NHS Contraceptive Services: England, Community Contraceptive Clinics

Statistics for 2013-14

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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 screening services.
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This is a National Statistics publication

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Executive Summary

This annual report primarily presents information on Sexual and Reproductive Health services (family planning clinics and clinics run by voluntary organisations such as Brook Advisory Centres) in England. It includes national and regional tables as well as tables by local authority and provider organisation.

Information on Sexual and Reproductive Health services excludes services provided in out-patient clinics and those provided by General Practitioners.

This has been collected since 1988/89 through the KT31 return, but since 2010/11 a quarterly attendance level collection known as Sexual and Reproductive Health Activity Dataset (SRHAD) has been running alongside the KT31 return. For this year’s publication, 14 organisations submitted full year data via KT31 and 133 organisations submitted SRHAD data.

The KT31 return ceased from 1 April 2014 and all providers were mandated to move to submitting SRHAD data. Therefore, there is an opportunity to improve the next version of this publication to exploit the richness of the attendance level SRHAD data, and feedback from users is required on some proposed changes which are detailed within this report.

Main Findings

During the period April 2013 to March 2014:

- There were 2.21 million contacts with Sexual and Reproductive Health services made by 1.34 million individuals. This represented a decrease of 2.2 per cent (49,844) on the number of contacts in 2012/13 (2.26 million), and a decrease of 0.9% (12,763) in individuals.

- The average number of contacts per individual during 2013/14 was 1.6 which is a decrease of 1.0% from 1.7 in 2012/13.

- 89.1 per cent (1.19 million) of individuals attending were women and 10.9 per cent (0.15 million) were men.

- 1.19 million women had at least one contact with a Sexual and Reproductive Health service, a decrease of 0.8 per cent (9,841) on the previous year. This represents 10.6 women per 100 resident population (or 10.6%) (based on the female population aged 13 to 44).

- Women aged 18 to 19 were most likely to use a service, with 21.9 per 100 population (21.9%) having at least one contact with a Sexual and Reproductive Health service.

1 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. This is also applicable when talking about number of first contacts.
NHS Contraceptive Services, England, 2013-14

- Oral contraceptives were the most common form of contraception in use, being the primary method for 47 per cent of women. They were the most common method in all age groups examined.

- The use of Long Acting Reversible Contraceptives (LARCs) as a primary method of contraception amongst women has been slowly increasing and in 2013/14 accounted for 31 per cent of all women making contact with Sexual and Reproductive Health services. This compares to 18 per cent in 2003/04. LARCs are non user-dependent methods of contraception and as such are not reliant on regular user adherence.

- The number of prescriptions dispensed for emergency contraceptives has been falling since 2000/2001 for both Sexual and Reproductive Health services and those dispensed in the community\(^2\) and is now less than half the value it was then. This fall could be due to the reclassification of EHC in 2001 which made it available for women aged 16 and over to buy EHC at pharmacies without a prescription\(^3\).

\(^2\) Prescription Cost Analysis data includes prescriptions dispensed in the community, ie. outside hospitals, and from a range of prescribers. It includes dispensed prescriptions written predominantly by GPs, and also includes prescriptions written by dentists, hospital doctors using FP10 forms and non-medical prescribers (eg. nurses, pharmacists, physiotherapists and optometrists).

Introduction

1.1 Background

The data used in this report has been collected since 1988/89 through the KT31 return, but since 2010/11 a quarterly attendance level collection known as the Sexual and Reproductive Health Activity Dataset (SRHAD) has been running alongside the KT31 return.

KT31 and SRAHD data covers services provided by:
- Sexual and Reproductive Health services including domiciliary visits and outreach.
- Brook Advisory Centres.

As such, 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 in the dataset.

Information on Sexual and Reproductive Health services excludes services provided in out-patient clinics and those provided by General Practitioners. Data on vasectomy and sterilisation procedures taking place in hospitals is taken from the HSCIC’s Hospital Episode Statistics (HES), and Prescription Cost Analysis data is obtained from the Prescribing team at the HSCIC.

Sexual and Reproductive Health Activity Dataset (SRHAD)

The Sexual and Reproductive Health Activity Dataset was implemented in April 2010 and mandates the collection of contraceptive activity data from sexual and reproductive health (SRH) services in a standardised attendance level data return. SRHAD is a quarterly record level electronic data extract and replaced the annual aggregate paper-based KT31 central return. Submission of KT31 was permitted up until the end of 2013-14 to allow services to implement the new arrangement.

The SRHAD data is collected on behalf of Public Health England and complements the Genitourinary Medicine Clinic Activity Dataset (GUMCADv2).

The KT31 return ceased from 1 April 2014 and all providers were mandated to move to submitting SRHAD data. Therefore, there is an opportunity to improve the next version of this publication to exploit the richness of the attendance level SRHAD data, and feedback from users is required on some proposed changes which are detailed within the this report.

Data for this year has been accepted via either the KT31 aggregated collection, or via the SRHAD record level dataset. For this year’s publication, 14 organisations submitted full year data via KT31 and 133 organisations submitted SRHAD data (although a small number did not submit data for the whole year – see table 15 for more details).

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4 Further details of the GUMCAD collection can be found on the PHE website at: https://www.gov.uk/genitourinary-medicine-clinic-activity-dataset-gumcadv2
KT31 data and SRHAD data are not collected on the same basis. KT31 is an aggregated dataset, collecting the total number of contacts, and information by gender, age and reason for the first contact only within the financial year. Changes in contraception method are not captured which was considered one of the limitations of the dataset. SRHAD includes an enhanced range of data, and is a record level dataset that captures all contacts at contraceptive clinics throughout the year. Therefore, all attendances for a particular person will appear in the dataset enabling all their interactions within a community contraceptive clinic to be reported.

KT31 data and SRHAD data are not compatible for organisations that returned part year data via each method as it is impossible to see whether those identified in SRHAD data have already been included in the KT31 data. Therefore, KT31 data is not used in this report for any organisation who switched to submitting SRHAD data during 2013/14. Instead, part year SRHAD submissions are scaled up to represent the picture for a full year (see Data Quality Statement for the methodology). For any organisations with scaled up SRHAD data, the figures therefore represent estimates (see table 15 for details of organisations submitting full and part year SRHAD data, and those who submitted KT31 data).

Not all the information collected via KT31 are available via SRHAD. Information on clinic sessions for people aged under 25 is not available, and as the majority of organisations are now returning data via SRHAD, this information is no longer presented.

Even though the data are collected on a different basis, the mapping and subsequent analysis of the SRHAD data are considered to make them comparable to the KT31 data, unless otherwise stated.

Full SRHAD coverage is expected to be achieved from 2014-15, at which point complete reporting from the SRHAD dataset will allow for additional analyses to take place, including more detailed reporting of all contacts. A small number of additional tables have already been added this year based on SRHAD only total contacts data, in order to encourage user feedback in advance of further changes (see data tables A and B in the excel annex). In addition Public Health England (PHE) have carried out some analysis of the SHRAD data for their Local Authority Sexual Health Epidemiology Reports (LASERs).

Whilst these reports are restricted to Local Authorities, the underlying data tables will be published jointly by HSCIC and PHE soon. Again we would encourage users to look at these analyses and offer feedback on their usefulness and whether they would like to see them included in future versions of this report.

Feedback is required from users on these tables as well as any other changes they would like to see. We are particularly interested in comments on:

- The additional SRHAD only tables A and B in the excel tables annex.
- The additional SRHAD only tables which will soon be jointly published by HSCIC and PHE.
- Which tables in the current report users would like to retain.
- Any new tables users would like to see added.
- Whether changing to a calendar year from a financial year basis for this report would cause problems for users. This would make the coverage period for this report consistent with reports issued by Public Health England on Contraception.
Please send any feedback to enquiries@hscic.gov.uk quoting “NHS Contraceptive Services” in the subject line.

Another point to note for future versions of this report is that it will be renamed to “Sexual and Reproductive Health Services, England YYYY” to reflect the fact that these services are now commissioned by local authorities rather than the NHS and there are now very few standalone contraceptive only services. Changes have been made to the text in this report to reflect this change. The excel annex tables have been left unchanged to avoid confusion but these will also change for the next version of this report.

1.2 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 validations conducted can be found in Appendix B of the Data Quality Statement.

Despite validation processes, there remain some known quality issues with the data. It can occasionally show large variations to that submitted in the previous year. These will be addressed as the SRHAD data becomes the sole source of data for this report.

More detailed information on known data quality issues can be found in the Data Quality statement.

1.3 Changes to the Report

Some changes have been made to the tables in the report to improve them and to make them consistent with the coverage of the SRHAD dataset. It is worth doing this now as the majority of providers have moved to submitting SRHAD data which is creating discontinuities in time series tables due to the differences in coverage between SRHAD and KT31. Therefore the time series tables in this report should be used for historical data rather than those previously published which are now superseded by this report.

Specifically, a new table 1A has been added to the report and it is intended to replace table 1 from the 2014/15 report onwards.

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5 YYYY will be either 2014/15 or 2015 depending on whether the report remains on a financial year basis or switches to a calendar year.
Regional reporting

As SHAs ceased to exist from 1st April 2013, regional data (presented in tables 5A to 5J and 12) are now derived from upper tier LA of residence and shown as LA regions. This is a change from previous reports where regional data was derived based on the SHA of the providing organisation. Tables 13 and 14 will continue to be presented by provider, but additionally by upper tier LA of residence.

Additional tables – Annex

Two additional tables have been added within the excel tables annex, as part of a move to more fully utilise the more detailed SRHAD data, and in response to previous user comments. Feedback on the usefulness/appropriateness of these new tables is welcomed. As these tables only include data submitted via SRHAD, they do not represent full coverage.

Table A has been added which represents a breakdown of all female contacts, broken down by age and general reason for contact. The age bands used are those that are proposed to be used throughout the publication from 2014-15.

Table B has been added which represents a breakdown of all contacts where a method of contraception was provided, broken down by contraception method status (new, change or maintain).

1.4 User Feedback

The Health and Social Care Information Centre welcomes feedback on all publications. If you wish to comment on this report a feedback form (Have Your Say) is available on the HSCIC website at: http://www.hscic.gov.uk/haveyoursay

We would be particularly interested in how you use the statistics in this report.

As previously stated, we are looking to make further changes to this report for future years and would welcome your feedback on this. See the end of section 1.1 for more details.
Analysis and Commentary

Sexual and Reproductive Health services and types of contraception

2.1 Overall contacts

There were 2.21 million contacts with Sexual and Reproductive Health services made by 1.34 million individuals\(^6\) (first contacts in year) in 2013/14. This represented a decrease of 2.2 per cent (49,844) on the number of contacts in 2012/13 (2.26 million) and a decrease of 10.5 per cent (259,987) on the number of contacts in 2011/12 (2.47 million). It also represented a decrease of 0.9% (12,763) in the number of individuals attending Sexual and Reproductive Health services.

The average number of contacts per individual during 2013/14 was 1.6 which is a decrease of 1.0% from 1.7 in 2012/13.

89.1 per cent (1.19 million) of individuals attending in 2013/14 were women and 10.9 per cent (0.15 million) were men (see figure 1).

Figure 1: Contacts with Sexual and Reproductive Health services
England, 2003/04 to 2013/14

*Data for individuals represents only the first contact in the year
Source: KT31/SRHAD, Health and Social Care Information Centre

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\(^6\) 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. This is also applicable when talking about number of first contacts.
Contacts by location

Although the majority of contacts with Sexual and Reproductive Health services in 2013/14 took place in the service location or a voluntary clinic (97.3%), a small number occurred in educational locations (1.2%) or as domiciliary visits (0.2%) (see table A).

Sexual and Reproductive Health services have traditionally provided domiciliary services to immobile individuals such as those with physical or learning difficulties. 'Domiciliary visits' may now also include outreach services for vulnerable groups such as teenage mothers, youth offenders and sex workers.

Table A: Number of contacts with Sexual and Reproductive Health services by location

<table>
<thead>
<tr>
<th>England, 2013/14</th>
<th>Thousands and Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td><strong>Thousands</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,208.3</td>
</tr>
<tr>
<td>Sexual and Reproductive Health Services</td>
<td>2,029.4</td>
</tr>
<tr>
<td>Voluntary</td>
<td>119.1</td>
</tr>
<tr>
<td>Domiciliary visit</td>
<td>4.9</td>
</tr>
<tr>
<td>Education</td>
<td>26.6</td>
</tr>
<tr>
<td>Other location*</td>
<td>28.3</td>
</tr>
</tbody>
</table>

*Includes prisons, public places and unspecified locations  
Source: KT31/SRHAD, Health and Social Care Information Centre
2.2 Women in contact with Sexual and Reproductive Health services

Likelihood of contact

In 2013/14, 1.19 million women had at least one contact with Sexual and Reproductive Health services, a decrease of 0.8% (9,841) on the previous year. This represents 10.6 women per 100 resident population (or 10.6%) (based on the female population aged 13 to 44).

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

Women aged 18 to 19 were most likely to use a service, with 21.9 per 100 population (21.9%) having at least one contact with Sexual and Reproductive Health services in 2013/14.

10.8 per 100 population (10.8%) of women aged 15 and 3.0 per 100 population (3.0%) of women aged under 15 (based on the female population aged 13 and 14) had at least one contact in 2013/14.

Figure 2: Women in contact with Sexual and Reproductive Health services, rate per 100 resident population, by age

England, 2013/14

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rate per 100 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>10.8</td>
</tr>
<tr>
<td>Under 15</td>
<td>3.0</td>
</tr>
<tr>
<td>All ages *</td>
<td>10.6</td>
</tr>
<tr>
<td>15</td>
<td>10.8</td>
</tr>
<tr>
<td>16-17</td>
<td>18.9</td>
</tr>
<tr>
<td>18-19</td>
<td>21.9</td>
</tr>
<tr>
<td>20-24</td>
<td>17.4</td>
</tr>
<tr>
<td>25-34</td>
<td>9.0</td>
</tr>
<tr>
<td>35 and over *</td>
<td>6.6</td>
</tr>
</tbody>
</table>

*All ages based on the female population aged 13 to 44; Under 15 based in the female population 13 and 14; 35 and over based on the female population 35 to 44
Source: KT31/SRHAD, Health and Social Care Information Centre

Reason for contact

76.2 per cent of women making their first contact with a Sexual and Reproductive Health service in 2013/14 did so in relation to the provision of a non-emergency contraception method. 11.9 per cent received advice only, 0.9 per cent emergency contraception only
and 11.0 per cent attended for reasons other than contraception (see figure 3 and table B).

Women over 35 were the most likely to attend for reasons other than contraception (17.7%).

Younger women were more likely to attend for emergency contraception only than older women. 1.6 per cent of those under 15 and 1.5 per cent of those aged 15 did so for their first contact compared to 0.5 per cent of those aged over 35.

Figure 3: Female first contacts with Sexual and Reproductive Health services by reason for contact and age
England, 2013-14

* All ages includes a small number of contacts where age was not recorded
Source: KT31/SRHAD, Health and Social Care Information Centre
Primary methods of contraception

All data on primary method of contraception is based on a person’s first contact with that service provider in the financial year only. Women attending community contraceptive clinics for pre-conception advice only or to seek advice on other matters (e.g. cervical screening) are excluded from the analyses in this section.

In 2013/14, user dependent methods\(^7\) of contraception accounted for around two thirds (66.6\%) of primary methods, though their use has fallen from 75 per cent in 2003/04 (see figure 4).

The use of Long Acting Reversible Contraceptives (LARCs)\(^8\) as a primary method of contraception amongst women has been slowly increasing. In 2013/14 they accounted for 31 per cent of all women making contact with Sexual and Reproductive Health services for the first time in the year. This compares to 18 per cent in 2003/04. LARCs are non user-dependent methods of contraception and as such are not reliant on regular user adherence.

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\(^7\) User dependent methods consist of oral contraceptives, male condom, female condom and the contraceptive patch.

\(^8\) LARCs consist of Inter-Uterine Devices (IUD), Intra Uterine System (IUS) injectable contraceptive and implants.
The proportion of women using user dependant methods was highest in the younger age groups, 79.2 per cent of those aged under 15, decreasing with age to 53.8 per cent of those aged 35 and over (see figure 5).

User dependant methods include oral contraceptives, which were the most common form of contraception in use, being the primary method for 47 per cent of women. (Oral contraceptives are also available via other sources not included in this report, for example a GP). They were the most common method in all age groups examined (see table C).

The male condom was the 2nd most common, with 18.2 per cent choosing this method.

Male condom was used most widely amongst the youngest age group, being provided to 36.2 per cent of females aged under 15.

The percentage of women choosing LARCs as a primary method of contraception increases with age, from 18.5 per cent of those aged under 15, to 43.3 per cent of those 35 and over (see figure 5).

Implants are the most common type of LARC in use, accounting for 12.9 percent of all contraceptive methods. The use of IU devices and IU systems increases with age with 9.0 per cent of those aged 35 and over using IU devices as their primary method of contraception for their first contact, and 17.5 per cent using an IU system. This compares to 0.2 per cent of those aged under 15 using an IU device with a further 0.2 per cent using an IU system (see table C).

9 “Other” consists of vaginal ring, cap/diaphragm, other chemicals such as spermicides but only when used on their own, natural family planning and emergency contraception.
Figure 5: Primary method of contraception for women in contact with Sexual and Reproductive Health services by age (first contact in year)

England, 2013/14

*Other methods consists of vaginal ring, cap/diaphragm, other chemicals such as spermicides but only when used on their own, natural family planning, and emergency contraception.

Source: KT31/SRHAD, Health and Social Care Information Centre

Table C: Primary method of contraception for women in contact Sexual and Reproductive Health services by age (first contact in year)

England, 2013/14

<table>
<thead>
<tr>
<th>Primary Method</th>
<th>All ages 1</th>
<th>Under 15</th>
<th>15</th>
<th>16 to 17</th>
<th>18 to 19</th>
<th>20 to 24</th>
<th>25 to 34</th>
<th>35 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>All methods</td>
<td>920.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>LARCs total</td>
<td>31.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IU devices</td>
<td>4.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.5</td>
<td>0.9</td>
<td>2.4</td>
<td>6.7</td>
<td>9.0</td>
</tr>
<tr>
<td>IU system</td>
<td>4.9</td>
<td>0.2</td>
<td>0.3</td>
<td>0.4</td>
<td>0.8</td>
<td>1.7</td>
<td>4.9</td>
<td>17.5</td>
</tr>
<tr>
<td>Injectable contraceptive</td>
<td>8.9</td>
<td>5.6</td>
<td>8.0</td>
<td>9.4</td>
<td>10.2</td>
<td>9.6</td>
<td>8.7</td>
<td>7.5</td>
</tr>
<tr>
<td>Implant</td>
<td>12.9</td>
<td>12.4</td>
<td>13.1</td>
<td>13.9</td>
<td>13.9</td>
<td>13.6</td>
<td>13.6</td>
<td>9.4</td>
</tr>
<tr>
<td>User dependant methods total</td>
<td>66.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>47.0</td>
<td>41.7</td>
<td>45.7</td>
<td>50.1</td>
<td>53.5</td>
<td>54.2</td>
<td>45.0</td>
<td>32.6</td>
</tr>
<tr>
<td>Male condom</td>
<td>18.2</td>
<td>36.2</td>
<td>29.2</td>
<td>22.9</td>
<td>17.2</td>
<td>14.4</td>
<td>16.9</td>
<td>20.6</td>
</tr>
<tr>
<td>Female condom</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Contraceptive patch</td>
<td>1.3</td>
<td>1.2</td>
<td>1.3</td>
<td>1.6</td>
<td>1.7</td>
<td>1.6</td>
<td>1.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Other methods</td>
<td>2.4</td>
<td>2.3</td>
<td>2.2</td>
<td>1.9</td>
<td>1.8</td>
<td>2.1</td>
<td>2.8</td>
<td>2.9</td>
</tr>
</tbody>
</table>

1Includes a small number of contacts where age was not recorded.

*Other methods consists of vaginal ring, cap/diaphragm, other chemicals such as spermicides but only when used on their own, natural family planning, and emergency contraception.

Source: KT31/SRHAD, Health and Social Care Information Centre
Emergency contraception (post-coital)

Emergency (post-coital) contraception was dispensed on prescription on 332,660 occasions in 2013/14. Just over a third (35.5%) were dispensed by Sexual and Reproductive Health services, and the remainder at other locations in the community (see section 2.4 for inclusions in community prescribing data). Emergency (post-coital) hormonal contraceptive pills, otherwise known as Emergency Hormonal Contraception (EHC), can also be purchased over the counter without a prescription.

Emergency contraception was provided on 117,978 occasions by Sexual and Reproductive Health services in 2013-14, down from 132,020 occasions in 2012-13 (a decrease of 10.6%).

The number of prescriptions dispensed for emergency contraceptives has been falling since 2000/2001 (see figure 6). This fall could be due to the reclassification of EHC in 2001 which made it available for women aged 16 and over to buy EHC at pharmacies without a prescription\(^{10}\). Data is not collected centrally for cases of women using EHC. In addition, nurses and pharmacists can supply EHC to women of all ages under a Patient Group Direction (PGD). 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. Most emergency contraception issued by Sexual and Reproductive Health Services was for the hormonal pill method (95%).

**Figure 6: Number of prescriptions for emergency contraception at Sexual and Reproductive Health services and by community pharmacists**

England, 1997/98 to 2013/14

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\(^{11}\) Prescription Cost Analysis data includes prescriptions dispensed in the community, i.e. outside hospitals, and from a range of prescribers. It includes dispensed prescriptions written predominantly by GPs, and also includes prescriptions written by dentists, hospital doctors using FP10 forms and non-medical prescribers (eg. nurses, pharmacists, physiotherapists and optometrists).
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 a main procedure has been falling steadily, from approximately 40,500 in 1997/98 to 8,904 in 2012/13 (the latest year that HES data is available at the time of publication) (see table 1 in the data tables).

Sterilisations can also be performed as a secondary procedure. There were 5,909 sterilisations recorded as a secondary procedure in 2012/13 giving a total of 14,813 sterilisations in 2012/13.

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

2.3 Men attending Sexual and Reproductive Health services

Likelihood of contact

146,268 men had at least one contact with Sexual and Reproductive Health services in 2013/14, representing 1.3 men per 100 resident population (or 1.3%) (based on the male population aged 13 to 44 - see table 2 in the data tables).

Reason for contact

59.5 per cent (86,969) of first contacts in 2013/14 were for the male condom, with 9.9 per cent (14,514) for pre-contraception advice only, and 30.6 per cent (44,761) for reasons other than contraception (the latter includes sexual health advice, psychosexual therapy and vasectomy procedures performed by Sexual and Reproductive Health services).

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 community contraceptive clinics to show how many vasectomies were performed in total in a year. The latest HES data is for 2012/13 as data for 2013/14 are not available at the time of publication.

The number of vasectomies being performed fell to 14,142 in 2012/13, from 17,138 in 2011/12 and 30,164 in 2006/07 (see figure 7). Most vasectomies are performed in hospital as either day cases (i.e. in hospital and using a bed, but not requiring an overnight stay) (9,619 in 2012/13), or on a small number of occasions as an inpatient stay (331). The remainder (4,192) were reported as occurring in community contraceptive clinics, or other out-patient clinics (see table 1A in the data tables).
Figure 7: Number of vasectomies performed in NHS hospitals and Sexual and Reproductive Health services

England, 1997/98 to 2013/14

N.B. HES data includes vasectomies performed as main or secondary procedures.
Source: HES and KT31/SRHAD, Health and Social Care Information Centre

The vasectomy figures incorporated into table 1 of the data tables, show a longer time series, but only include HES data where a vasectomy was performed as a main procedure. The data does however illustrate the longer term trend in the fall in the number of vasectomy procedures.

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

2.4 Prescriptions for contraceptives dispensed in the community

Contraception prescription 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 (i.e. by community pharmacists and appliance contractors, dispensing doctors, and prescriptions submitted by prescribing doctors for items personally administered in England). Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. The data do not cover drugs dispensed in hospitals, including mental health trusts, or private prescriptions. It includes prescriptions dispensed in the community, i.e. outside hospitals, and from a range of prescribers. It includes dispensed prescriptions written predominantly by GPs, and also includes prescriptions written by dentists, hospital doctors using FP10 forms and non-medical prescribers (e.g. nurses, pharmacists, physiotherapists and optometrists). Each single item written on the form is counted as a prescription item. The number of women receiving each contraception method cannot be derived from the number of prescriptions dispensed in this data.

Prescriptions for Long Acting Reversible Contraceptives (LARCs) have increased steadily from 0.70 million in 1997/98 to 1.32 million in 2013/14. During the same period
prescriptions for user dependent methods have remained more stable over the same time period and were 7.5 million in 2013/14 (see table 11 in the data tables).

2.5 Regional summary

Regional data has been derived from LA of residence for those records who submitted a valid LSOA code in their SRHAD data.

There are regional variations in the likelihood of women making contact with NHS community contraceptive clinics. North West had the highest rate, with 15.6 per 100 resident population (based on the female population aged 13 to 44) and East of England had the lowest rate with 7.0 per 100 resident population (see figure 8).

Figure 8: Women in contact with Sexual and Reproductive Health services, rate per 100 resident population, by region
England, 2013/14

N.B: For the purpose of the analysis shown in Figure 8 regional figures from KT31 submissions were derived from the location of the providing organisation, and therefore represent estimates. Refer to section 1.3 (regional reporting) for more details. Data excludes 66,073 SHRAD records (3.2% of the total) where the person’s residence was unknown or they were resident outside of England.

Source: KT31/SRHAD, Health and Social Care Information Centre

Nationally, 66.6 per cent of women’s primary method of contraception was one of the user dependent methods. Regionally this varies from 57.8 per cent (East Midlands) to 69.7 per cent (South East). For LARCs it ranges from 27.3 per cent (London) to 39.9 per cent (East Midlands) (see table 12 of the data tables).

2.6 Local Authority / Provider level data

Selected information about Sexual and Reproductive Health services for each upper tier local authority and service provider is shown in data tables 13, 13a, 14 and 14a, including summary counts of all and first contacts, occasions that emergency contraception prescribed and a breakdown of the reasons for the contact.
Some organisations return their data through a nominated organisation. Organisations shown in tables 13a and 14a are not necessarily the only organisations providing community contraceptive services. Refer to table 15 for a list of organisations who returned data in 2013/14.

2.7 National comparisons

The Welsh Assembly Government produces their own statistics on NHS contraceptive services for Wales. These statistics are comparable. The latest information can be found in NHS Community Contraceptive Services, 2012-13 which was released on 13th November 2012 and can be found at the following link:

Statistics for Scotland are produced by Information Services Division of NHS National Services Scotland. There is no comparable data for 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/

2.8 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
0.0 less than 0.05

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; the relevant table / figure reference is given in the discussion around each table. For data where no table is presented in this document, a reference to the Excel data tables is provided in the relevant section of text.
Appendices

Appendix A – Definitions

A **contact** is defined in the KT31 as “…a client is seen by professional staff for counselling or in order to be prescribed contraceptives...”. 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.

A contact includes all face to face contacts with the service, whether at the clinic or other locations recorded on the KT31/SRHAD. Non face to face contacts (e.g. by telephone) are not currently included in the dataset but there are plans to extend the SRHAD dataset to included non face to face contacts during 2015.

A **first contact** is the first time a client is seen in the financial year by the Sexual and Reproductive Health service. For KT31, subsequent contacts with the same provider are not recorded, so that each client is only recorded once in any year. The count of first contacts is broadly the number of different persons seen in the course of the year. A person attending for a number of years will be counted as a first contact in each of those years.

All contacts are included in the SRHAD dataset but the equivalent of a first contact can be established. This is done by identifying all contacts for a particular individual and only including the first contact in any subsequent analysis of first contact data. Multi-site services, without a master patient index should ensure all patients on first contact to a service are asked if they have attended another site in the current financial year to limit ‘double-counting’ of first contact in financial year.

The **primary 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 primary methods. To ensure consistency in reporting, the main method for new clients should be the substantive method chosen and given after a first contact consultation.

Where a couple are seen together only one first 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.
Appendix B – Changes to report

Time Series

Some changes have been made to tables containing time series to make them consistent with the coverage of the SRHAD dataset. It is worth doing this now as the majority of providers have moved to submitting SRHAD data which is creating discontinuities in time series tables due to the differences in coverage between SRHAD and KT31. Therefore the time series tables in this report should be used for historical data rather than those previously published which are now superseded by this report.

Regional reporting

As SHAs ceased to exist from 1\textsuperscript{st} April 2013, regional data (presented in tables 5A to 5J and 12) are now derived from upper tier LA of residence and shown as LA regions. This is a change from previous reports where regional data was derived based on the SHA of the providing organisation. Tables 13 and 14 will continue to be presented by provider, but additionally by upper tier LA of residence.

LA of residence has been derived from the Lower Super Output Area (LSOA) of residence in SRHAD. In 3.2 per cent of SRHAD cases an English LA could not be derived. This was mainly due to the LSOA being recorded as unknown (56,455 contacts) with the remaining 9,329 contacts being due to either an invalid LSOA being submitted or because the person was resident outside of England.

It is not possible to determine LA of residence from data provided by the organisations that submitted via the KT31 (representing 140,743 contacts – 6.4\% of the total), and so this data has not been allocated to an LA or a region in tables 5A to 5I, 13 and 14. The impact across regions was disproportionate, with 44 per cent of all KT31 contacts submitted from providers based in the Yorkshire & Humber region and 34 per cent from providers based in the East of England region. As such, for table 12, where contacts per head of population are reported, it was necessary to allocate KT31 data to a region to avoid presentation of misleading data. This has been done based on the location of the providing organisation, and as such only represents an estimate, as some attenders may have travelled across regional boundaries from their place of residence.

A revised version of the SRHAD return, due to be implemented during 2015, will include LA of residence as a required data item which is submitted by the data provider. Therefore, the LA of residence will not need to be derived from the LSOA.

All KT31 and SRHAD data is still included in England and provider level analysis.

Provider reporting

Changes in how services are delivered can affect local time series data – the number of organisations that return contraception data varies each year as a result of any restructuring. The move of the responsibility of contraceptive services from one organisation
to another can result in the figures being reported against a different provider to previously in tables 13A and 14A – the data are presented according to the returning organisation each year so changes in responsibility will need to be considered when interpreting local results. Table 15 contains information on the organisations that returned data.

Sterilisations and vasectomies

The KT31 return included sterilisation and vasectomies as a method of contraception based on first contact. The SRHAD collects data on the services provided to the patient for each attendance. 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. Sterilisations and vasectomies are therefore no longer included in analysis of primary contraception methods (previously reported under ‘other methods’), but are reported alongside hospital data in table 10.

Time series data back to 2011/12 has been amended to exclude sterilisations and vasectomies procedures from all contraception method data (including KT31). This will create a time series break in 2011/12 but does mean that all data from then is comparable.

For Table 8, which has a column reporting first contact vasectomies only, the time series will be discontinued from 2010/11. From that time it represents a false decline in volume due to the SRHAD data only including those taking place at community contraceptive clinics, unlike KT31 which also included outpatient clinic procedures. Vasectomy time series data will continue to be reported in Table 1 where it is combined with HES data to provide a more complete dataset.

For Table 1, statistics for female sterilisations and outpatient & community contraceptive clinic vasectomies now includes outpatient data from HES (for organisations not submitting KT31 data). Time series data has been adjusted back to 2010/11 based on this revised approach.

Table 10 data now also includes HES sourced outpatient sterilisations and vasectomies for the reasons mentioned previously.

Emergency contraception only

In all tables where method of contraception is presented, an additional breakdown of ‘emergency contraception only’ is shown. Within KT31 data this was previously reported in ‘other methods’ whilst the data was excluded entirely from those submitting via SRHAD since 2011/12, creating a mix of data. Time series data in tables 1, 2 and 3 has been amended back to 2011/12, in order that ‘emergency contraception only’ from SRHAD is included. For table 3 there is a break in time series, with ‘emergency contraception only’ remaining within ‘other methods’ prior to that date. As stated earlier, tables in this report containing time series data supersede those previously published for historical values.
**Table 1A**

This table is proposed to replace Table 1 from 2014-15. Survey data on contraceptive use has been removed as this has not been available since 2008-09. Detailed results from this survey are available from the ONS website: [http://www.ons.gov.uk/ons/rel/lifestyles/contraception-and-sexual-health/2008-09/index.html](http://www.ons.gov.uk/ons/rel/lifestyles/contraception-and-sexual-health/2008-09/index.html)

The number of clinic attendances has been replaced with total contacts, to include contacts that take place away from a clinic (e.g. domiciliary visits). The reporting of women using the contraceptive pill and male condom has been replaced with women using LARCs and user dependant methods (including as a percentage of first contacts).

SRHAD only records vasectomy procedures taking place at community clinics, unlike KT31, which also included outpatient clinic vasectomy procedures. As such, vasectomy data from outpatients and community contraceptive clinics will be shown on separate rows from 2013/14, with the time series for outpatients and community clinic vasectomy procedures ending. Going forward, outpatient vasectomies will be extracted from Hospital Episode Statistics (HES) and community contraceptive clinic vasectomies from SRHAD. Emergency contraception data is reported in thousands rather than millions to provide greater detail.

Additionally, all HES sourced data from 2008/09 has been updated to include secondary procedures as well as primary procedures. This includes hospital in-patients, hospital day cases and hospital outpatients, providing a more complete data set, which is also consistent with the methodology used for Table 10.

**Table 13**

Data for first female contacts and emergency contraception has been broken down into ‘under 16’ and ‘16 and over’ age groups. Total contacts cannot yet be broken down by age group until full compliance with SRHAD, as an age breakdown is not captured in KT31.

**Additional tables – Annex**

Two additional tables have been added within the excel tables annex, as part of a move to more fully utilise the more detailed SRHAD data, and in response to previous user comments. Feedback on the usefulness/appropriateness of these new tables is welcomed. As these tables only include data submitted via SRHAD, they do not represent full coverage.

**Table A** has been added which represents a breakdown of all female contacts, broken down by age and general reason for contact. The age bands used are those that are proposed to be used throughout the publication from 2014-15.
Table B has been added which represents a breakdown of all contacts where a method of contraception was provided, broken down by contraception method status (new, change or maintain).
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 – KT31 and SRHAD returns

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