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NATIONAL STATISTICS

Sexual and Reproductive Health Services, England

Statistics for 2014-15

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This report may be of interest to members of the public, policy officials and other stakeholders to make local and national comparisons and to monitor the quality and effectiveness of sexual and reproductive services.

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Contents

This is a National Statistics publication

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- are well explained and readily accessible;
- are produced according to sound methods; and
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Executive Summary

This publication covers activity taking place in the community at dedicated Sexual and Reproductive Health (SRH) services, including from non NHS service providers where available. SRH services include family planning services, community contraception clinics, integrated Genitourinary Medicine (GUM) and SRH services and young people's services e.g. Brook advisory centres.

Important note: This report does not represent all ways in which a person may access sexual and contraceptive health services. For example, it excludes services provided in out-patient clinics and those provided by General Practitioners as well as contraceptives purchased over the counter at a pharmacy or in other retail settings. Therefore changes over time presented in this report may be due to changes in the way people access sexual and contraceptive health services.

Main Findings

During the period April 2014 to March 2015:

Overall contacts

- There were 2.13 million contacts with dedicated SRH services made by 1.31 million individuals. This represented a decrease of 4 per cent (81,843) on the number of contacts in 2013/14 (2.21 million). It also represented a decrease of 2 per cent (32,051) in the number of individuals attending SRH services.

- 8 per cent of the resident population of women between the ages of 13 and 54 had at least one contact with an SRH service. For men in the same age group, 1 per cent of the resident population had at least one contact.

- Women aged 18 to 19 were most likely to use an SRH service, with 21 per cent having at least one contact.

Contacts for contraception

- Almost 1 million (941,169) women contacted SRH services on one or more occasions for reasons of contraception (excluding where only advice was provided). 31,765 (3 per cent) of those were aged under 16.

- Over the last ten years, the proportion using Long Acting Reversible Contraceptives has been increasing and the proportion using user dependent methods has been decreasing. However, oral contraceptives (a user dependent method) are still the most common form of contraception item in use, being the main method for 45 per cent of women.

Emergency contraception

- The number of emergency contraception items provided to women by both SRH services and at other locations in the community was approximately 318,000 in 2014/15. This has fallen steadily over the last ten years, from a total of approximately 521,000 in 2004/05, a decrease of 39 per cent[1].

- The number of emergency contraception items provided to under 16s by SRH services over the last ten years, has fallen both in real terms and as a percentage of those provided to women of all ages. 8,884 items of emergency contraception were provided to under 16's by SRH services in 2014/15, representing 8 per cent of the total, compared to 24,544 items in 2004/05 (a decrease of 64 per cent), which represented 14 per cent of the total.

- There were 7,511 women aged 13 to 15 provided with emergency contraception by an SRH service at least once, representing 8 per 1000 population.

[1] Please note, these figures do not represent the full volume of emergency contraceptives provided. Since 2001, the reclassification of emergency hormonal contraception (EHC), meant that it could also be purchased over the counter at a pharmacy without a prescription (by women aged 16 and over).

1 Introduction

1.1 Background

This publication covers activity taking place in the community at dedicated Sexual and Reproductive Health (SRH) services, including activity at non NHS service providers where available.

SRH services include family planning services, community contraception clinics, integrated GUM and SRH services and young people's services e.g. Brook advisory centres. They provide a range of services including, but not exclusively, contraception provision and advice, sexual health treatment and advice, pregnancy related care, abortion related care, cervical screening, psychosexual therapy, PMS treatment, colposcopy services, fertility treatment and care and gynaecological treatment and care.

A contact within this report may be a clinic attendance or a contact with the service at a non-clinic venue. Non face to face contacts (e.g. by telephone) are not currently included, but it does include activity at non-clinic venues (such as home visits / outreach).

The data includes non-English residents using services based in England.

This report excludes services provided in out-patient clinics, at community pharmacies and those provided by General Practitioners, unless otherwise stated.

1.2 Data sources

The data used in this report has been collected since 1988/89 through the KT31 return, and from 2010/11 an attendance level collection known as the Sexual and Reproductive Health Activity Dataset (SRHAD). The 2 datasets were used alongside each other between 2010/11 and 2013/14, as the rollout of SRHAD progressed across submitting organisations. From 2014/15, KT31 returns were no longer accepted, and so SRHAD is now the sole source of sexual and reproductive activity data for this report.

The KT31 return was an aggregated data return containing counts of activity at Local Authority (LA) level. By contrast, SRHAD is an activity based collection with each attendance being a record within the dataset.

Though the SRHAD data is collected on a different basis to the KT31, the mapping and analysis of the SRHAD data are considered to make time series data comparable, unless otherwise stated.

As SRHAD is an attendance level dataset, all attendances for a particular person will appear in the dataset enabling all their interactions within a community contraceptive clinic to be reported and joined together. However if a person visits different services then their attendances cannot be linked and they will appear as two different people in the dataset.

For this year's publication, 140 providers submitted SRHAD data.

The SRHAD collection is sponsored by Public Health England and complements the Genitourinary Medicine Clinic Activity Dataset (GUMCADv2)[2].

A revised version of the SHRAD collection was introduced on 1 January 2015. It expands the collection to include non-face to face contacts (e.g. telephone contacts), and makes the following field changes:

- Responsible PCT is replaced by LA of Residence
- GP practice code of patient is added
- Consultation medium code is added
- A number of additional SRH activity codes have been added

Full details of the new version can be found at the following link:

http://www.hscic.gov.uk/datacollections/srhad

Providers are not required to have moved to SRHAD version 2 until 31 December 2015. As such the new content will not be fully available for reporting and analytical use until the 2016/17 reporting year. As at 31 March 2015, 15 providers had moved to submitting SRHAD version 2.

Data on vasectomy and sterilisation procedures taking place in hospitals is also included in this report. This information is taken from the HSCIC's Hospital Episode Statistics (HES).

Prescription Cost Analysis data is also included which is obtained from the Prescribing team at the HSCIC.

1.3 Accuracy

Validation is undertaken by the HSCIC to ensure that the data are robust and providers are asked to resubmit invalid data. Failure to satisfy key validation requirements will mean that the return will not be accepted until they are resolved. Details of the validation rules can be found in the document below:

http://www.hscic.gov.uk/media/16889/SRHAD-Technical-Guidance/pdf/SRHAD_Technical_Guidance.pdf

Further information on validations and known data quality issues can be found in the Data Quality statement which accompanies this report.

[2] Further details of the GUMCAD collection can be found on the PHE website at:
https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2

1.4 Changes to the report

The additional information provided by the SRHAD dataset compared to KT31 provides an opportunity to revisit some of the existing analyses in this report and also consider some new analyses.

Reporting changes and additions

During the first half of 2014, the HSCIC in conjunction with a number of key SRHAD stakeholders, including Public Health England (PHE), developed a proposal of changes to the report to be implemented from 2014/15. A final proposal was subsequently communicated to our known users and data suppliers, of which a number of changes have been implemented. A change note was issued to make users aware of the methodological changes[3]. Details of all the changes can be found in Appendix B.

Publication of record level extract

A record level file has also been published to allow users to carry out their own analysis of the SRHAD data. This file has undergone some transformation to ensure the data is anonymised, and further information is available in the guidance document which is within the zip file on the publication webpage.

If users find this extract is not suitable for their needs then they can apply for access to additional data fields. More information on how to apply along with the relevant application forms is available from the Data Access Request Service:

http://www.hscic.gov.uk/dars

1.5 User Feedback

The Health and Social Care Information Centre welcomes feedback on all publications. If you wish to comment on this report, including the changes outlines in appendix B, or would like to be added to our user distribution list, please contact enquiries@hscic.gov.uk quoting “Sexual and Reproductive Health Services” in the subject line.

Alternatively, a general feedback form (Have Your Say) is available on the HSCIC website at:
http://www.hscic.gov.uk/haveyoursay

[3] http://www.hscic.gov.uk/media/18431/Sexual-and-Reproductive-Health-Services-England--201415/pdf/MethChange_20150902_Sexual_and_Reproductive_Health_Services.pdf

2 Analysis and Commentary[4]

2.1 Overall contacts

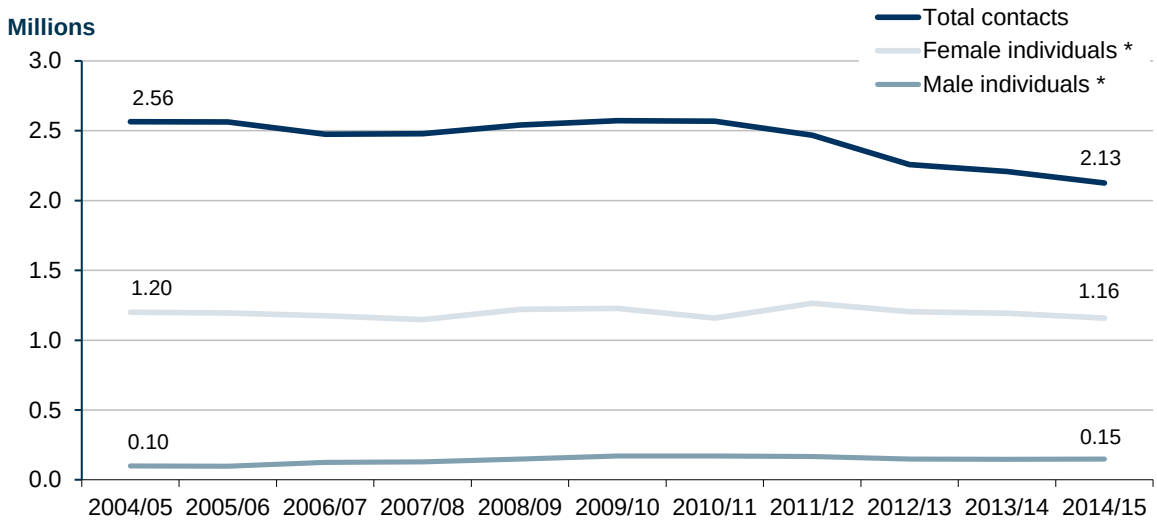
There were 2.13 million contacts with dedicated SRH services made by 1.31 million individuals[5] in 2014/15. This represented a decrease of 4 per cent (81,843) on the number of contacts in 2013/14 (2.21 million). It also represented a decrease of 2 per cent (32,051) in the number of individuals attending SRH services.

The average number of contacts per individual during 2014/15 was 1.63, down from 1.65 in 2013/14.

89 per cent (1.16 million) of individuals attending in 2014/15 were women and 11 per cent (0.15 million) were men (see figure 1).

Figure 1: Contacts with Sexual and Reproductive Health services

England, 2004/05 to 2014/15



*For individuals, a person using a service multiple times during the year will only be counted once.
Source: up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also table 1 in the Excel data tables.

[4] Important note: This report does not represent all ways in which a person may access sexual and contraceptive health services. For example, it excludes services provided in out-patient clinics and those provided by General Practitioners as well as contraceptives purchased over the counter at a pharmacy or in other retail settings. Therefore changes over time presented in this report may be due to changes in the way people access sexual and contraceptive health services.

[5] Note that if a person attends different services in the same year then they will be counted more than once, but if they attend the same service several times then they will only be counted once.

2.2 Likelihood of contact

Please note, people contact SRH services for a variety of reasons, including many non-contraception related services (see table 5 in the Excel data tables for a full breakdown of activity in 2014/15).

In 2014/15, 8 per cent of the resident population of women between the ages of 13 and 54 had at least one contact with an SRH service. For men in the same age group, 1 per cent of the resident population had at least one contact

Likelihood of contact by age

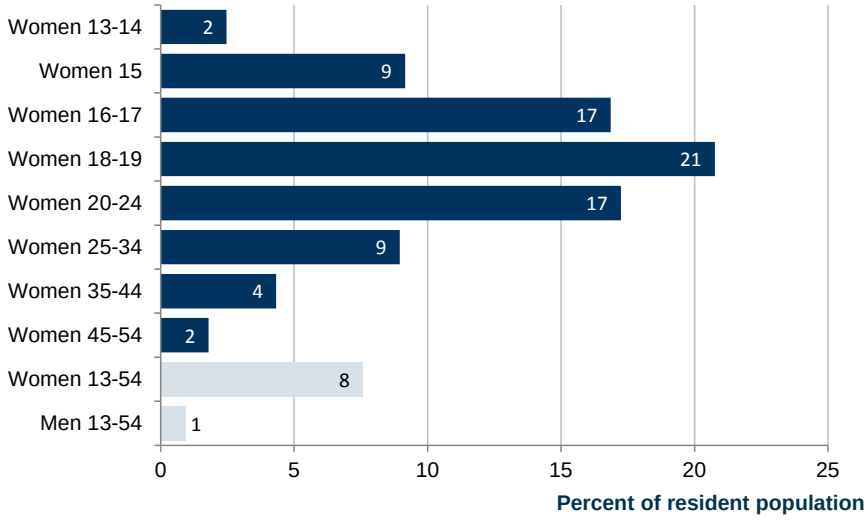
The likelihood of a woman contacting a service varies considerably between ages (see figure 2).

Women aged 18 to 19 were most likely to use a service, with 21 per cent having at least one contact in 2014/15.

9 per cent of women aged 15 and 2 per cent of women aged 13 to 14 had at least one contact in 2014/15. When combined this equates to 5 per cent of women aged 13 to 15.

Figure 2: People in contact with Sexual and Reproductive Health services, percentage of resident population, by gender and age

England, 2014/15



Source: SRHAD, Health and Social Care Information Centre. See also table 2 in the Excel data tables.

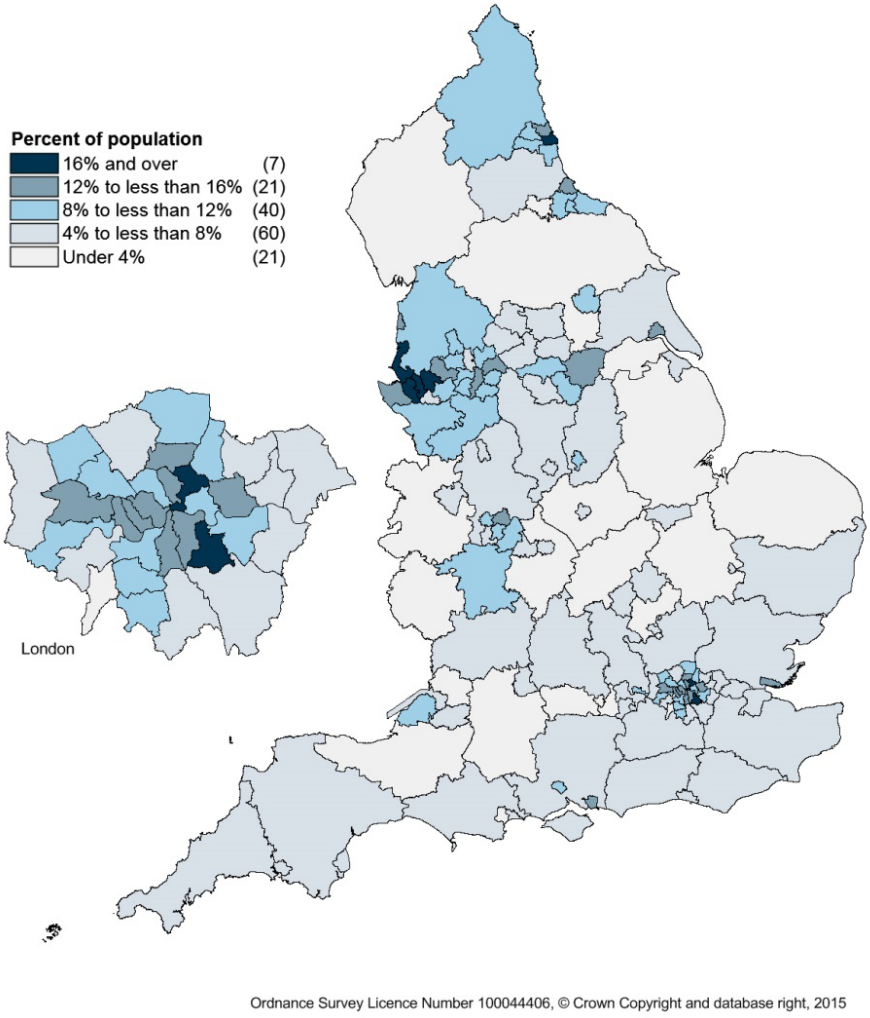
Likelihood of contacts by women by local authority

The likelihood of a woman making contact with an SRH service will be influenced by the availability of such services in their area of residence.

Across LA's the proportion of the resident population of women aged 13 to 54 that used a service in 2014/15 ranged from 1 per cent in West Berkshire to 19 per cent in St. Helens (see figure 3).

Figure 3: Women aged 13 to 54 in contact with Sexual and Reproductive Health services, percent of resident population, by local authority

England, 2014/15



Data excludes records where the person's residence was unknown or they were resident outside of England.
Source: SRHAD, Health and Social Care Information Centre.
See also table 16 in the Excel data tables - please note that as the map is based on unrounded data, local authorities may fall into different ranges than indicated by the data tables.

2.3 Reason for contact

People attend SRH services for a variety of reasons, including many non-contraception related services. A single contact with a person may involve more than one type of reason. This means that during a contact a person may receive any or all of the following services: provision/maintenance/advice relating to a main method of contraception; provision of emergency contraception; one or more other non-contraception related SRH services.

In contacts by women, 14 per cent involved the provision of a new main method of contraception, 15 per cent a change of main method and 50 per cent the maintenance of an existing main method. This is a total of 79 per cent of contacts where a main method was supplied or maintained. 11 per cent of contacts involved pre contraception advice (without a main method being in use), 6 per cent emergency contraception, whilst 65 per

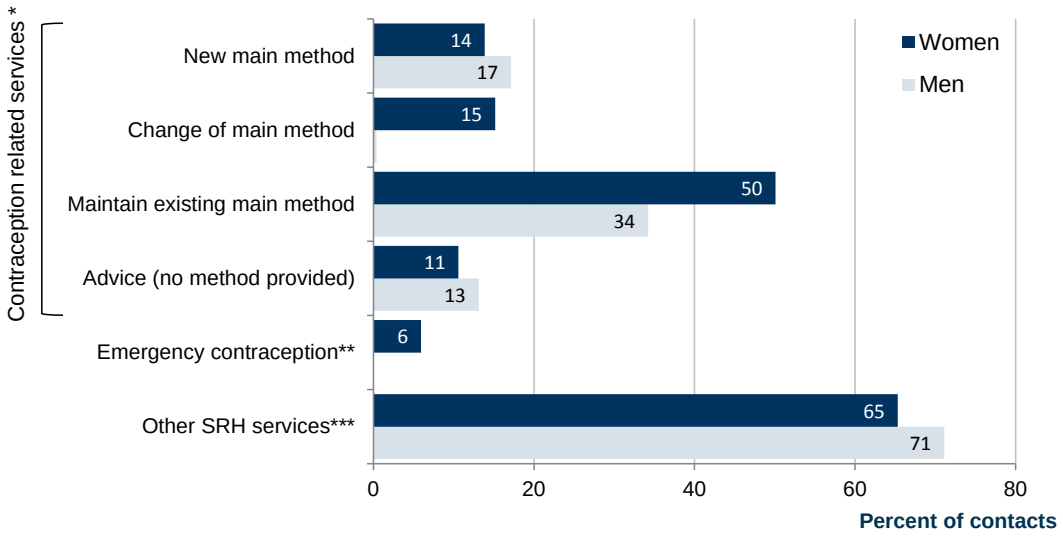
cent involved one or more other SRH services (whether with or without a contraception/emergency contraception related service) (see figure 4).

The most common types of other SRH services used (those not involving contraception) were sexual health advice and pregnancy related. See table 5 in the Excel data tables for a full breakdown of activities at SRH services.

For men, 52 per cent of contacts involved the supply/maintenance of a main method, 13 per cent pre-contraception advice whilst 71 per cent of contacts involved reasons other than contraception.

Figure 4: Contacts with Sexual and Reproductive Health services by gender and reason for contact

England, 2014-15



One contact may involve more than one of the reasons shown. As such, the sum of parts will not equal 100 per cent.

* Only one contraception related service can take place per contact.
** These are contacts where one or more forms of emergency contraception were provided.
*** These are contacts where one or more other sexual and reproductive health activity services were provided.

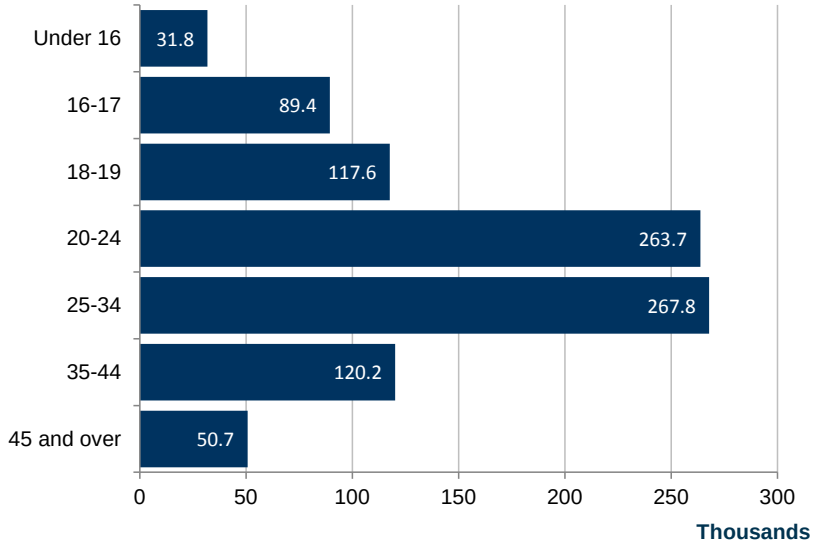
Source: SRHAD, Health and Social Care Information Centre. See also table 4 in the Excel data tables.

2.4 Contacts for contraception

In 2014/15, almost 1 million (941,169) women contacted SRH services on one or more occasions for reasons of contraception (excluding where only advice was provided). 56 per cent of these (531,502) were aged between 20 and 34. 3 per cent (31,765) were aged under 16 (see figure 5).

Figure 5: Women contacting Sexual and Reproductive Health services for contraceptive reasons by age

England, 2014-15



Source: SRHAD, Health and Social Care Information Centre. See also table 7 in the Excel data tables.

2.5 Main methods of contraception

Analysis in this section relates to women only. Almost all contraception provided to men by SRH services is the male condom (99 per cent), with spermicides and natural family planning representing the only other options available.

For all data on main method of contraception, a woman contacting the same service multiple times during the year will only be counted once. From 2014/15 the methodology used to determine the choice of contact was revised. As such, the data prior to 2014/15 is not directly comparable. See appendix B of this report for more details.

Analysis also excludes women where no main method of contraception was recorded during the year.

The information presented here is not necessarily representative of the uptake of contraception methods across the whole population. Contraceptives can be obtained from other sources such as GPs or direct from pharmacies, whilst non-prescription items like condoms can be obtained easily without a visit to a medical specialist.

Contraceptive methods are classified as either User Dependent[6] or Long Acting Reversible Contraceptives (LARCs)[7]. LARCs are not reliant on regular user adherence.

[6] User dependent methods consist of oral contraceptives, male condom, female condom, the contraceptive patch, diaphragm, spermicides, vaginal ring and natural family planning.

[7] LARCs consist of Inter-Uterine Devices (IUD), Intra Uterine System (IUS) injectable contraceptive and implants.

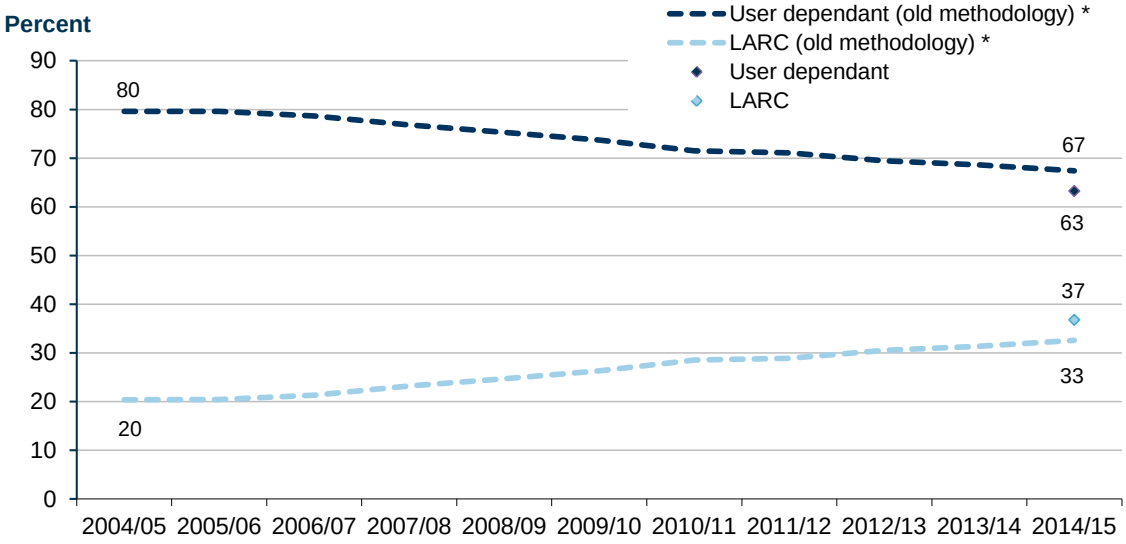
The NICE guidelines on LARCs for England and Wales published in October 2005 suggested that increased uptake of long-acting methods would reduce unintended pregnancy and be most cost-effective for the National Health Service[8].

In 2014/15, 63 per cent of women in contact with SRH services for reasons of contraception (excluding for advice only), had a user dependent main method, and 37 per cent were using a LARC.

Over the last ten years, the proportion using LARCs has been increasing and the proportion with user dependent methods has been decreasing. Although there is currently no comparable time series data (see comments on previous page on methodological change), data produced with the previous methodology shows the increase in LARC uptake (see figure 6).

Figure 6: Main method of contraception for women in contact with Sexual and Reproductive Health services

England, 2004/05 to 2014/15



* This data was produced using an old methodology for determining a woman's main method, which is still deemed suitable for illustrating relative change in main method uptake. See appendix B for details of the methodological change that occurred in 2014/15.

Source: up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also table 6 and 6a in the Excel data tables.

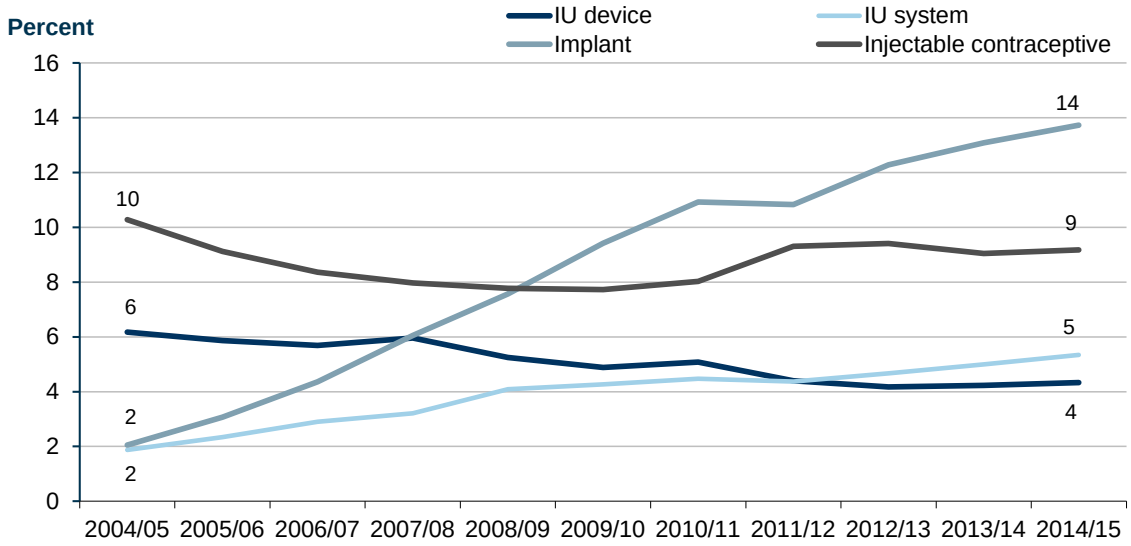
Main methods – LARCs

Implants are the most common type of LARC, and the increase in overall LARC uptake has been largely driven by a rise in implant use. As stated previously there is no directly comparable time series data due to this year's methodological change, but data produced with the previous methodology demonstrates the increase. The use of IU systems has seen a more moderate rise, whilst use of IU devices and injectable contraceptives has fallen over the same period (see figure 7).

[8] https://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations

Studies suggest that injectable contraceptives are less cost effective than other LARC methods, with a higher failure rate[9].

Figure 7: LARC uptake for women in contact with Sexual and Reproductive Health services, by type of main method*
England, 2004/05 to 2014/15



*This chart uses data produced using an old methodology for determining a woman's main method, which is still deemed suitable for illustrating relative change in main method uptake. See appendix B for details of the methodological change that occurred in 2014/15.

Source: up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also table 6 and 6a in the Excel data tables.

The percentage of women who choose LARCs as a main method of contraception generally increases with age, from around 30 per cent of those aged under 20, to around 50 per cent of those 35 and over (see figure 8).

Implants were the main method of contraception for 15 per cent of women (based upon the new methodology), with younger women more likely to use them. The use of IU devices and IU systems increases with age, with 38 per cent of those aged 45 and over using one or the other as their main method of contraception. This compares to less than 3 per cent of women under 20, and less than 1 per cent of under 16's.

Main methods - user dependent

The proportion of women choosing user dependent methods was highest in younger age groups, just over 70 per cent of those aged under 20, decreasing with age to around 50 per cent for women aged 35 and over (see figure 8).

User dependent methods include oral contraceptives, which are the most common form of contraception item in use, being the main method for 45 per cent of women. They were the most common method in all age groups, with the exception of women aged 45 and over.

[9] http://www.fsrh.org/pdfs/CEUGuidanceProgestogenOnlyInjectables.pdf

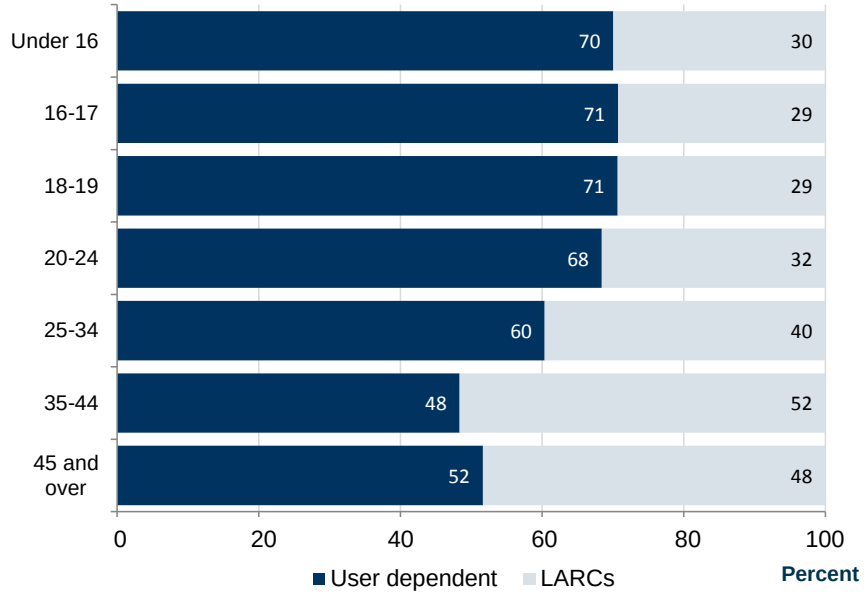
The male condom was the next most common, with 15 per cent choosing this as a main method. The male condom was used most widely amongst the youngest age group - 23 per cent of females aged under 16. As the male condom is easily available to people of all ages direct from retail outlets, the proportion of women using them as a main method across the full population is likely to be much higher.

User dependant methods other than oral contraceptives and the male condom, collectively account for less than 3% of main methods in use.

Table 7 in the Excel data tables shows the full breakdown of LARCs and user dependent methods in use by people in contact with SRH services. This includes the numbers of women using each type of contraceptive item.

Figure 8: Percentage of women in contact with Sexual and Reproductive Health services with a main method user dependent or LARC, by age group

England, 2014/15



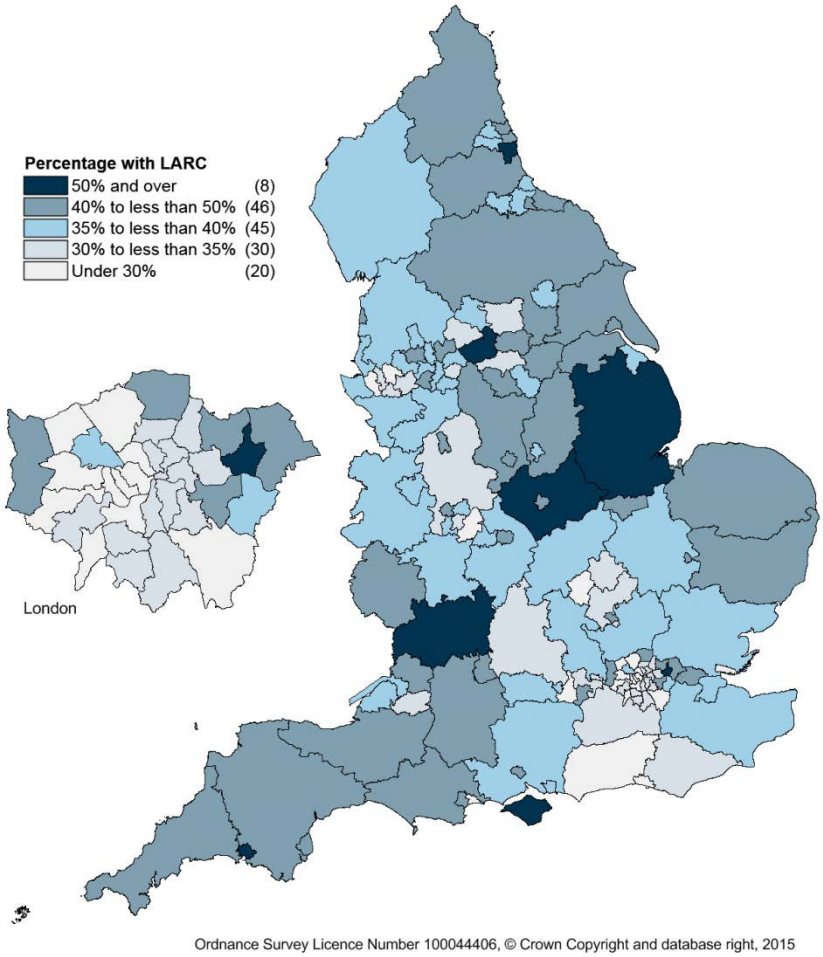
Source: SRHAD, Health and Social Care Information Centre. See also table 7 in the Excel data tables.

LARC uptake by local authority

Across LA's the proportion of women using SRH services for contraceptive purposes who had a main method of LARC in use, ranged from 24 per cent in Southend-on-sea, Hammersmith & Fulham and Kensington & Chelsea to 55 per cent in Kirklees (see figure 9).

Figure 9: Percentage of women in contact with Sexual and Reproductive Health services with a main method LARC, by local authority of residence

England, 2014/15



Data excludes records where the person's residence was unknown or they were resident outside of England.
Source: SRHAD, Health and Social Care Information Centre.
See also table 17 in the Excel data tables - please note that as the map is based on unrounded data, local authorities may fall into different ranges than indicated by the data tables.

2.6 Emergency contraception (post coital)

Total provided (SRH services and dispensed in the community)

The number of emergency contraception items provided to women over the last ten years by both SRH services and at other locations in the community (see section 2.8 for inclusions in community prescribing data) was approximately 318,000 in 2014/15. This has fallen steadily, from a total of approximately 521,000 in 2004/05, a decrease of 39 per cent (see figure 10).

At SRH services, the number of items provided was 113,976 in 2014/15, a fall of 36 per cent from 178,522 in 2004/05.

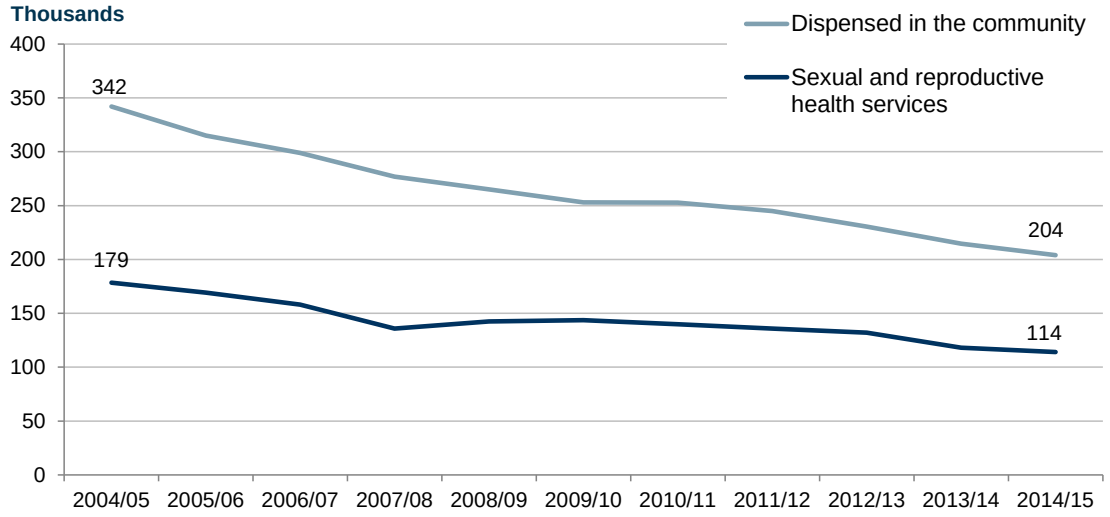
Please note, these figures do not represent the full volume of emergency contraceptives provided. Since 2001, the reclassification of emergency hormonal contraception (EHC),

meant that it could also be purchased over the counter at a pharmacy without a prescription (by women aged 16 and over). In addition, nurses and pharmacists can supply EHC to women of all ages under a Patient Group Direction (PGD)[10].

95 per cent of emergency contraception issued by SRH services was for the hormonal pill (oral) method.

Figure 10: Emergency contraception items provided by Sexual and Reproductive Health services and community pharmacists

England, 2004/05 to 2014/15



Source: Community – Prescription Cost Analysis data. Clinics – up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also tables 9a and 13 in the Excel data tables.

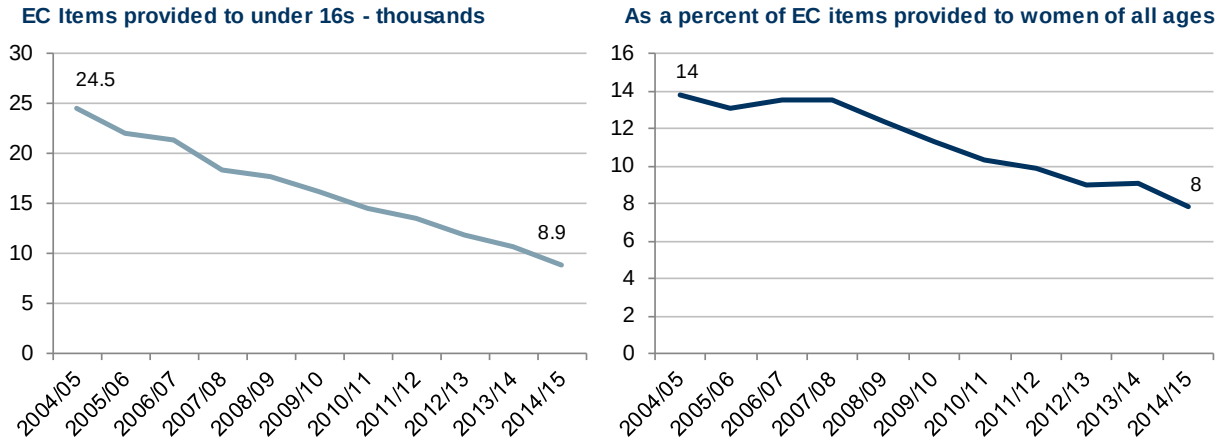
Total provided to under 16s (by SRH services only)

The number of emergency contraception items provided to under 16s by SRH services over the last ten years, has fallen both in real terms and as a percentage of those provided to women of all ages. 8,884 items of emergency contraception were provided to under 16's by SRH services in 2014/15, representing 8 per cent of the total, compared to 24,544 items in 2004/05 (a decrease of 64 per cent), which represented 14 per cent of the total (see figure 11).

[10] PGDs are documents which make it legal for medicines to be provided to groups of patients without individual prescriptions having to be written for each patient. Data on supply by PGD are not collected centrally

Figure 11: Emergency contraception items provided to women under 16 by Sexual and Reproductive Health services – total and as a percentage of those provided to all women

England, 2004/05 to 2014/15



Source: up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also table 9a in the Excel data tables.

Likelihood of women being provided emergency contraception (by SRH services only)

The likelihood of a woman using an SRH service to obtain emergency contraception varies with age. Women aged 16 to 19 were the most likely, with 26 per 1000 population having done so at least once during 2014/15 (see figure 12).

There were 7,511 women aged 13 to 15 provided with emergency contraception by an SRH service at least once in 2014/15, representing 8 per 1000 population (see table 9c in the data tables).

As mentioned previously, this is not the only means of a woman obtaining emergency contraception, so this analysis is not necessarily representative of the greater population of women using emergency contraception.

Figure 12: Women provided emergency contraceptives by Sexual and Reproductive Health Services, rate per 1000 population by age

England, 2014/15

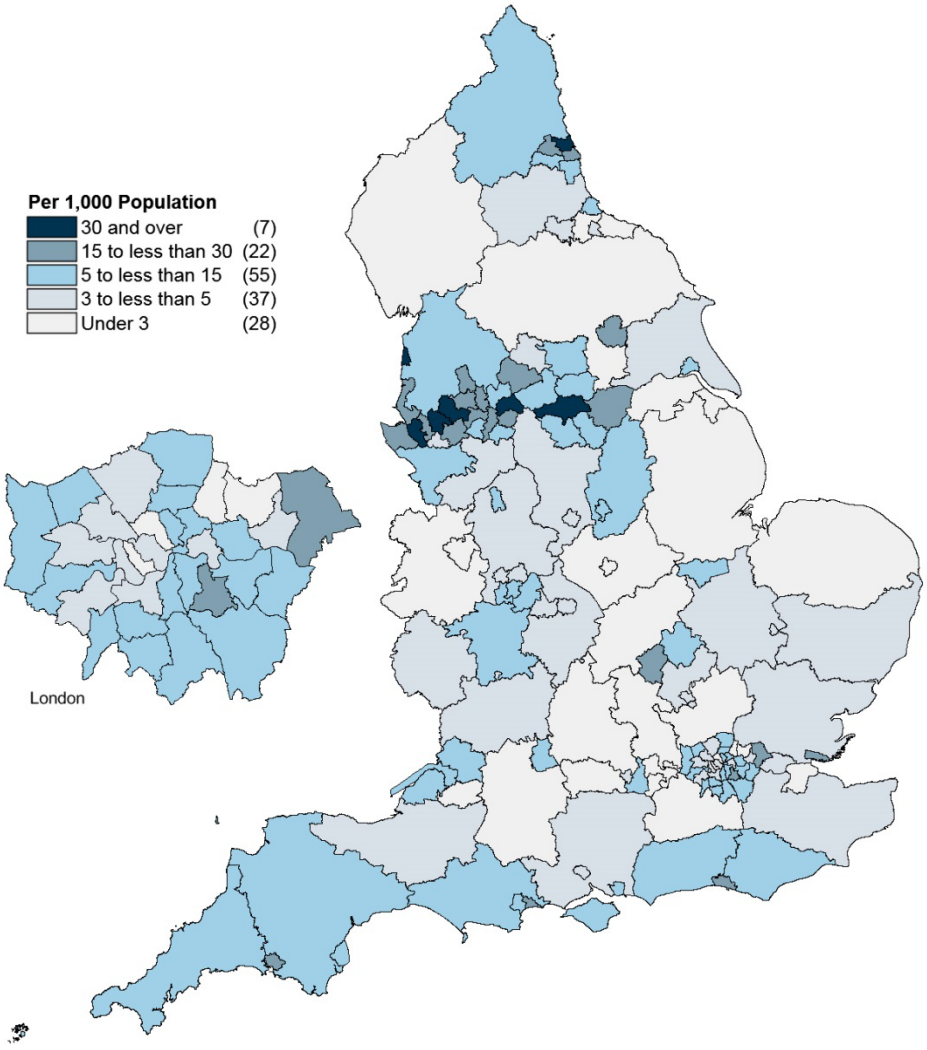
Source: SRHAD, Health and Social Care Information Centre. See also table 9c in the Excel data tables.

Likelihood of young women being provided emergency contraception by SRH services by local authority

The likelihood of a woman making contact with an SRH service for emergency contraception will be influenced by the availability of such services in their area of residence.

Across LA's the likelihood that women aged 13 to 15 were provided emergency contraception by an SRH service in 2014/15, ranged from under 1 per 1000 population in Lincolnshire, Norfolk and Wiltshire to 59 per 1000 population in St. Helens. The next highest figure was 40 per 1000 population in Oldham (see figure 13).

Figure 13: Women aged 13 to 15 provided emergency contraception by Sexual and Reproductive Health services, per 1000 resident population, by local authority of residence
England, 2014/15



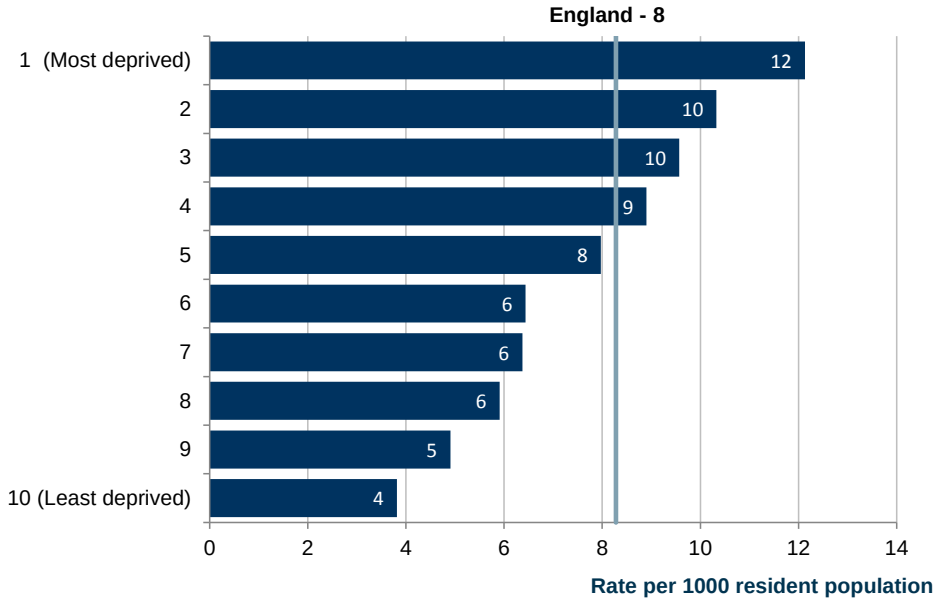
Data excludes records where the person's residence was unknown or they were resident outside of England.
Source: SRHAD, Health and Social Care Information Centre.
See also table 18 in the Excel data tables - please note that as the map is based on unrounded data, local authorities may fall into different ranges than indicated by the data tables.

Likelihood of young women being provided emergency contraception by SRH services by level of deprivation

The likelihood of young women (those aged 13-15) using SRH services to obtain emergency contraception increases with the level of deprivation in their area of residence. This varied from 4 per 1000 population in the least deprived areas, to 12 per 1000 population in the most deprived areas (see figure 14).

Figure 14: Women aged 13 to 15 provided emergency contraception by Sexual and Reproductive Health services, by Index of Multiple Deprivation (IMD) decile

England, 2014/15



Data is based on the Lower Super Output Area (LSOA) of residence mapped to IMD scores for 2001.
Source: SRHAD, Health and Social Care Information Centre. IMD data from the Office for National Statistics (ONS).See also table 11 in the Excel data tables.

2.7 Sterilisations and vasectomies

Sterilisations

As female sterilisation is an operation which necessitates a stay in hospital there are very few procedures recorded on SRHAD. However, data from the HES system shows that the number of sterilisations performed in NHS hospitals (as either a main or secondary procedure) fell steadily to around 15,000 in 2010/11, a level at which it has remained in the 3 years since (2013/14 is the latest year that HES data is available at the time of publication) (see figure 15).

See Appendix C for a full list of sterilisation procedure codes.

Vasectomies

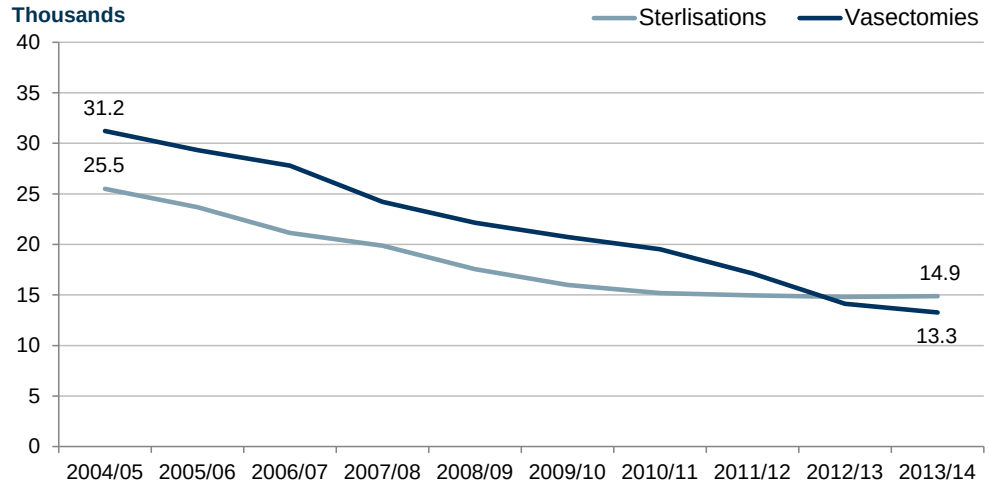
Vasectomies may be performed as operations requiring a hospital stay or as procedures in outpatient clinics. Data from HES can be added to data from SRH services to show how many vasectomies were performed by the NHS in a year.

The number of vasectomies being performed has fallen from 31,216 in 2004/05, to 13,263 in 2013/14 which is a decrease of 58 per cent (see figure 15). Most vasectomies are performed in hospital as either day cases (i.e. in hospital and using a bed, but not requiring an overnight stay), in outpatient departments or as an inpatient stay. 2,330 were reported as occurring at SRH services (see table 1 in the data tables).

Data from SRHAD only, shows that the number performed by SRH services in 2014/15 has almost halved to 1,202, when compared to 2013/14.

Figure 15: Number of sterilisations and vasectomies performed in NHS hospitals and at Sexual and Reproductive Health services

England, 2004/05 to 2013/14



N.B. HES data Includes vasectomies/sterilisations performed as main or secondary procedures.
Source: HES, up to 2009/10: KT31, 2010/11 - 2013/14: KT31 and SRHAD, 2014/15: SRHAD, Health and Social Care Information Centre. See also table 1 in the Excel data tables.

See Appendix C for a full list of vasectomy procedure codes.

2.8 Prescriptions for contraceptives dispensed in the community

Data for items dispensed in the community are sourced from the Prescribing team at the HSCIC. The system used is the Prescription Cost Analysis (PCA) system, supplied by the Prescription Services Division of the NHS Business Services Authority (NHS BSA) and is based on the full analysis of all prescriptions dispensed in the community[11]. The majority of items provided by SRH services would not be captured in this data, though there is likely to be a small amount of overlap where the prescription item is unavailable directly from the service.

Prescriptions for LARCs fell to 1.29 million in 2014/15 from 1.32 million in 2013/14, a decrease of 2 per cent. This follows a period of gradual annual increases from 1.14 million in 2007/08. Although prescriptions for user dependent methods have remained fairly stable over the last ten years, the 7.46 million recorded in 2014/15 (a drop of 1 per cent from 7.52 million in 2013/14), was the lowest across the last 10 years (see table 13 in the data tables).

[11] Prescriptions written by General Medical Practitioners and Non-medical prescribers (nurses, pharmacists etc.) in England represent the vast majority of prescriptions included. Prescriptions written by dentists and hospital doctors are also included provided that they were dispensed in the community. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. The data do not cover items dispensed in hospital or on private prescriptions.

2.9 National comparisons

Up until 2012/13 the Welsh Assembly Government produced statistics on NHS contraceptive services for Wales. At that time it was reported as being the last publication in that format, due to the integration of sexual health services. At this time, no replacement statistics are evident. The latest information was released on 13th November 2013 and can be found at the following link:
http://wales.gov.uk/statistics-and-research/nhs-community-contraceptive-services/?lang=en

Statistics for Scotland are produced by Information Services Division of NHS National Services Scotland. Long acting contraceptive methods are prescribed in a variety of settings throughout Scotland and data are collected on contraception provision in all these centres. A report published on 30th September 2014 can be found at the link below:
http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/

2.10 Editorial Notes

For the purpose of clarity, figures in the bulletin are shown in accordance with the HSCIC publication conventions.
These are as follows:

. not applicable
.. not available
- zero

Percentages and rates are shown to the nearest whole number.
Totals may not sum due to rounding.

Most data in the bulletin discussed in the text are presented in a table or chart, either within the report, or in the accompanying data table file. A reference to the appropriate figure, or Excel data table is provided in the relevant section of text.

Appendices

Appendix A – Definitions

A **contact** is defined as a face to face contact with the service (including external face to face contacts, i.e. where an individual patient receives care outside the clinic setting i.e. in his or her own home or other location). Non face to face contacts are not currently part of the scope of the dataset, but these will be included from 2015/16.

Modernisation of services and the multidisciplinary team approach means this professional contact may include a nurse working under a Patient Group Direction (PGD) to supply and administer contraceptives and provide advice, with health advisers, youth workers, and reception staff. Additionally, individuals attending for 'other' services such as cervical cytology, pregnancy testing and menopause advice are recorded.

The **main method** of contraception for new clients is that chosen after counselling; for existing clients it is the main method in use unless a change is advised.

Sterilisation and vasectomies in SRHAD are recorded if the procedure was carried out by the clinic during a patient attendance, but it does not record these as methods of contraception if the procedure was carried out previously or at a different clinic. As such, people attending for those procedures are excluded from analysis of main methods. The main method reported should be the substantive method chosen and given after a first contact consultation.
Where a couple are seen together only one contact is recorded; if the male condom is the main method chosen by the couple it is recorded as a male contact and if any other method is chosen it is recorded as a female contact.

Long Acting Reversible Contraceptives (LARCs) are defined by NICE as contraceptive methods that require administration less than once per cycle or month. Their effectiveness does not depend on daily concordance. In this publication they consist of Inter-Uterine Devices (IUD), Intra Uterine System (IUS) injectable contraceptive and implants.

Index of Multiple Deprivation (IMD) is a Lower Super Output Area (LSOA) level measure of deprivation, and is made up of seven LSOA level domain indices. These relate to income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment deprivation, and crime which reflect the broad range of deprivation that people can experience. IMD data presented in this publication is based on the 2010 index.

Appendix B – Changes to report

Change to methodology for determining the choice of contact when conducting analysis of main method of contraception

For analysis of a person's main contraception method, where a person contacts a service on multiple occasions during the year, it is necessary to select only one of these contacts for analysis. This has previously been based on a person's first contact in the year.

The methodology has been changed from 2014/15 so that it is based on:

- a person's final visit to a service in the year where a main method of contraception was identified i.e. if a person's final visit during the year related to advice or non-contraception related activity only, then this has been discounted from the analysis in favour of an earlier visit, IF in that earlier visit a main method of contraception was recorded.

This method ensures that it reflects the most current main method of a person, and that contacts where a main method of contraception was recorded, are prioritised over non-contraception related contacts.

A change to the methodology has caused a break in the time series meaning that the data from 2014/15 is not directly comparable to previous data. As such, analysis of main contraception for 2014/15 has been presented for both methodologies so the impact of the change can be observed (see tables 6 and 6a in the data tables). From 2015/16 onwards the data will be presented for the new methodology only.

Exclusion of emergency contraception from main method of contraception analysis

An adjustment has been made in the methodology to calculate the percentage of persons with each main method of contraception in use. This has previously included those persons where only emergency contraception was provided. From 2014/15, these will not be included in the analysis of main methods, and will be removed from the denominator for total persons.

This change has been made because emergency contraception is not considered a permanent method of contraception, and any person using only emergency contraception as a method, is not considered to have a main method in use. The change to methodology will reflect this.

Removing persons where only emergency contraception was recorded (approximately 1 per cent of persons in 2013/14), causes a small increase in the percentages for the remaining main method categories. Time series data in the 2014/15 report has been updated to reflect the revised methodology so data will be comparable on this basis (though the time series concerned is affected by the change to the choice of contact as mentioned previously). Comparisons should not be made with data from the previously published reports which were based on the old methodology.

Change to age group reporting

Age bands have been updated so that they are in line with Public Health England (PHE) reporting (Under 16, 16-17, 18-19, 20-24, 25-34, 35-44, 45 and over). This will provide a greater insight for those women aged 35 to 44 and 45 and over, who were previously banded together in one age group, as collected by the KT31.

Change to reporting of contacts per head of / percentage of population (likelihood of contact)

Historically, per head/percentage of population data was calculated using data for all ages. From this year we will no longer include an ‘all ages’ figure when reporting per head of population data, instead just reporting specified age groups, covering the range 13 to 54.

Time series tables in this report should be used for historical data rather than those previously published which are now superseded by this report.

Additional tables

The following additions/changes have been made to the data tables (please note there has also been some renumbering of existing tables from last year):

Table 3: Breakdown of location types has been added.

Table 4: New table showing the general reasons a person contacts an SRH service, by gender and age group.

Table 5: New table showing a more detailed breakdown of activities that take place during contacts with SRH services.

Table 8: New table showing contraception methods in use by contraception status (new method, change of method, maintain existing method).

Table 9b: New table showing how many women were provided emergency contraceptives by SRH services, as a proportion of the resident population.

Table 11: New table showing key measures by Index of Multiple Deprivation.

The local authority and provider level tables have been expanded to include the following:

Table 15/15a: Breakdown of location types has been updated to reflect the availability of data in the SRHAD collection. Emergency contraception information has been moved to table 18 (see below).

Table 16/16a: New table showing the number of women using services by age and percentage of resident population.

Table 17/17a: New table showing the breakdown of main methods of contraception in use.

Table 18/18a: New table showing emergency contraceptives provided, including rate per 1000 resident population, by age.

Table 19/19a: New table showing a more detailed breakdown of activities that take place during contacts with SRH services.

Table 20: New table showing cross boundary use of services across local authorities. This data is experimental and user feedback on the methodology and presentation is welcomed (see section 1.5).

Appendix C – OPCS Procedure codes used in this report

The following OPCS-4.6 codes classify vasectomy, vasectomy reversal, female sterilisation and female sterilisation reversal:

Procedure codes identifying vasectomies

N17.1 Bilateral vasectomy
N17.2 Ligation of vas deferens NEC
N17.8 Other specified excision of vas deferens
N17.9 Unspecified excision of vas deferens

Procedure codes identifying vasectomy reversals

N18.1 Reversal of bilateral vasectomy
N18.2 Suture of vas deferens NEC
N18.8 Other specified repair of spermatic cord
N18.9 Unspecified repair of spermatic cord

Procedure codes identifying female sterilisations

Q27.1 Open bilateral ligation of fallopian tubes
Q27.2 Open bilateral clipping of fallopian tubes
Q27.8 Other specified open bilateral occlusion of fallopian tubes
Q27.9 Unspecified open bilateral occlusion of fallopian tubes
Q28.1 Open ligation of remaining solitary fallopian tube
Q28.2 Open ligation of fallopian tube NEC
Q28.3 Open clipping of remaining solitary fallopian tube
Q28.4 Open clipping of fallopian tube NEC
Q28.8 Other specified other open occlusion of fallopian tube
Q28.9 Unspecified other open occlusion of fallopian tube
Q35.1 Endoscopic bilateral cauterisation of fallopian tubes
Q35.2 Endoscopic bilateral clipping of fallopian tubes
Q35.3 Endoscopic bilateral ringing of fallopian tubes
Q35.4 Endoscopic bilateral placement of intrafallopian implants
Q35.8 Other specified endoscopic bilateral occlusion of fallopian tubes
Q35.9 Unspecified endoscopic bilateral occlusion of fallopian tubes
Q36.1 Endoscopic occlusion of remaining solitary fallopian tube
Q36.2 Endoscopic placement of intrafallopian implant into remaining solitary fallopian tube
Q36.8 Other specified other endoscopic occlusion of fallopian tube
Q36.9 Unspecified other endoscopic occlusion of fallopian tube

Procedure codes to identify female sterilisation reversals

Q29.1 Reanastomosis of fallopian tube NEC
Q29.2 Open removal of clip from fallopian tube NEC
Q29.8 Other specified open reversal of female sterilisation
Q29.9 Unspecified open reversal of female sterilisation
Q37.1 Endoscopic removal of clip from fallopian tube
Q37.8 Other specified endoscopic reversal of female sterilisation
Q37.9 Unspecified endoscopic reversal of female sterilisation

Appendix D – Users and uses of the statistics

Department of Health (DH) and **Public Health England (PHE)** use these statistics to inform policy and planning.

The data supports the Government's Sexual Health Strategy objective to reduce unintended pregnancies. It also feeds into the Sexual and Reproductive Health Profiles produced by PHE which provide a suite of nationally agreed indicators at local authority level (http://fingertips.phe.org.uk/profile/sexualhealth), and into their local authority sexual health epidemiology reports (LASERs) which describe STIs, HIV and reproductive health in the local area.

Local authorities use these statistics in the planning and management of service delivery (commissioning) and for performance management. They can help forecast the demand for services and assist in planning how services will be delivered.

The information supports **NHS trusts** by providing a key source of sexual health information for public health and performance management. As set out in the 2009/10 NHS Operating Framework, services to reduce teenage pregnancy rates, including provision of a full range of contraceptive services, have a key role in keeping children well, improving their health and reducing health inequalities.

National Institute for Health and Clinical Excellence (NICE) used the data in cost effectiveness studies of Long Acting Reversible Contraceptives.

The statistics are used by the HSCIC to answer **Parliamentary questions**, **freedom of information requests**, and **ad-hoc queries**.

The statistics are used by the **media** to underpin various articles/journals etc. on matters of public interest. Examples of articles published using data from the 2013/14 report are:

Huddersfield Daily Examiner –
http://www.examiner.co.uk/news/west-yorkshire-news/calderdale-double-national-average-underage-8022054

Liverpool Echo –
http://www.liverpoolecho.co.uk/news/liverpool-news/girls-young-10-seeking-emergency-8160692

Daily Express –
http://www.express.co.uk/news/uk/593989/33-000-underage-girls-given-contraception

Daily Telegraph –
http://www.telegraph.co.uk/news/health/news/11763162/Tens-of-thousands-of-under-age-girls-given-long-acting-NHS-contraceptives.html

Daily Mail –
http://www.dailymail.co.uk/news/article-3175153/Contraceptive-implants-injections-girls-16-nearly-TRIPLED-past-decade.html

The report is free to access via the HSCIC website and therefore the majority of users will access the report without being known to the HSCIC. On the webpage where the report is surfaced there is a link to a feedback webform which the HSCIC uses for all its reports (http://www.hscic.gov.uk/haveyoursay). Responses received are passed onto the team responsible for this report, which are then considered during the design stage for the following year's publication.

Appendix E – Useful Links

For detail on the KT31 return please see:
http://www.hscic.gov.uk/datacollections/KT31

For detail on the SRHAD record level data please see:
http://www.hscic.gov.uk/datacollections/srhad

General NICE guidance:
https://www.nice.org.uk/guidance/conditions-and-diseases/fertility--pregnancy-and-childbirth/contraception

NICE LARC advice for main method of contraception:
https://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations

Governments Teenage Pregnancy Strategy 2010:
https://www.education.gov.uk/consultations/downloadableDocs/4287_Teenage%20pregnancy%20strategy_aw8.pdf

Advisory Group on Contraception (AGC) recommendations to NHS England 2014:
http://theagc.org.uk/wp-content/uploads/2013/08/Commissioning-high-quality-contraceptive-services-Recommendations-to-NHS-England-February-2014.pdf

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