

RECOMMENDATIONS FOR THE CO-DELIVERY OF INTRAUTERINE DEVICES FOR ALL CONTRACEPTIVE OR NON CONTRACEPTIVE INDICATIONS

A briefing by the English HIV and Sexual Health Commissioners Group, the Primary Care Women's Health Society, the College of Sexual and Reproductive Healthcare and the Advisory Group on Contraception.

September 2026



INTRODUCTION

Commissioning responsibilities for sexual and reproductive health services are complex across the health system. Local Authorities are responsible for commissioning sexual health specialist services, including long-acting reversible contraception (LARC) for contraceptive purposes in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts. ICBs (Integrated Care Boards) are responsible for commissioning gynaecology services, primary care gynaecology services, maternity services and abortion services including contraception provided as part of the abortion pathway. Overall, this complex commissioning landscape can result in women and service users experiencing inequitable access to care and inappropriate variation in service provision.

To provide a snapshot of the current landscape, two complementary surveys were undertaken. The first, undertaken by the Primary Care Women's Health Society (PCWHS), focused on the delivery of contraception and gynaecological services within primary care, examining issues relating to access, capacity and workforce sustainability. The second, conducted by the English HIV and Sexual Health Commissioners Group (EHSHCG), explored the experiences and perspectives of Local Authority (LA) commissioners, capturing insights into commissioning priorities, challenges and wider system pressures.

The survey findings highlight significant structural and commissioning challenges, particularly in relation to intrauterine devices (IUDs) used for gynaecological (e.g. heavy menstrual bleeding, dysmenorrhoea, perimenopausal and menopausal symptoms) rather than contraceptive indications.

Despite the Department of Health and Social Care (DHSC) updating its Commissioning Local HIV, Sexual and Reproductive Health Services guidance in January 2025, stakeholders continue to report that aspects of commissioning responsibility remain unclear, particularly where sexual and reproductive health pathways intersect with primary care, maternity, abortion and gynaecology services.

This lack of clarity has contributed to considerable variation in commissioning and reimbursement arrangements across the country, including differing levels of ICB funding for non-contraceptive procedures and, in some areas, limited or no ICB engagement.

As a result, LAs are often required to fund the majority, and in some cases the entirety, of LARC provision, creating inequities in both access and funding responsibility while placing additional pressure on already stretched sexual and reproductive health services.

The impact of recent ICB restructuring, and loss of experienced staff, has reduced capacity for strategic development. In some areas this has slowed progress towards more aligned commissioning and integrated pathway development, underlining the need for greater clarity around commissioning responsibilities and accountability across the system.

In response to these findings, the ESHCG and PCWHS have jointly developed a series of recommendations. By strengthening collaboration between LAs, ICBs, primary care, sexual and reproductive health services, gynaecology, abortion and maternity providers, the system can move beyond managing immediate operational pressures towards delivering sustainable service transformation.

This is essential not only to address current challenges in contraception and IUD provision, and to improve access to gynaecological care, but also to create a more coherent, equitable and person-centred women's health system. Additional benefits of funding IUDs for non-contraceptive indications include reducing unnecessary referrals to hospital, enabling earlier intervention and personalised care for patients. An integrated approach enables women to receive the right care in the right place at the right time, frees up secondary care capacity and reduces long waits.

Achieving these recommendations will be critical to delivering the vision of neighbourhood health, reducing unwarranted variation, and realising the ambitions set out in the Women's Health Strategy.

RECOMMENDATIONS

1. Clarify national commissioning responsibilities and accountability for LARC Services

The Department of Health and Social Care (DHSC) issue explicit national commissioning guidance that clearly sets out organisational roles, responsibilities, and accountability for LARC services across all care settings and clinical indications. The commissioning guidance would:

- Clearly articulate commissioning responsibilities for LARC provision across the system, including sexual health services, primary care, maternity services, abortion services, and gynaecology services, for both contraceptive and gynaecological (non-contraceptive) indications.
- Clarify commissioning accountability with ICBs for the provision of LARC for non-contraceptive indications, helping to reduce local interpretation and unwarranted variation.
- Support local systems to develop agreed pathways that enable women to access the most appropriate service without being redirected between providers because of commissioning uncertainty.
- Support care in the community to reduce travel time, enable convenient services for women, encourage LARC uptake and to help reduce inequalities.

Greater national clarity would reduce variation in local commissioning arrangements, strengthen accountability across organisations, improve consistency for providers, and support equitable access to all LARC irrespective of where a woman lives or the clinical reason for requiring the intervention. It would also provide a stronger foundation for collaborative working between LA, ICBs, and providers, enabling local discussions to focus on service improvement rather than interpretation of responsibilities.

2. Develop a single commissioning model for IUD across all indications

ICBs and LAs have a single commissioning model for IUD services for both contraception and gynaecological care to improve access, reduce delays, and create a more seamless experience for women.

Current commissioning arrangements often mean women are bounced between services before they can access IUDs, leading to inequitable care and inefficiencies. Providing IUD procedures in community settings is considerably cheaper than in secondary care, is more convenient for patients, and supports NHS net zero ambitions by reducing travel.

A single commissioning model would include:

- Shared commissioning principles.
- Clear funding responsibilities for contraceptive and gynaecological indications.
- Agreed pathways that prevent women being redirected between services.
- Consistent service specifications across an ICB footprint.

To promote transparency, reduce duplication, and support greater consistency nationally, agreed service specifications should also be published and maintained within a centrally accessible repository, such as a national NHS website or database, enabling commissioners and providers across England to understand, compare and adopt established commissioning models and effective practice.

3. Establish a system-wide IUD tariff

ICBs and LAs work together to develop system-wide tariff for all IUD fitting and removal procedures, regardless of whether the primary indication is contraceptive or non-contraceptive.

This would:

- Reduce unwarranted variation in payments across localities.
- Remove financial disputes between organisations.
- Avoid LAs from subsidising gynaecological activity inadvertently.
- Eliminate miscoding of activity in order to receive payment, therefore creating a greater understanding of the local needs of women.
- Improve transparency and accountability for commissioners and providers.
- Support equitable access to IUD services regardless of where a woman lives.

A system-wide tariff, should reflect:

- IUDs can be a complex clinical procedure and require appropriate training and number of fits to ensure quality and safety of delivery.
- Time associated with information giving, fitting, removal and follow-up.
- The costs of maintaining competency through training and supervision.
- The value for convenience and financial savings in preventing referrals into secondary care and reducing acute trust waiting lists.

Survey findings suggest that current tariffs vary considerably. An agreed system-wide tariff would help make IUD provision sustainable within primary care and provide clarity for commissioners.

Payment should be based on national unit cost data and cover the full cost of allocated clinical time (including locum cover) and expertise, training and cost of consumables, including the cost of adequate anaesthesia for the procedures.

The agreed tariffs should be reviewed intermittently to ensure that payments for all IUD fitting procedures are increased in line with service delivery. This will ensure reimbursement levels remain sustainable.

4. Provide clear assurance to Primary Care on data collection and payment

ICBs in partnership with LAs should issue clear, joint guidance and contractual assurances that providers will be reimbursed appropriately when recording the primary reason for the IUD procedure.

Survey findings indicate that some providers currently code gynaecological procedures as 'contraceptive' services due to concerns about not receiving reimbursement. Inaccurate coding limits the quality of commissioning intelligence and prevents a true understanding of the demand for gynaecological IUD services.

The guidance would include:

- Standardised coding and reporting requirements.
- Explicit confirmation that recording a gynaecological indication will not lead to non-payment.
- Shared accountability arrangements between commissioners.
- Routine monitoring of activity data to improve understanding of demand and trends.

5. Use data to inform future commissioning and workforce planning

ICBs work in partnership with LAs and providers to strengthen routine collection of indication specific IUD data. Improved data quality would:

- Quantify the growing demand for IUDs for heavy menstrual bleeding, menopause management and other non-contraceptive indications.
- Support fair allocation of funding responsibilities.
- Inform workforce planning and training needs.
- Provide evidence of the contribution made by primary care in reducing pressure on secondary care services.
- Demonstrate a need to ensure services are available to prevent further increases in abortions rates and enable easy access to post procedure contraception.

6. Strengthen system leadership and accountability

ICBs and LAs in partnership should provide visible leadership to and engagement with primary care for women's health and IUD delivery by:

- Convening regular discussions with LAs and providers.
- Overseeing alignment of tariffs and pathways.
- Monitoring equity of access and waiting times.
- Reporting progress against agreed women's health outcomes.
- Delivering training and briefing events (e.g. LARC fitter forums) to maintain strong clinical leadership and practice.

SUMMARY OF RECOMMENDATIONS

CLARIFY NATIONAL
COMMISSIONING
RESPONSIBILITIES AND
ACCOUNTABILITY FOR
LARC SERVICES

DEVELOP A SINGLE
COMMISSIONING
MODEL FOR IUD
ACROSS ALL
INDICATIONS

ESTABLISH
A **SYSTEM
WIDE** IUD
TARIFF

PROVIDE **CLEAR
ASSURANCE TO
PRIMARY CARE**
ON DATA
COLLECTION
AND PAYMENT

USE DATA TO INFORM
COMMISSIONING AND
WORKFORCE
PLANNING

STRENGTHEN
SYSTEM
LEADERSHIP AND
ACCOUNTABILITY

SUMMARY

ICBs, working in partnership with LAs, have a key role in establishing a standardised, equitable and sustainable commissioning framework for IUDs across both contraceptive and non-contraceptive indications.

Public health commissioners and primary care clinicians can support this by providing robust population health intelligence, evidence of need and outcomes, and examples of effective integrated service models and best practice from frontline delivery.

This approach should be underpinned by an evidence-based minimum tariff, aligned funding arrangements between ICBs and LAs, and clear assurances that primary care providers will receive appropriate reimbursement through accurate recording of clinical indications.

Collectively, this would remove uncertainty about where patients can access IUD services, regardless of their clinical presentation, improve access through community and primary care settings, and reduce pressure on secondary and emergency care. This aligns with the ambitions of the NHS 10-Year Plan while promoting greater patient choice, improving equity of provision, and ensuring timely access to care.

A briefing by the English HIV and Sexual Health Commissioners Group, the Primary Care Women's Health Society, the College of Sexual and Reproductive Healthcare and the Advisory Group on Contraception.

September 2026

