This search summary contains the results of a literature search undertaken by the Lincolnshire Knowledge and Resource Service librarians in;

July 2013

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If you would like this search re-run with a different focus, or updated to accommodate papers published since the search was completed, please let us know. This literature searching service is available to support public health / health and social care commissioning in Lincolnshire.

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“Google can bring you back 100,000 answers, a librarian can bring you back the right one.”
Neil Gaiman
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*Neil Gaiman*
Please find below the results of your literature search request. If you would like the full text of any of the abstracts included, or would like a further search completed on this topic, please let us know.

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Literature Search Results

Search request date: 25th July 2013  
Search completion date: 30th July 2013  
Search completed by: Alison Price

Enquiry Details

I am completing a service toolkit around the primary care enhanced services for LARC (largely IUD/IUS and implants).

I need to set out any benchmarking information that can be found comparing it to other areas and justify its need.

I have quoted NICE CG 30 but need information which supports it or be used as a benchmark.
Benchmarking Resources - NICE

Services for the provision of IUDs and the IUS for contraception and the management of heavy menstrual bleeding - Commissioning guide Implementing NICE guidance

The 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.

www.nice.org.uk/media/815/A0/ServicesForThe Provision Of IUDs And The IUS.pdf
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.

Determining local service levels for the provision of IUDs and the IUS

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).
Statistics relating to LARC are available on the Association of Public Health Observatories Sexual Health Balanced Scorecard website.

Sexual Health Balanced Scorecard - Rate of GP prescribed Long Acting Reversible Contraception (LARC) and by LARC type, by PCT and SHA, 2011/12

The SHORE Programme contains a detailed example of benchmarking in practice;


The Sexual Health Outcomes, Research and Evaluation (SHORE) Programme presents the results of a study to better understand the overall spend on sexual health and how to prioritise spending in relation to outcomes. This was conducted across all Primary Care Trusts in the South West by the Office for Sexual Health. Reviewing the invest to save potential of increasing long-acting reversible contraception coverage and the potential to improve the efficiency of chlamydia screening was part of this work. Local Primary Care Trust data were used in two costing models (Model 1: chlamydia screening, Model 2: long-acting reversible contraception) to illustrate how to inform best practice and decision making in sexual health.

REQUEST FROM LKRS.
What is the actual cost of providing the intrauterine system for contraception in a UK community sexual and reproductive health setting?

J Fam Plann Reprod Health Care doi:10.1136/jfprhc-2012-100377

Louise Cook, Charlotte Fleming.

Background The anticipated increase in uptake of intrauterine system (IUS) fittings is slower than predicted by the National Institute for Health and Clinical Excellence (NICE). There is evidence to suggest that this is because of a high perceived cost of providing this contraceptive method. Whereas studies to date have all guessed at these costs, we calculated the actual costs of providing the IUS.

Methods We tracked the notes of 283 women who had an IUS fitted in our community sexual and reproductive health service for 5 years. We recorded duration of use, measured the actual cost of all appointments and interventions over the lifespan of the device, and compared our findings with NICE predicted costs.

Results With 70% complete follow-up, the average duration of use of the IUS was 3.44 years compared to NICE’s prediction of 3.32. The average annual cost of providing an IUS for contraception in community clinics was £54.55 per woman; this compares with £70.49 modelled by NICE for provision in primary care. Most (80%) of the cost is incurred in the first year. The cost of managing problems is small.

Conclusions Providing the IUS for contraception was 23% cheaper in the present study than that predicted by NICE and cheaper than providing combined oral contraception in our service. Fitting IUSs in community clinics may be cheaper than in primary care. Streamlining the patient pathway will reduce costs further. Restricting access to the IUS because of initial cost is a false economy.


BACKGROUND:
The National Institute for Health and Clinical Excellence (NICE) has judged Implanon to be the most cost effective of the long-acting reversible contraception (LARC) methods, and its cost effectiveness is enhanced with increased duration of use. Gwent Sexual and Reproductive Health service provides unrestricted use of Implanon, and with the number of implants fitted increasing annually the service wanted to know how long clients were keeping their contraceptive implants in and the cost of implant provision.

METHODS:
The actual cost of providing Implanon was calculated in a cohort of 493 patients within a community-based sexual and reproductive health service, and compared to that predicted in the NICE Clinical Guideline 30 on LARC.

RESULTS:
The annual cost for the method (using Implanon) was pound77.49, 25% lower than the estimate made by NICE, despite a shorter duration of use of the method.

CONCLUSION:
The actual cost in this community-based sexual and reproductive health service may not be transferable to other settings such as general practice.

http://jfprhc.bmj.com/content/35/2/75.long
The cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence (NICE) clinical practice guideline.

Mavranezouli I; LARC Guideline Development Group.
National Collaborating Centre for Women’s and Children’s Health (NCC-WCH), Royal College of Obstetricians and Gynaecologists, London, UK. i.mavranezouli@ucl.ac.uk

BACKGROUND:
Long-acting reversible contraceptive (LARC) methods are highly effective in preventing unintended pregnancies. However, their uptake is low in much of the developed world. This study aimed at assessing the cost-effectiveness of LARC methods from the British National Health Service (NHS) perspective.

METHODS:
A decision-analytic model was constructed to estimate the relative cost-effectiveness of the copper intrauterine device (IUD), the levonorgestrel intrauterine system (LNG-IUS), the etonogestrel subdermal implant and the depot medroxyprogesterone acetate injection (DMPA). Comparisons with the combined oral contraceptive pill (COC) and female sterilization were also performed. Effectiveness data were derived from a systematic literature review. Costs were based on UK national sources and expert opinion.

RESULTS:
LARC methods dominated COC (i.e. they were more effective and less costly). Female sterilization dominated LARC methods beyond 5 years of contraceptive protection. DMPA and LNG-IUS were the least cost-effective LARC methods. The incremental cost-effectiveness ratio of implant (most effective LARC method) versus IUD (cheapest LARC method) was pound13 206 per unintended pregnancy averted for 1 year of use and decreased until implant dominated IUD in 15 years. Discontinuation was a key determinant of the cost-effectiveness of LARC methods.

CONCLUSIONS:
LARC methods are cost-effective from the British NHS perspective. Practices improving user satisfaction and continuation of LARC method use should be identified and promoted.

http://humrep.oxfordjournals.org/cgi/pmidlookup?view=long&pmid=18372257

The cost-effectiveness of a long-acting reversible contraceptive (Implanon) relative to oral contraception in a community setting

Author(s) Lipetz C., Phillips C.J., Fleming C.F.
Citation: Contraception, April 2009, vol./is. 79/4(304-309), 0010-7824 (April 2009)
Abstract: Background: Within the setting of a UK community sexual health service, the cost-effectiveness of Implanon and oral contraception provision over a 36-month period was compared. Study design: A case-controlled retrospective cost-effectiveness study was done on a cohort of 493 Implanon users and 493 oral contraceptive users. The actual cost of provision of both methods was calculated. Cost-effectiveness was calculated based on provision of method and pregnancy costs of each cohort. Results: Implanon provision is more cost-effective than oral contraception at all time points. After 12 months of use, Implanon is half the cost of oral contraception. Oral contraception reached similar annual cost to Implanon at 36 months of use. Conclusions: Long-acting reversible contraception is perceived to be expensive. It is reassuring to contraception providers that Implanon is, in fact, highly cost-effective when compared to oral contraception with typical use.
Cost-effectiveness of a low-dose contraceptive levonorgestrel intrauterine system (LNG-IUS 12) in Sweden

European Journal of Contraception and Reproductive Health Care, May 2013, vol./is. 18/(S257-S258), 1362-5187 (May 2013)

Henry N., Lekander I., Hawes C., Thuresson P.-O., Filonenko A.

Abstract: Objectives: To evaluate the cost-effectiveness of LNG-IUS 12 (Jaydess) versus a weighted market mix of hormonal contraceptive methods (hormonal market mix, hMM) in Sweden from both a payer and societal perspective. Method: A Markov model was constructed to compare the effectiveness and costs of LNG-IUS 12 and hMM over a 3-year period in a cohort of 1000 women aged 15 to 44 years requiring reversible contraception and at risk of pregnancy. hMM comprised hormonal contraceptives currently used by this cohort, including short-acting methods (SARC: oral contraceptives (OC), the ring and the patch) and long-acting methods (LARC: injection, the implant and IUS). Primary health states included initial/continued use of contraceptive method, method failure (unintended pregnancy, UP) and subsequent method (following either discontinuation or UP). Subsequent method was defined as a market mix of all available methods (MM). Probabilities of method failure and first year discontinuation rates were estimated based on published US and Swedish data. Discontinuation rates in subsequent years were derived based on local KOL advice. Weighted probabilities of failure and discontinuation for hMM and MM were estimated by combining these data with market share distribution data according to published Swedish sales data. Medical resource use and productivity losses were estimated following KOL input. Direct costs of contraception and the outcomes of unintended pregnancy were derived from FASS and the Swedish Association of Local Authorities and Regions, respectively. Indirect costs were estimated based on annual average wage statistics. One-way sensitivity analyses (OWSA) were performed on all key variables subject to uncertainty. Probabilistic sensitivity analyses (PSA) were also conducted. Scenario analyses assessed the use of alternative comparator compositions in the model. Results: LNG-IUS 12 dominated hMM in the cohort of 1000 women, resulting in fewer unplanned pregnancies (52 vs. 271), and both lower total direct (6.5 million SEK vs. 9.4 million SEK) and indirect (0.7 million SEK vs. 0.8 million SEK) costs over 3 years. Results of the OWSA and PSA indicated that the model was robust to plausible changes in input values. Scenario analyses indicated that LNG-IUS 12 remained dominant when compared against either SARC or LARC, but results were sensitive to the composition of the LARC basket. Conclusions: From both a payer and societal perspective, the current model estimates that LNG-IUS 12 is cost saving when compared to the weighted market mix of hormonal contraceptive methods, and results in fewer unintended pregnancies.