general practice. The topic-specific advisory group noted that where patient counselling is poor and patients do not have adequate time to reflect before the fitting, removal rates of IUDs and the IUS within the first year of fitting may be high. This could be used as an indicator of service quality.

**NICE public health guidance PHI003 on preventing sexually transmitted infections and reducing under-18 conceptions** recommends that commissioners should:

• Ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have a sexually transmitted infection (partner notification).

• Ensure staff are appropriately trained, and that an audit and monitoring framework is in place.

Commissioners may wish to consider which of the various service models to provide IUDs and the IUS are the most appropriate for their locality, and mixed models of provision may be appropriate across a local health economy. They may also need to consider arrangements for difficult fittings and removals, and the provision of information and choice of all methods of contraception, including IUDs and the IUS, within the follow-up care provided by termination of pregnancy services.

Examples of service models are given in the report Shifting care closer to home: care closer to home demonstration site – report of the specialty subgroups. The report identifies innovative ways of delivering gynaecology and contraceptive services. These include: primary care led models of integrated care provided by GPwSIs, community contraceptive services, GP enhanced services and nurse led models of provision. The use of integrated care pathways for HMB have been shown to reduce outpatient attendance.
while improving patient experience and maintaining quality of care\textsuperscript{[1][2]}. The examples are offered to share local practice, but NICE makes no judgement on the compliance of these services with its guidance.

The national enhanced service for IUDs sets out the requirements for the provision of IUDs within primary care. The specification notes that special equipment is required. This includes an appropriate room fitted with a couch and with adequate space and equipment for resuscitation, equipment for cervical anaesthesia and a variety of vaginal specula and cervical dilators. In addition, an appropriately trained nurse needs to be present to support the patient and assist the doctor during the procedure. NICE clinical guideline CG30 on long-acting reversible contraception also recommends that antiepileptic medication should be available at the time of IUD or IUS insertion in a woman with epilepsy.

Local stakeholders, including service users, should be involved in determining what is needed from a service providing IUDs and the IUS in order to meet local needs. The service should be patient-centred, meeting the needs of the local population (including those at risk of unintended pregnancy), and be integrated with other elements of contraceptive care and care for women with HMB. Commissioners may wish to audit current provision, local GP referral rates, uptake of LARC methods and where patients are attending for fittings and removals. This will provide them with the opportunity to review current practice and to develop an integrated care pathway with clinicians to provide assessment and treatment for people requiring contraception or with HMB at a single visit where appropriate. As the management of HMB shifts from secondary to primary care, commissioners will need to engage local clinicians in agreeing treatment thresholds for intervention and develop strategies for how to manage the care of more women in general practice or community contraceptive services.

The service specification needs to consider:

- the required competencies of, and training for, existing and new staff responsible for providing the service
- the expected number of patients (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access and service location including direct access, self referral and out-of-hours provision; commissioners should engage with service users and other relevant individuals and organisations locally
- care and referral pathways for contraceptive service providers who do not offer LARC methods to support choice and access to appropriate care
information and audit requirements, including IT support and infrastructure to monitor offer of choice and take up of LARC methods of contraception and treatment for HMB.

planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway for HMB or equitable waiting times locally for those services currently outside 18 weeks. See Choice of scan: guidance.

service monitoring criteria.

Useful sources of information may include:

- NICE cost impact report for CG30 on long-acting reversible contraception
- Delivering the 18 week patient pathway: 18 week commissioning pathways and the heavy menstrual bleeding pathway.
- Getting it right for teenagers in your practice
- The Map of medicine provides an information resource that visually organises the latest evidence and best practice guidelines.
- The NICE shared learning database offers examples of how organisations have implemented NICE guidance locally, including services for the care of women with HMB, for example Bradford and Airedale tPCT.

References


Determining local service levels for the provision of intrauterine devices and the intrauterine system for contraception and the management of heavy menstrual bleeding

**Benchmarks for a standard population**

Available data suggest that the standard benchmark rate for services providing intrauterine devices (IUDs) and the intrauterine system (IUS) is 2%, or 2000 per 100,000, of the female population aged 15–54 years per year.

For a **standard primary care trust** with a population of 250,000, assuming that around a third are aged 15–54 years and female (approximately 83,333 people), the average number of women requiring IUDs or the IUS would be **around 1670 per year** (that is, 2% of the female population aged 15–54 years).

For an **average practice** with a list size of 10,000, assuming around a third are aged 15–54 years and female (approximately 3333), the average number of women requiring IUDs or the IUS would be **around 67 per year** (that is, 2% of the female population aged 15–54 years).

This represents the number of women who may require IUDs and the IUS across primary and secondary care for contraception and for the management of heavy menstrual bleeding (HMB). It includes the number of women per year who require either new fittings or re-fittings.

The topic-specific advisory group advised that the use of IUDs and the IUS is most likely to be indicated in the female population aged 15–54 years. However, the female population aged 15–64 years has been used to calculate the indicative benchmark rate because of the availability of population data at general practice level and its use within the commissioning and benchmarking tool. Commissioners should therefore be aware that the indicative benchmark rate may slightly underestimate the need in females aged 15–54 years.

This service is likely to fall under the **programme budgeting** category 218X (maternity and reproductive health).

Examine the **assumptions used in estimating these figures**.

Use the IUDs and the IUS **commissioning and benchmarking tool** to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.
Further information

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the Commissioning framework for health and well-being (published for consultation) outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health Delivering quality and value – focus on benchmarking.
- NICE Health equity audit – learning from practice briefing.
- Delivering the 18 week patient pathway: 18 week commissioning pathways.
- The No delays achiever provides access to service improvement tools aimed at reducing time between referral and treatment.
- PRIMIS+ provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.
Assumptions used in estimating a population benchmark

The assumptions used in estimating an indicative population benchmark rate of 2% per year for referrals into a service providing intrauterine devices (IUDs) and the intrauterine system (IUS) are based on the following sources of information:

- **Hospital episode statistics data** to establish the number of fittings of IUDs or the IUS in secondary care per year
- **current practice** on the numbers of women currently receiving IUDs or the IUS per year
- **published research** on contraceptive preferences of women in the population
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

The topic-specific advisory group advised that the use of IUDs and the IUS are most likely to be indicated in the female population aged 15–54 years. However, the female population aged 15–64 years has been used to calculate the indicative benchmark rate due to the availability of population data at general practice level and its use within the commissioning and benchmarking tool. Commissioners should therefore be aware that the indicative benchmark rate may slightly underestimate the need in females aged 15–54 years.

**Activity data – Hospital episode statistics**

The ‘Hospital episode statistics’ (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

IUDs and the IUS are usually fitted in GP surgeries or community contraceptive services, but they can also be fitted in secondary care. Analysis of 2005/06 HES data suggests that the annual rate of fittings of IUDs and the IUS in secondary care was around **0.08%**, or 80 per 100,000, of the female population aged 15–54 years. This figure is based on episodes where the fitting of an IUD or the IUS was either for contraception (in around 10% of cases, that is 0.01%) or for the management of heavy menstrual bleeding (HMB), including after a hysteroscopy (approximately **0.07%**).

The topic-specific advisory group advised that a proportion of these fittings could probably be carried out in community settings – for example, general practices and community contraceptive services. Fittings of IUDs or the IUS following a termination of pregnancy have been excluded as these data are
not presented in the commissioning and benchmarking tool for data governance reasons, and care of these individuals is usually via a different care pathway.

**Current practice**

**Prescribing**

There has been an increase of around 60% in the prescribing of the IUS in primary care in England between February 2003 and July 2007 (see figure 1). However, there remains a large variation in the prescribing of IUDs and the IUS within the community that may not be accounted for by differences in population and choice of contraception.

**General practice data**

Data were extracted from IMS Disease Analyser and the Doctors' Independent Network Database, which hold data on a sample of GP practice databases, to determine the following for England.

- Annual diagnosis rate of HMB within primary care. The analysis suggests that this is around 2.71% of the female population aged 15–54 years.

- Annual prescribing rate of the IUS to women with HMB. The analysis suggests that around 13% of women aged 15–54 years who were diagnosed with HMB were prescribed the IUS for the management of HMB between September 2006 and August 2007. Therefore the annual prescribing rate of the IUS to the female population aged 15–54 years for the management of HMB is 0.35%. However, there is evidence\[1\] that pharmaceutical management of HMB may not be optimal and that increases in the prescribing of the IUS for the management of HMB could be anticipated.

- Annual prescribing rate of IUDs and the IUS to women without HMB (that is, for contraception). The analysis suggests that IUDs and the IUS represent over 4% of current annual prescribing for contraception. This equates to around 0.79% of the female population aged 15–54 years being prescribed IUDs or the IUS for contraception per year.

The figure of 0.79% is likely to be an underestimate of true prescribing levels of IUDs and the IUS because some women are prescribed IUDs or the IUS within specialist community contraceptive services. The Findings of the baseline review of contraceptive services in England in 2007 suggests that, on average, around 25% of women who use contraceptive services attend specialist community contraceptive services, and the estimated level of prescribing long-acting reversible contraception (LARC) within these services is 20% of the total contraceptive prescribing, compared with 14% in general practice. Therefore the prescribing of IUDs and the IUS within general practice
represents around 68% of the total prescribing of IUDs and the IUS within the community. Adjusting the figure of 0.79% (the annual level of prescribing within general practice) to account for prescribing in the community as a whole means that 1.16% of women aged 15–54 years are prescribed an IUD or the IUS for contraception in the community per year.

Therefore, 1.59% of women aged 15–54 years are prescribed IUDs or the IUS per year. This comprises the 0.08% of women having an IUS or IUD fitted in secondary care for HMB or contraception, 0.35% prescribed for the management of HMB in primary care and 1.16% prescribed for contraception, in the community, per year. This is current practice and may not represent best practice.

The assumptions used in estimating the current level of annual prescribing of IUDs and the IUS will be reviewed when new data and sources of information become available.

**Published research**

Armstrong and Donaldson (2005) used consensus methods to arrive at an ideal profile of contraception provision. Their research looked at relative proportions of all prescribable methods of contraception. The findings relating to IUDs and the IUS have been applied to the age specific rates of those being prescribed contraception in general practice in a year (see table 1). We have assumed that the overall numbers of women using contraception have remained the same.

Armstrong and Donaldson did not provide estimates on contraception use for women over 49 years, so the estimate for the 45–49 years age band has been applied to the 50–54 years age band also (see table 1).

**Table 1. Optimal proportion of women receiving IUDs or the IUS in primary care in England**

<table>
<thead>
<tr>
<th>Age band (years)</th>
<th>Number of women receiving prescribable contraception in a year</th>
<th>Percentage of women prescribed an IUD or the IUS in a year</th>
<th>Expected percentage of women receiving contraception who could be prescribed an IUD or the IUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–19</td>
<td>554000</td>
<td>0.22%</td>
<td>4.54%</td>
</tr>
<tr>
<td>20–24</td>
<td>846000</td>
<td>0.76%</td>
<td>14.69%</td>
</tr>
<tr>
<td>25–29</td>
<td>775000</td>
<td>1.90%</td>
<td>16.30%</td>
</tr>
<tr>
<td>30–34</td>
<td>581000</td>
<td>3.81%</td>
<td>22.93%</td>
</tr>
<tr>
<td>35–39</td>
<td>474000</td>
<td>6.39%</td>
<td>34.79%</td>
</tr>
<tr>
<td>40–44</td>
<td>311000</td>
<td>9.53%</td>
<td>41.97%</td>
</tr>
<tr>
<td>45–49</td>
<td>159000</td>
<td>12.02%</td>
<td>57.44%</td>
</tr>
<tr>
<td>50–54</td>
<td>45100</td>
<td>9.48%</td>
<td>57.44%</td>
</tr>
</tbody>
</table>

* Armstrong and Donaldson (2005).

Applying the expected preference for IUDs and the IUS to the populations aged 15–54 years currently receiving medical contraception, 22% of women aged 15–54 years currently receiving medical contraception, 22% of women...
receiving medical contraception may choose to use an IUD or the IUS. This equates to 4.84% of all women aged 15–54 years.

The figure of 4.84%, however, may be an underestimate as the age specific populations that the preferences have been applied to relate only to those in general practice. Therefore it has been adjusted to account for the estimated 25% of women receiving contraception in specialist community contraceptive services giving a figure of 6.45% for women aged 15–54 years.

Furthermore, the NICE cost impact report for CG30 on long-acting reversible contraception notes that the average duration of use of IUDs and the IUS is around 3 years, and therefore the figure of 6.45% does not represent the expected annual prescribing rate.

**Expert clinical opinion**

The topic-specific advisory group advised the following.

- The NICE cost impact report for CG30 on long-acting reversible contraception notes that more women will choose a LARC method if they are given better information and improved access to all methods of contraception. Commissioners need to be aware that this is central to moving towards the benchmark rate offered.

- Based on clinical practice, a 15–20% increase in the current annual prescribing rate of IUDs and the IUS (1.59%) might be expected.

- Commissioners should examine local prescribing patterns of IUDs and the IUS, as well as of implants and injections, to ensure that women are given a choice of contraception methods.

- Commissioners should examine local referral patterns, prescribing practice, referral rates into secondary care and differences in local populations to ensure that women with HMB receive optimal care.

**Conclusions**

Based on the data from current practice and other information outlined above, it is concluded that around 2% of the female population aged 15–54 years may require an IUD or the IUS per year. This is based on the following assumptions:

- The current annual prescribing rate of IUDs and the IUS for contraception in specialist community contraceptive services and general practice is around 1.16% of the female population aged 15–54 years, and rates will continue at or above this level.

- 0.35% of the female population aged 15–54 years per year are currently prescribed the IUS for the management of HMB in general practice. While this represents current practice it may not
be best practice, and it is therefore the minimum level of prescribing that can be expected.

- The current national level of IUD and IUS fitting in secondary care for the management of HMB and for contraception (not including fittings post termination of pregnancy) is around 0.08%, of which a proportion could be moved into the community.

- It is not possible to determine what proportion of women had an IUD or the IUS both prescribed and subsequently fitted within general practice. However, it is assumed that each prescription represents identified need. Therefore the figures of 0.35% (prescribed for HMB) and 1.16% (prescribed for contraception) have been added to the rate of fittings of IUDs and the IUS in secondary care (0.08%) to determine the current level of prescribing/fitting of IUDs and the IUS of 1.59%.

- Optimally around 6.45% of the female population aged 15–54 years could use IUDs or the IUS as a preferred contraceptive method.

- Taking into account the expected 15–20% increase in prescribing/fitting from the current rate of 1.59% suggested by the topic-specific advisory group means that the annual prescribing/fitting rate could be around 1.98% per year.

- Optimally the proportion of women who could be prescribed an IUD or the IUS for contraceptive purposes is around 6.45% of the female population aged 15–54 years, which, when divided by the average duration of use of an IUD or the IUS (3.34 years) gives an annual prescribing rate for IUDs or the IUS of 1.93%. Adding to this the annual prescribing rate of the IUS for the management of HMB in primary and secondary care (around 0.35% and 0.07%, respectively), the annual requirement for IUDs and the IUS could be around 2.35% per year.

- The mid-point of the estimate suggested by the topic-specific advisory group and published research on the ideal profile of contraception provision is 2.15% per year.

Therefore the population benchmark for the service requirement for IUDs and the IUS is estimated to be around **2% per year**. This represents the numbers of women who may require IUDs and the IUS across primary and secondary care for contraception and in the management of HMB. It includes those women who require either new fittings or re-fittings in a year.

Commissioners should ensure that there is appropriate access to services for IUDs and the IUS, and monitor choice and uptake of LARC methods of contraception for both HMB and for contraception. Commissioners may wish to review these planning assumptions in the commissioning and benchmarking tool to meet local population and service needs. In addition,
commissioners will need to take into account the variable time in situ of different IUDs and the IUS.

Because some fittings of IUDs and the IUS in secondary care have been included in the benchmark, commissioners will need to be aware that some of these fittings will need to continue to be performed in secondary care, but others could be performed in the community.

Use the IUDs and the IUS commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

**References**


The commissioning and benchmarking tool

Download the IUD and IUS commissioning and benchmarking tool.

Use the intrauterine devices (IUDs) and intrauterine system (IUS) service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

**Identify indicative local service requirements**

The indicative benchmark based on the national average for services providing IUDs and the IUS is 2%.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, you may need to provide services for relatively fewer or more people.

**Review current commissioned activity**

You may already commission a service for IUDs and the IUS for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.
Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the service for IUDs and the IUS may be provided, comparing the costs of commissioning the service across the various settings. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account patients’ views and those of other stakeholders when making commissioning decisions.

A service providing intrauterine devices (IUDs) and the intrauterine system (IUS) needs to:

- **be effective and efficient** – commissioners should consider one stop assessment and treatment where appropriate
- **be responsive to the needs of patients, and support patient choice** of all methods of contraception and their access to clinically appropriate treatment for heavy menstrual bleeding (HMB)
- **provide treatment and care based on best practice** as defined in NICE clinical guideline CG30 on long-acting reversible contraception, NICE clinical guideline CG44 on heavy menstrual bleeding and NICE public health guidance PHI003 on preventing sexually transmitted infections and reducing under-18 conceptions
- **deliver the required capacity**
- **be integrated** with other elements of contraceptive services and care for women with HMB
- **define agreed criteria for referral**, local protocols and the care pathway for women with HMB
- **be patient-centred and provide equitable access**, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- **audit uptake** of long-acting reversible contraception, including IUDs and the IUS, and pharmaceutical treatments for the management of HMB to ensure clinically appropriate care
- **demonstrate how it meets requirements under equalities legislation**
- **demonstrate value for money**.
Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- **Service and performance targets**, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that patients do not experience unnecessary delays), complaints procedures. Commissioners may wish to consider developing key performance indicators within contractual arrangements in line with the guidance in Care and resource utilisation: ensuring appropriateness of care. This could be, for example, by developing integrated care pathways and thresholds for treatment with clinicians, and seeking to manage levels of activity to an agreed local level for some procedures.

- **Clinical governance arrangements**, including incident reporting. Commissioners and contraceptive providers should be aware that the risk of perforation is related to the skill of the healthcare professional inserting the IUD or IUS. Policies and procedures should be considered for the management of potentially difficult fittings and removals, complications, uterine perforation, and for the treatment of people with epilepsy during insertion of an IUD or the IUS.

- **Clinical quality criteria**: appropriateness of referral, consenting procedures, clinical protocols including referral where healthcare professionals do not provide LARC within their own practice.

- **Audit arrangements**: frequency of reporting, reporting route and format, and dissemination mechanisms. See audit criteria in appendix D of NICE clinical guideline CG30 on long-acting reversible contraception and audit criteria for NICE clinical guideline CG44 on heavy menstrual bleeding.

- **Health, safety and security**: infection control, waste management, confidentiality procedures, legislative requirements.

- **Equipment**: including decontamination requirements.

- **Accreditation requirements**: for some or all elements of the service, the premises and/or staff. Healthcare professionals undertaking the insertion of IUDs and IUS should have appropriate training. This should be based on modern, authoritative medical opinion.

- **Patient satisfaction**: patient perspective and perception of service provision, complaints.

- **Patient outcomes**: increased uptake of LARC methods of contraception, removal of IUDs and the IUS within 1 year of...
fitting, numbers of unintended pregnancy, optimising pharmaceutical management of HMB, and hysterectomy rates

- **Staff competencies**: individual and team baseline requirements, monitoring and performance. NICE clinical guideline CG30 on LARC recommends that IUDs and the IUS should only be fitted by trained personnel with continuing experience of inserting at least one IUD or one IUS a month. The need for appropriate training and regular continuing professional development should be considered and monitored. The topic-specific advisory group recommends that service providers should also be able to provide local anaesthesia and pain management during IUD and IUS fittings.

- **Information requirements**, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral trends by healthcare professionals who do not provide LARC within their own practice/service, number of complaints). The Findings of the baseline review of contraceptive services recommends that commissioners monitor the usage of LARC methods of contraception. However, current availability of data within specialist community contraceptive services is variable, and may not identify if the use of IUDs and the IUS is for contraception or management of HMB. KT31 data collection is currently being amended to include PCT wide data. Commissioners may wish to monitor clinical indicators i.e. the number of IUDs and IUS fittings being carried out in secondary care, endometrial ablation, hysterectomy and sterilisation rates.

- **The process for reviewing the service with stakeholders**, including decisions on changes necessary to improve or to decommission the service.

- **Achieving targets associated with equalities legislation.**

**Further information**

**General information** on quality and corporate assurance can be obtained from the following sources:

- Implementing care closer to home: Convenient quality care for patients part 3: [accreditation of GPs and pharmacists with special interests](#).

- Department of Health and Royal College of Nursing publication [Freedom to practice: dispelling myths](#).

- The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient
safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

- The **NHS Clinical Governance Support Team** runs a series of programmes to support the implementation of clinical governance 'on the ground'. The team provides practical support through its development programmes, information about clinical governance and lessons from development work across the country, and serves as a place to find answers to questions about clinical governance.

- **NHS Alliance online resources.** NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

- The **DH commissioning framework** provides guidance on the commissioning process in the context of the NHS reform agenda.

- **Delivering the 18 week patient pathway** provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008, and the **heavy menstrual bleeding pathway**.

- NHS Institute for Innovation and Improvement priority programmes, including **Care outside hospital: No delays** and the **No delays achiever**, an integrated service improvement tool to help providers reduce delays in services; and **Quality and value**, including **Better care, better value** indicators to help inform planning, to inform views on the scale of potential efficiency savings in number of referrals into secondary care and hysterectomy rates different aspects of care, and to generate ideas on how to achieve these savings.

- **10 Steps to your SES: a guide to developing a single equality scheme.** This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

Specific information on quality and corporate assurance for a service for IUDs and the IUS can be obtained from the following sources:

- Specification for the **national enhanced service for IUDs**

- **Faculty of Family, Sexual and Reproductive Healthcare** offers training, competence assessment in intrauterine techniques,
service standards, guidance on good medical practice and clinical governance arrangements.

- The Royal College of Nursing (RCN) offers the following guidance: Contraception and sexual health in primary care: guidance for nursing staff and Fitting intrauterine devices: RCN training guidance for nurses and midwives.

- ‘Better metrics’ is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See improving the patient experience metric number 11 relating to adult inpatient and outpatient experience.

- ‘Skills for health’ works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the clinical health skills competency framework.
Topic-specific Advisory Group: intrauterine devices and the intrauterine system

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

Dr Anne Connolly
GP with special interest in gynaecology and hysteroscopy, Bradford and Airedale tPCT

Dr Tim Daniel
Consultant in Public Health Medicine, Leicestershire County and Rutland PCT

Dr Alyson Elliman
Consultant in Family Planning, Croydon PCT

Dr Jon D Fear
Head of Healthcare Effectiveness and Equity, Leeds PCT

Kathy French
Adviser in Sexual Health, Royal College of Nursing

Dr Sarah Gray
GP and primary care lead for women’s health, Cornwall and Isles of Scilly PCT

Shelley Mehigan
Clinical Nurse Specialist, Berkshire East PCT

Dr Carl David Parker
GP and professional executive committee (PEC) Chair, Hartlepool PCT and North Tees PCT

Sara Weech
Director of Strategy, West Sussex PCT

Dr Chris Wilkinson
Lead Consultant in Sexual and Reproductive Healthcare, Camden PCT