

#### **Next Chapter**

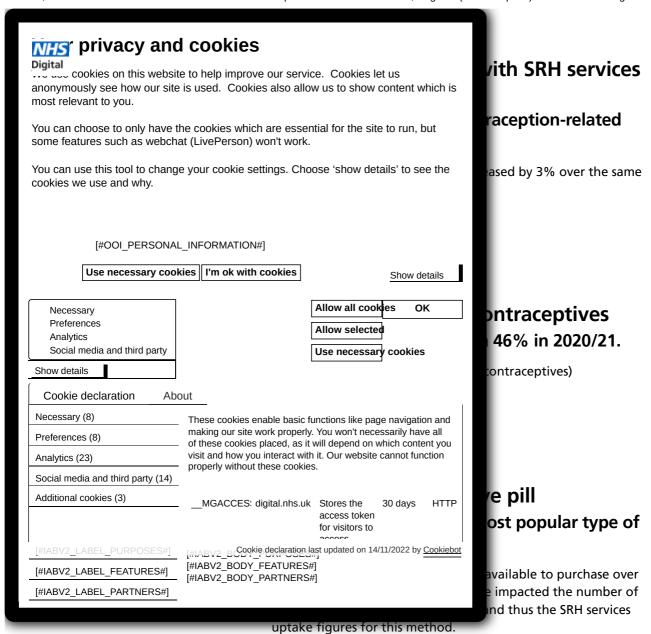
Introduction

## **Summary**

This publication primarily covers contraceptive activity taking place at dedicated Sexual and Reproductive Health (SRH) services in England, as recorded in the Sexual and Reproductive Health Activity Dataset (SRHAD), a mandated collection for all providers of NHS SRH services. Data from GP settings and pharmacies is not included (unless otherwise stated). People attend SRH services for a variety of reasons, but the main focus of this report is contraception.

Latest available year of data is 2021/22 unless otherwise stated.

Data is for SRH services only unless otherwise stated.

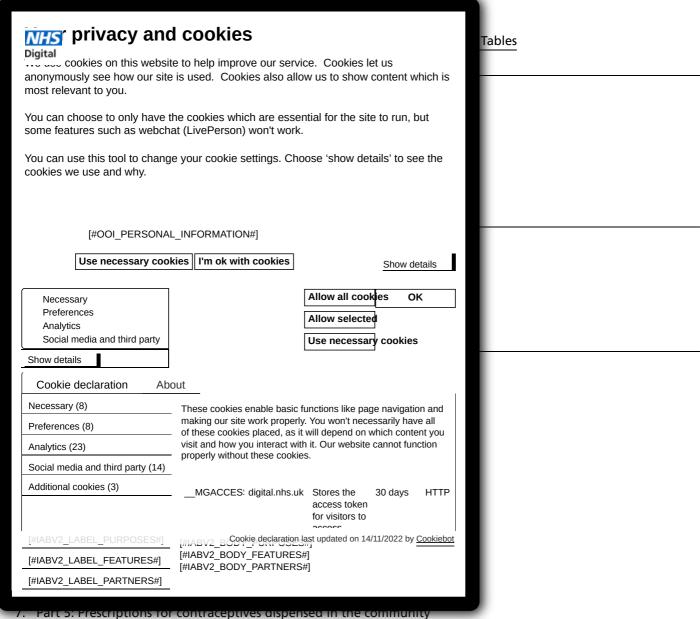


# 32% fewer emergency contraceptive items provided by SRH services compared to 2019/20 (pre-Covid pandemic)

Over the last ten years, there has been a steady decline in the number of emergency contraception items provided by both SRH services and at other locations in the community.

#### Give us your feedback on this publication

We'd love to know what you think of this publication, including how you use it, and any ideas for improvement



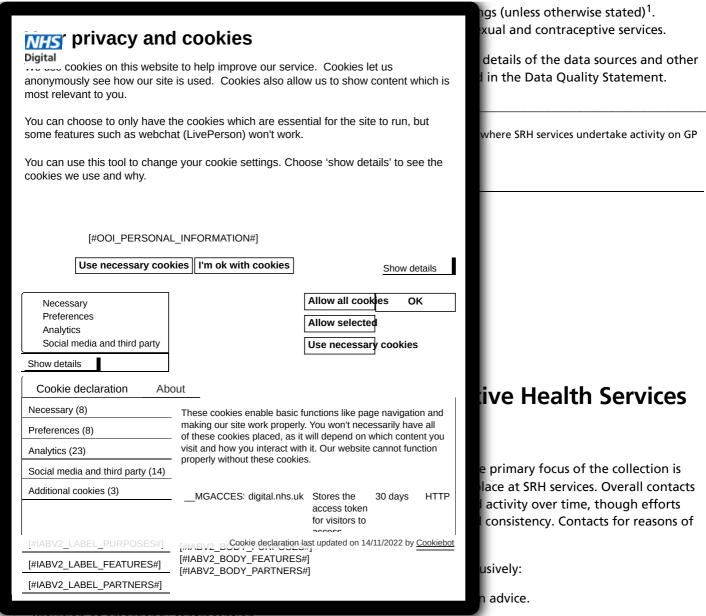
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- 8. Data quality statement
- Appendices
- 10. Author, Copyright and Licensing

## Introduction

This publication primarily covers contraceptive activity taking place at dedicated Sexual and Reproductive Health (SRH) services in England, as recorded in the Sexual and Reproductive Activity Dataset (SRHAD). 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. They provide a range of services including, but not exclusively, contraception provision and advice. A limited amount of data is presented from other sources; sterilisations and vasectomies in NHS hospitals (see part 4) and contraceptives dispensed in the community (see parts 3 and 5).

The primary focus of the SRHAD collection is contraception. Though a summary of other types of activity is collected, only contraception information is covered in detail, and this is reflected in the content of this report. SRHAD may not capture all non-contraception related activity taking place at SRH services.

Please note, the publication does not represent all ways in which a person may access contraceptive services. For example, it excludes services provided in hospital out-patient clinics and those provided by GPs as well as



- Provision of emergency contraception.
- Removal of contraception devices.
- Sexual health advice and STI care.
- · Pregnancy or abortion related issues.

For non-contraceptive activity taking place at SRH services, SRHAD only includes summary data. More detailed data on services relating to Genitourinary Medicine, is collated by the UK Health Security Agency:

https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

A contact is defined as a contact with the service, including external contacts, i.e. where an individual patient receives care outside the clinic setting, for example in his or her own home. Non-face to face contacts were added to the scope in version 2 of SRHAD from 2015/16.

# Overall contacts with Sexual and Reproductive Health Services

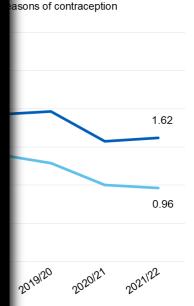
### Contacts by year

In 2021/22, there were 1.62 million contacts with dedicated SRH services made by 0.86 million individuals. This was an increase of 3% compared to the number of contacts in 2020/21 (1.58 million).

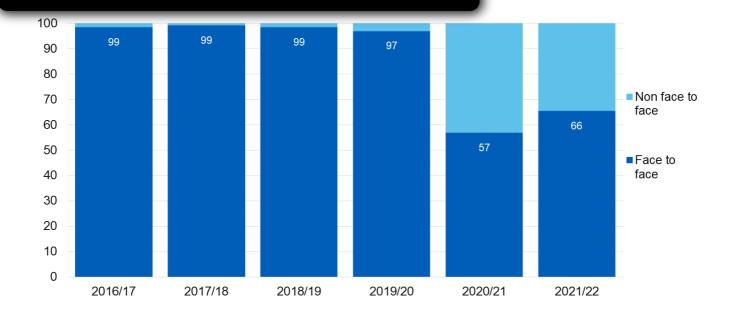
The number of contacts per year has fallen 34% since 2011/12 (when there were 2.47 million). Changes over time may be affected by variation in the way services record the non-contraception related activity included in this

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4% compared to 2020/21 (1 million), or to 2014/15 due to differences in

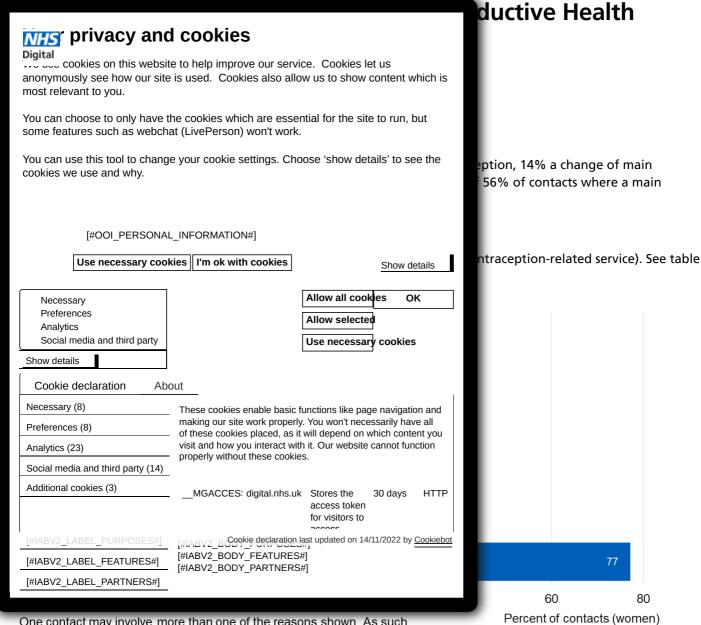


re added to the scope in version 2 of annual contacts (between 1 and 3%). of Covid related lockdown, this ace at a clinic.



For more information: Data tables 1 and 3

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

- 1. Contacts where one or more forms of emergency contraception were provided.
- 2. Contacts involving one or more other activities.

## Reason for contact by males

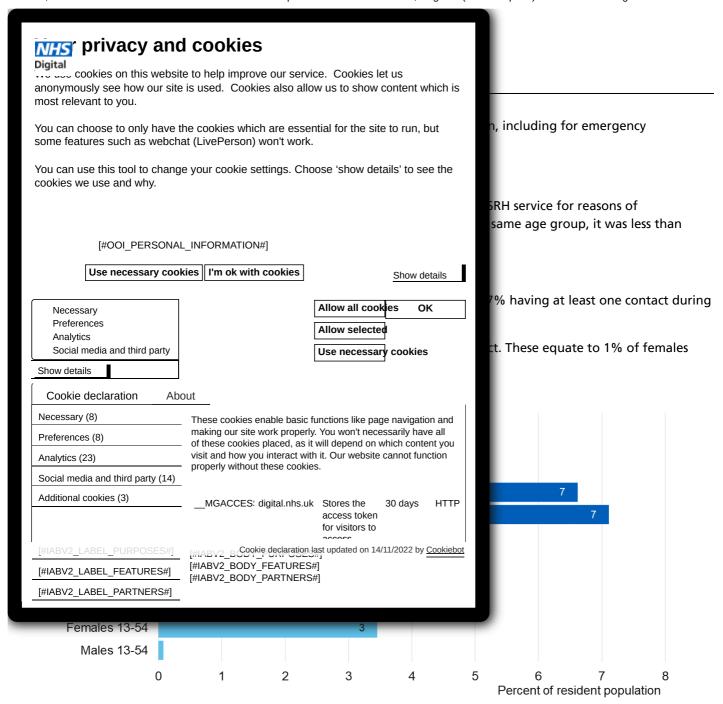
20% of all contacts with SRH services were by males (318 thousand contacts).

3% of male contacts involved the supply/maintenance of a main method, and 3% pre-contraception advice.

99% involved other activities (whether with or without a contraception-related service).

For more information: Data tables 4 and 5

# Likelihood of contact with an SRH service (for reasons of contraception)

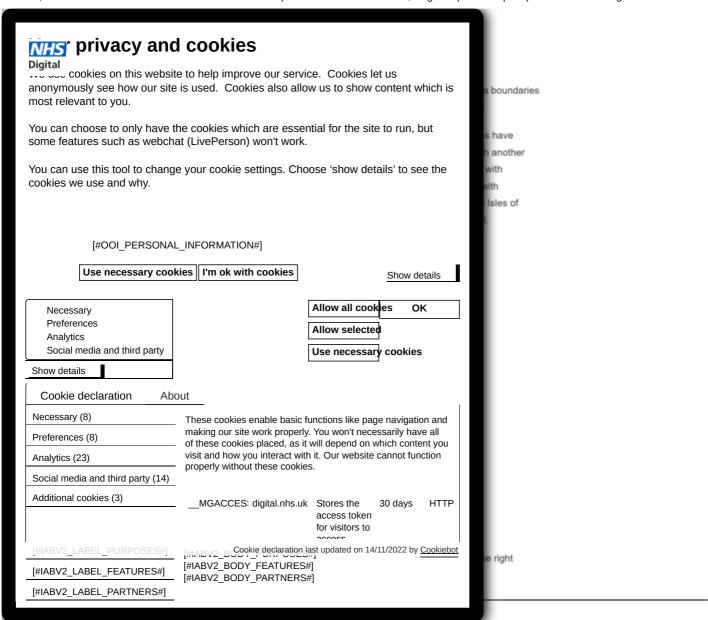


# Likelihood of contacts for reasons of contraception by females (aged 13 to 54), by Local Authority (LA) of patient residence

The likelihood of a female using an SRH service for reasons of contraception will be influenced by the availability of such services in their area of residence.

The proportion of the female population (aged 13 to 54) that used a service for reasons of contraception, was highest in Blackpool (11%), St. Helens, Hackney & City of London, and Lewisham (all 10%).

Note: As population estimates are not yet available for the 2 new LA's of North Northamptonshire and West Northamptonshire, these LAs are shown as blank on the map. Counts of females attending for these LAs can be found in table 16a.



Across LAs, up to 29% of 18-19 year olds used a service for reasons of contraception, and up to 25% of 20-24 year olds, though there was a large amount of variation. See data table 16a for a full set of data by age group.

For more information: Data tables 2a, 2b and 16a.

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**Previous Chapter** 

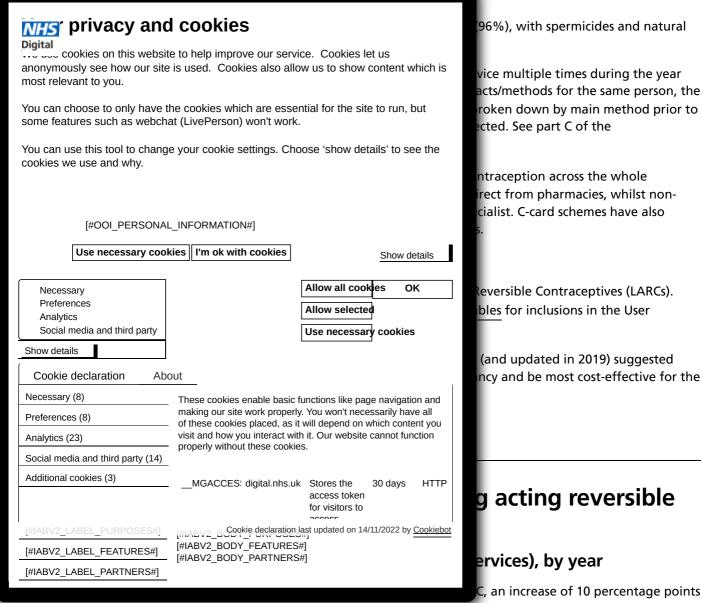
Introduction

**Next Chapter** 

Part 2: Methods of contraception

# Part 2: Methods of contraception Introduction

Analysis of uptake in this part relates to females using SRH services only (female and male attending together will be recorded as a female contact), and just those for whom a method of contraception was recorded during the year; this

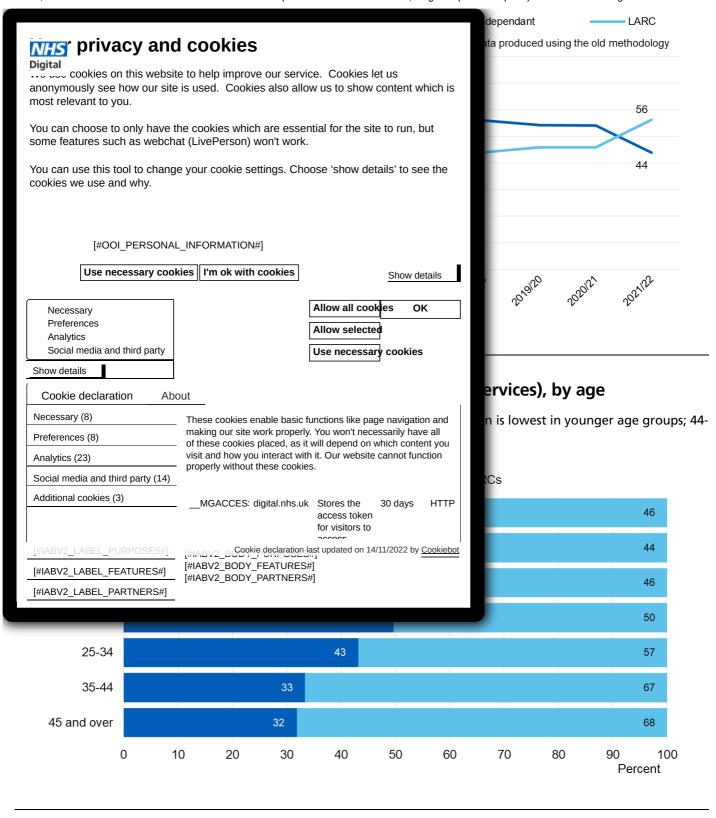


from 46% in 2020/21. The remaining 44% had a user dependent main method.

Over the last ten years, LARC uptake has been increasing and uptake of user dependent methods has been decreasing. The pause in this increase seen in 2020/21 was likely due to more restricted access to LARCs during the Covid-related lockdowns. In 2021/22, LARC uptake at SRH services was above user dependent uptake for the first time. The large change seen in 2021/22 was driven by a sharp decrease in women using contraceptive pills as their main method, and rises in the use of IU systems, IU devices, and implants (see later sections for more detail).

Note that at the end of July 2021, progesterone only pills became available to purchase over the counter at pharmacies without prescription. This is likely to have impacted the number of women needing to attend SRH services for the contraceptive pill, and thus the SRH services uptake figures for this method (and user dependant methods as a whole).

#### Change in methodology 2014/15

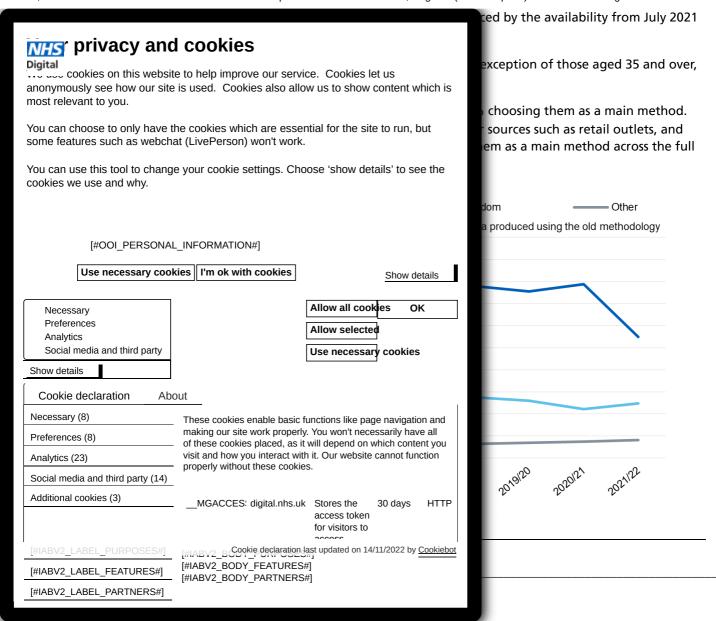


For more information: Data tables 6 and 7

## Uptake of user dependant contraceptives

## Uptake of user dependant contraceptives (at SRH services), by method and year

Uptake of oral contraceptives at SRH services has fallen from 39% in 2020/21 to 27% in 2021/22, though they remain the most common of any method (whether user dependant or LARC). Though uptake was already on a



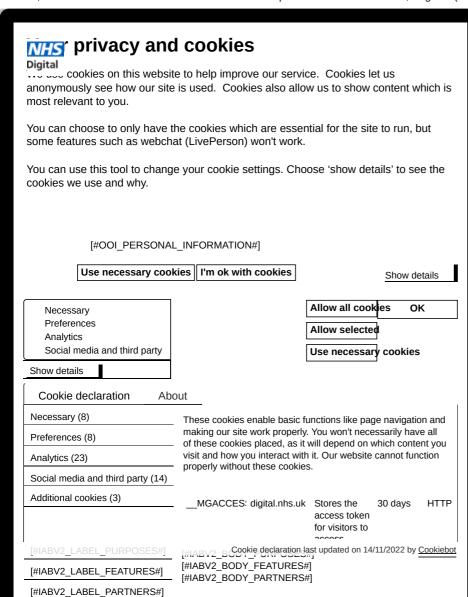
# Uptake of long acting reversible contraceptives

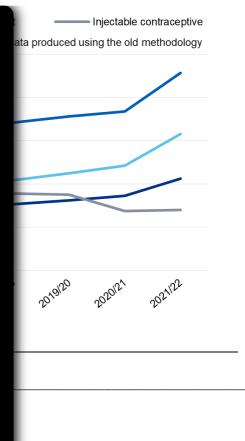
### LARC uptake (at SRH services), by method and year

The increase in overall LARC uptake over the last 10 years has been driven by a rise in implants, IU systems and devices, and all saw further increases In 2021/22. Implants (the most common type of LARC), were now the main method of contraception for 23% of females using SRH services. 16% were using IU systems as their main method, and 11% IU devices.

Younger age groups more likely to use implants; 38% of under 16's, compared to 16% of those aged 45 and over. Use of IU devices and systems increases with age, with 50% of those aged 45 and over using one or the other as their main method. This compares to 19% of 20-24 year olds, 11% of 18-19 year olds, and 5% of 16-17 year olds.

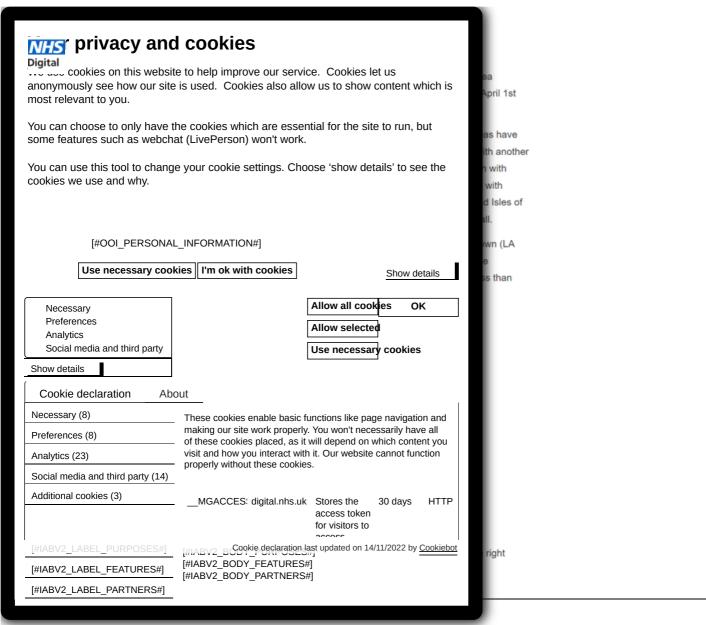
Injectable contraceptives are the only LARC method where uptake (7%) has not risen in recent years. Studies suggest that injectable contraceptives are less cost effective than other LARC methods, with a higher failure rate (See part E of the Appendices for examples).





## tient residence

As, up from 13 in 2020/21. The thamptonshire (75%), and (39%) and Wigan (39%).



Equivalent data by service provider can be found in table 17b.

For more information: Data tables 17a and 17b

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#### **Previous Chapter**

Part 1: Contacts with Sexual and Reproductive Health Services

#### Next Chapter

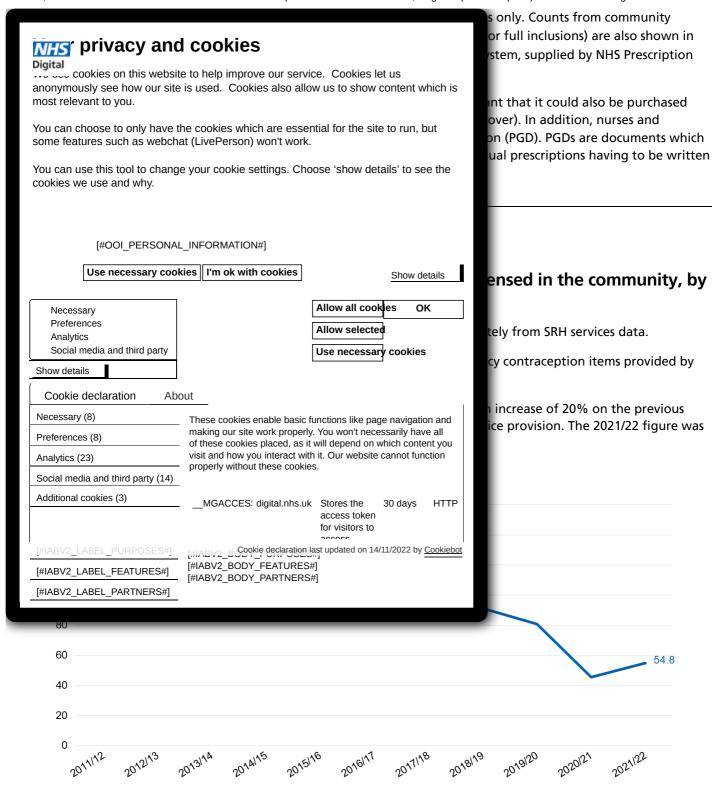
Part 3: Emergency contraception

# Part 3: Emergency contraception

## Introduction

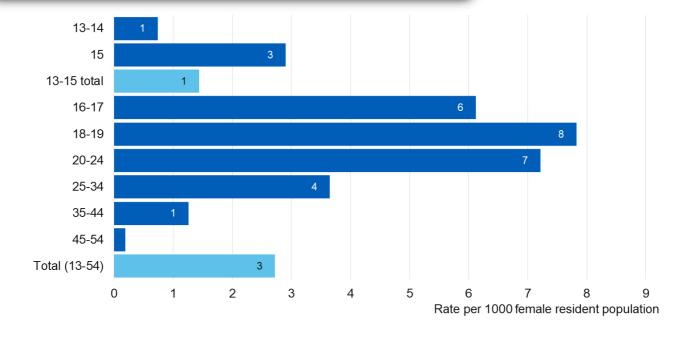
Figures in this part do not represent the full volume of emergency contraceptives provided in England.

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The number of emergency contraception prescriptions dispensed in the community was 86,537 in 2021, a fall of 4% compared to 2020 (90,068). Over the last ten years, this has fallen by 65%, from around 245 thousand items in 2011.

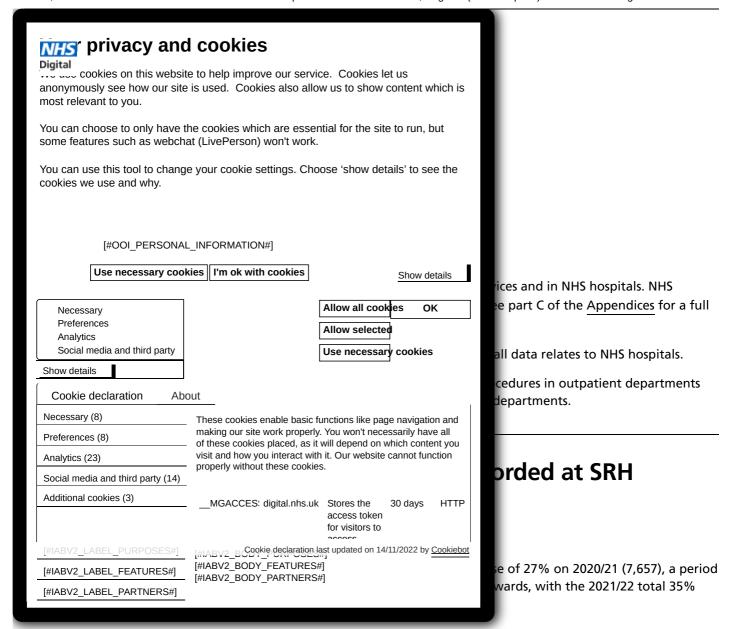
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⇔r more information: Data tables 1, 9a, 9b, 9c, and 13

### r 16s (SRH services **NHS** privacy and cookies cookies on this website to help improve our service. Cookies let us anonymously see how our site is used. Cookies also allow us to show content which is most relevant to you. ear You can choose to only have the cookies which are essential for the site to run, but vices over the last ten years has some features such as webchat (LivePerson) won't work. ages (see data table 9a for a longer You can use this tool to change your cookie settings. Choose 'show details' to see the cookies we use and why. 3% of total emergency /12 (which represented 10% of the [#OOI\_PERSONAL\_INFORMATION#] Use necessary cookies I'm ok with cookies Show details Allow all cookies ΟK Necessary Preferences Allow selected Analytics Social media and third party Use necessary cookies Show details Cookie declaration About Necessary (8) These cookies enable basic functions like page navigation and making our site work properly. You won't necessarily have all Preferences (8) of these cookies placed, as it will depend on which content you visit and how you interact with it. Our website cannot function Analytics (23) properly without these cookies. Social media and third party (14) Additional cookies (3) 1.7 \_MGACCES: digital.nhs.uk Stores the 30 days HTTP access token for visitors to [#IABV2\_B Cookie declaration last updated on 14/11/2022 by Cookiebot [#IABV2\_BODY\_FEATURES#] [#IABV2\_LABEL\_FEATURES#] [#IABV2\_BODY\_PARTNERS#] [#IABV2\_LABEL\_PARTNERS#] Percent 12 10 10 8 6

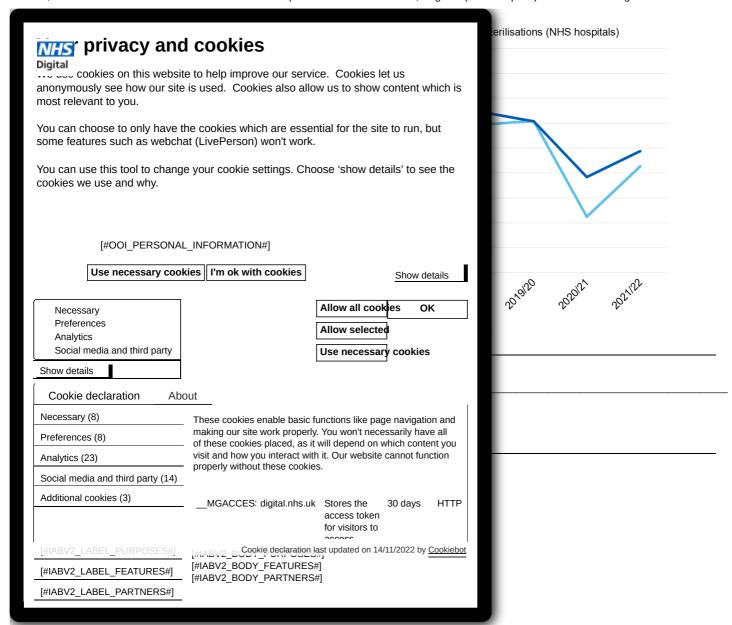
For more information: Data tables 9a, 11 and 18a/b



## Vasectomy procedures by year (SRH services and NHS Hospitals)

Prior to 2015/16, there had been a long-term decline in the number of vasectomies performed. The number then stabilised until 2019/20 at around 11 to 12 thousand per year.

8,531 vasectomies were performed in 2021/22, 27% higher than the heavily Covid pandemic affected year of 2020/21 (4,487), but still 30% below the last pre-pandemic number in 2019/20 (12,157).



# Part 5: Prescriptions for contraceptives dispensed in the community

## Introduction

Data for items dispensed in the community are sourced from the prescribing team at NHS Digital. 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.

Prescriptions written by GPs 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 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.

The majority of items provided by SRH services would not be captured in this prescribing data, though there is likely to be a small amount of overlap where the prescription item is unavailable directly from the service.

Prescribing data is collected on a different basis to SRHAD and so the datasets cannot generally be combined. It represents a count of items prescribed, unlike the activity based nature of SRHAD.

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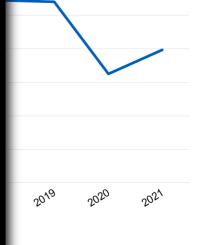
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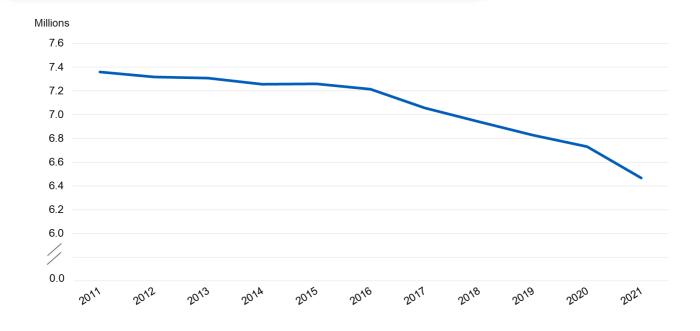
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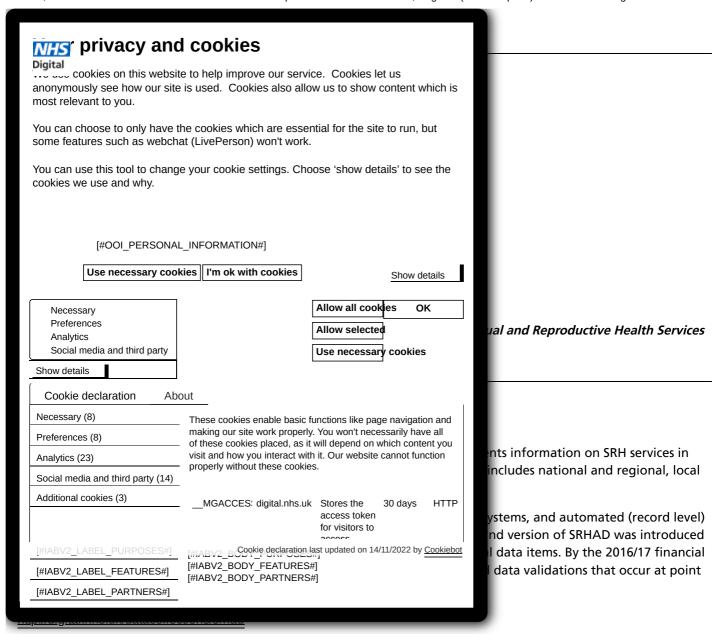
## at other locations in

which is 7% higher than in 2020



dispensed in the community, a fall of been a fall of 12% since 2011, when





Data is then processed by the NHS Digital Lifestyles team using SAS applications, and combined and stored in a single SQL database. Source data files are deleted after a short retention period (minimum 3 months).

Publication outputs are compiled using a combination of SAS Enterprise Guide, Microsoft Excel, and Microsoft Power BI.

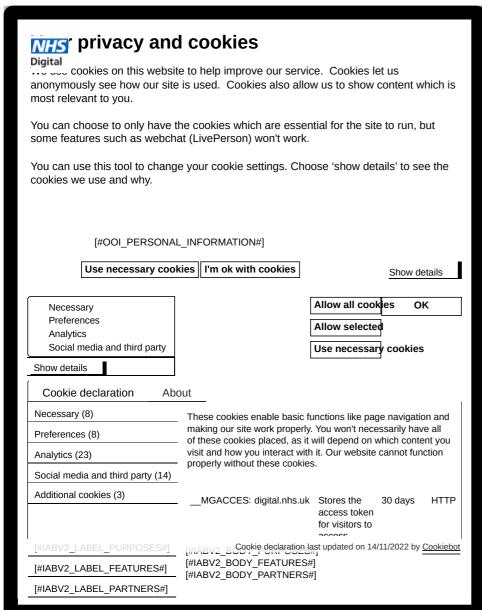
Outputs are published to the NHS Digital website.

NHS Digital - Sexual and Reproductive Health Services Publications

## **Purpose of document**

This data quality statement aims to provide users with an evidence-based assessment of quality of the statistical output included in this publication.

It reports against those of the nine European Statistical System (ESS) quality dimensions and principles appropriate to this output. The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.



Authority (UKSA) code of practice for

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be equally available to all, not given of detail and remain publicly

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of activity in relation to contraception raception recorded, but this does not

RH services. They are completed on a accuracies that sampling may ed in more detail within this data the total number of contacts with

these services.

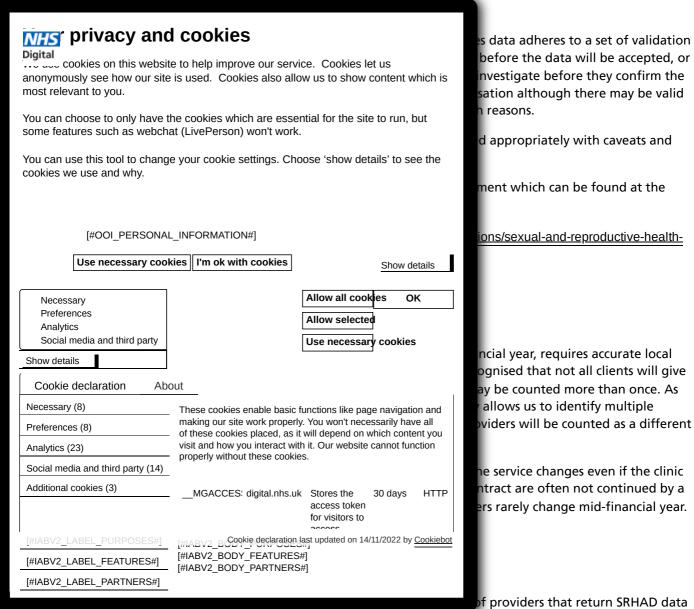
A contact within this report may be a clinic attendance or a contact with the service at a non-clinic venue (such as home visits or outreach), including non-face to face contacts (e.g. by telephone).

Information is presented by age and gender, and also at regional level and by Local Authority (LA) and provider. Certain information is presented as a percentage of the resident population. For these figures, the population (denominator) is aged between 13 and 54. Note there will be a small number of patients attending SRH services that fall outside of these age ranges but they are not included in the population related calculations as the resident population which falls outside these ranges is also not included.

Further coverage of contraception data is provided by the inclusion of prescribing information from the prescribing team at NHS Digital. Prescriptions written by General Medical Practitioners and Non-medical prescribers (nurses, pharmacists etc.) in England represent the vast majority of what is 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 does not cover items dispensed in hospital or on private prescriptions.

# **Accuracy and reliability**

This dimension covers, with respect to the statistics, their proximity between an estimate and the unknown true <u>value</u>.



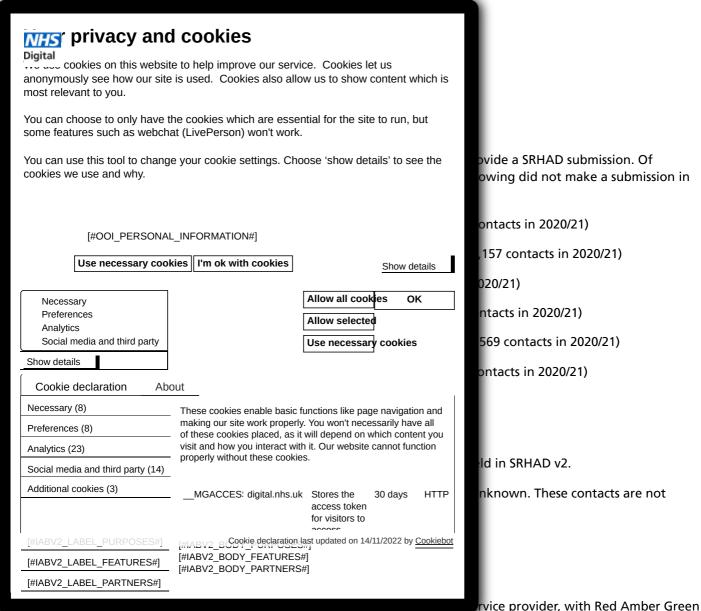
varies each year as a result of any re-structuring/change in service provision. The move of the responsibility of services from one service provider to another can result in the figures being reported against a different service provider to previously, so changes in responsibility will need to be considered when interpreting provider based outputs.

#### Completeness of provider submissions

There is no centrally held register of organisations that offer SRH services so we cannot be certain the dataset is complete but efforts are made each year to update the list of organisations whom we expect to receive data from, e.g. following up organisations' who have previously provided data, asking regional commissioning contacts to review submitter lists, etc.

## The number of providers (NHS and independent) submitting SHRAD data since 2014/15

Year	Providers
2014/15	139
2015/16	113
2016/17	103
2017/18	101



indicator. These represent features of the data which are not rejected during the validation process (though may have been highlighted as warnings), but may impact on the quality of reporting and analysis.

## **Timeliness and punctuality**

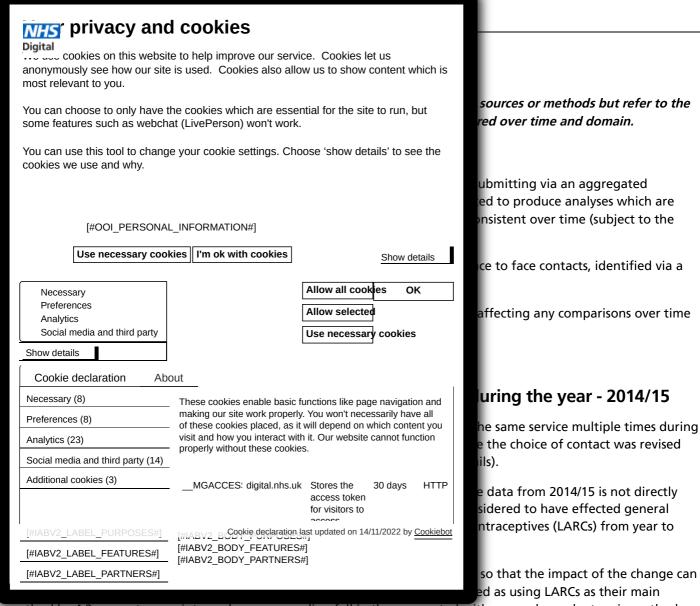
Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

Usually, the data are collected following the end of the financial year (1st April to 31st March) by NHS Digital. The final annual dataset is usually passed to the publication team during August. The data are then analysed and the report prepared for publication in October which is 7 months after end of the time period to which it refers.

In 2020/21, an April to September collection was additionally conducted in order to provide an early picture at a national and local level of the impact of the Covid 19 pandemic on contraception provision during 2020.

# **Accessibility and clarity**

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.



method by 4.2 percentage points, and a corresponding fall in those reported with a user dependent main method.

The impact can be seen across all main methods by comparing Excel data tables 6 and 6a in the 2014/15 report:

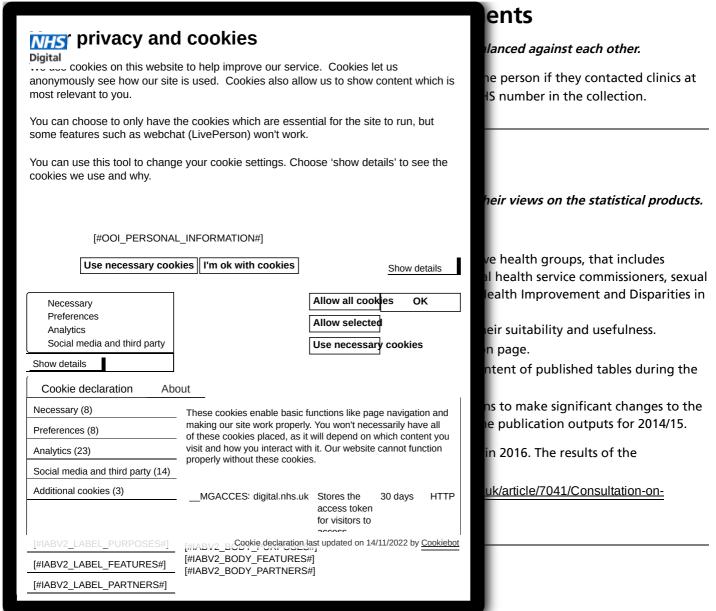
https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/sexual-and-reproductive-health-services-england-2014-15

#### Availability of progesterone only pills over the counter - 2021/22

At the end of July 2021, progesterone only pills became available to purchase over the counter at pharmacies without prescription. This is likely to have affected the number of women needing to attend SRH services for the contraceptive pill, and thus the SRH services uptake figures for this method (and user dependant methods as a whole).

## **Prescribing data**

Prescribing data is collected on a different basis to SRHAD and so the datasets can not generally be combined. It represents a count of items prescribed, unlike the activity based nature of SRHAD. The majority of items provided by SRH services would not be included in the prescribing data, though there is likely to be a small amount of overlap where the prescription item is unavailable directly from the SRH service.



rms aimension describes the effectiveness, efficiency and economy of the statistical output.

The burden to providers was assessed as part of the move to SRHAD v2 mentioned previously. This gave an estimate of £103,000 per year, although SHRAD data was collected on a quarterly basis at the time this estimate was produced. It is now collected annually, which should have reduced the burden.

The cost to NHS Digital of collecting, validating, processing and disseminating the data was estimated to be around £60,000.

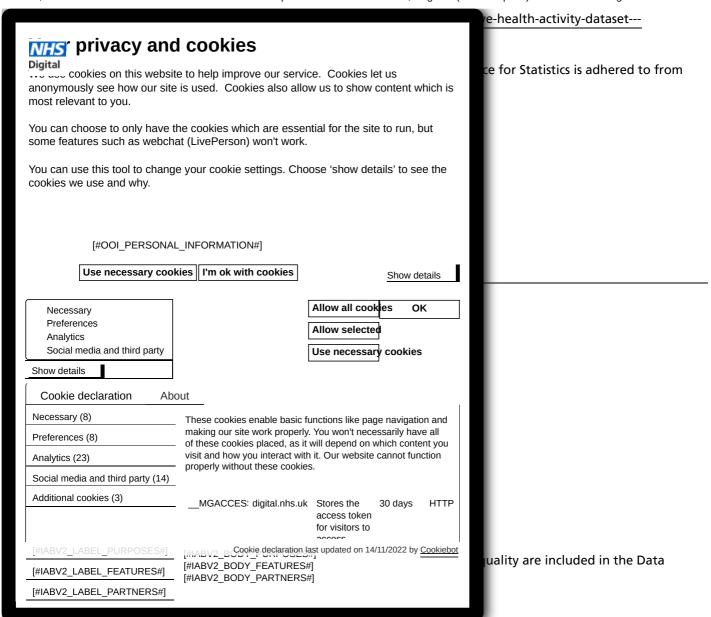
# Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

This publication is accompanied by an internal Risk Assessment. The Risk Assessment assesses the data for risk of an individual being identified or the data being disclosive. It considers the relevant legislation around data protection and the NHS anonymisation standard:

http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/library/standard/128

Controls are implemented to ensure the data remain non-identifiable/non-disclosive. Local level data has been rounded, and in a few cases some small numbers suppressed where rounding is not sufficient. The disclosure control method applied to SHRAD was amended for the 2019/20 publication as part of a move towards more consistent methods of disclosure control across NHS Digital datasets and to bring automation benefits. For details see the



The annual Sexual and Reproductive Health (SRH) services report primarily presents information on community based SRH services in England. It includes national and regional tables as well as tables by local authority and provider organisation.

Data on Sexual and Reproductive (SRH) services has been collected since 1988/89 through the KT31 return, and since 2010/11 via the Sexual and Reproductive Health Activity Dataset (SRHAD). Between 2010/11 and 2013/14 providers were able to submit either a KT31 return or SRHAD.

SRHAD is an activity based collection with each contact being a record within the dataset. An updated version (SRHAD version 2) was introduced on 1st January 2015, which includes additional fields and extends the remit of the collection to include non-face to face contacts. All providers have been required to submit this new version since 2016/17.

Further details of the SRHAD collection are available.

#### **Prescribing data**

Prescription items dispensed in the community are sourced from the Prescribing team at NHS Digital. Information is taken from the Prescription Cost Analysis System (PCA), 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. Prescribers are GPs, nurses, dentists and hospital

ingle item written on the form is **NHS** privacy and cookies cookies on this website to help improve our service. Cookies let us anonymously see how our site is used. Cookies also allow us to show content which is most relevant to you. tatistics (HES) hosted by NHS Digital. You can choose to only have the cookies which are essential for the site to run, but England. It includes private patients some features such as webchat (LivePerson) won't work. e delivered by treatment centres You can use this tool to change your cookie settings. Choose 'show details' to see the s details of all NHS outpatient cookies we use and why. E departments, single specialty A&E a finished consultant episode (FCE). [#OOI\_PERSONAL\_INFORMATION#] and a patient may experience more Use necessary cookies | I'm ok with cookies ne episode finishes. Show details ained within Appendix C. Allow all cookies ΟK Necessary Preferences Allow selected Analytics Social media and third party Use necessary cookies Show details Cookie declaration About where an individual patient receives Necessary (8) These cookies enable basic functions like page navigation and face to face contacts were added to making our site work properly. You won't necessarily have all Preferences (8) of these cookies placed, as it will depend on which content you rom 2015/16. visit and how you interact with it. Our website cannot function Analytics (23) properly without these cookies. ofessional contact may include a Social media and third party (14) ontraceptives and provide advice, Additional cookies (3) MGACCES: digital.nhs.uk Stores the 30 days HTTP s attending for 'other' services such access token for visitors to

vasectomies and occasionally sterms attor procedures, can take place at skirt service clinics and are recorded as an SRH care activity in SRHAD. However, they are not considered as a main method of contraception for the purpose of this analysis.

[#IABV2\_BCookie declaration last updated on 14/11/2022 by Cookiebot

[#IABV2\_BODY\_FEATURES#]

[#IABV2 BODY PARTNERS#]

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 is a measure of the overall deprivation experienced by people living in a neighbourhood, although not everyone who lives in a deprived neighbourhood will be deprived themselves.

IMD data presented in this publication is based on the 2019 index.

# **Appendix C – Methodologies**

### Disclosure control rules

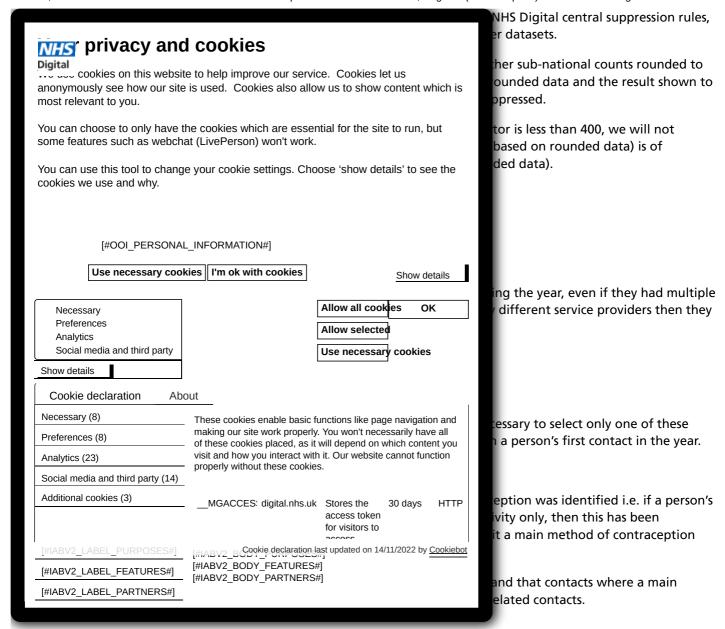
[#IABV2 LABEL FEATURES#]

[#IABV2 LABEL PARTNERS#]

g; for existing clients it is the main

d to report is shown in Appendix C.

vice on more than one occasion



## Compilation of sterilisation and vasectomy data

The following OPCS-4.7 codes classify vasectomy, vasectomy reversal, female sterilisation and female sterilisation reversal:

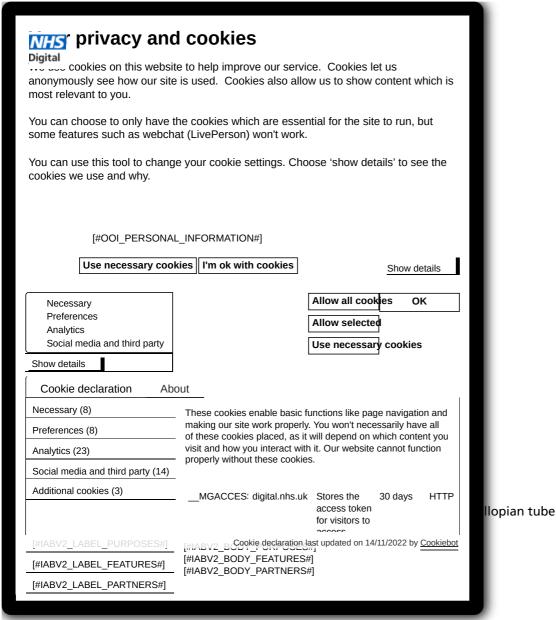
#### Procedure codes identifying vasectomies

- 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

#### Frocedure codes identifying female sterilisations

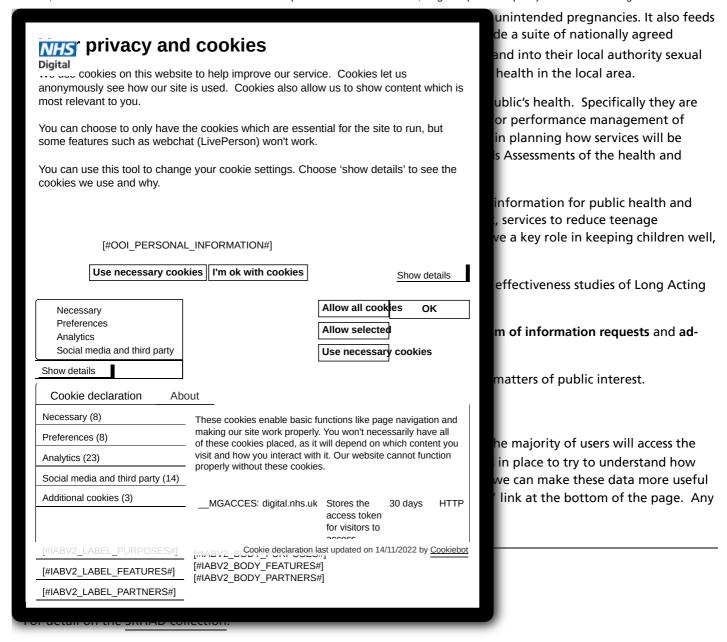


- Q29.1 Reanastomosis of fallopian tube NEC
- Q29.2 Open removal of clip from fallopian tube NEC
- Q29.8 Other specified open reversal of female sterilisation
- Q29.9 Unspecified open reversal of female sterilisation
- Q37.1 Endoscopic removal of clip from fallopian tube
- Q37.8 Other specified endoscopic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

# Appendix D – Users and uses of the statistics

Office for Health Improvement and Disparities (OHID) within the Department of Health and Social Care (DHSC) use these statistics to inform policy and planning.

The Secretary of State for Health has a statutory duty to protect health and address inequalities, and promote the health and wellbeing of the nation. DHSC will use SRHAD data to support these public health functions with regard to sexual and reproductive health.



#### General NICE guidance

NICE LARC advice for main method of contraception

Department of Health's Sexual Health Improvement Framework 2013

Government's Public Health Outcomes Framework, which includes three sexual health outcomes

Office for Heath improvement & Disparities Sexual and Reproductive Health Profiles

Public Health England's guide to data on sexual and reproductive health

Governments Teenage Pregnancy Strategy 2010

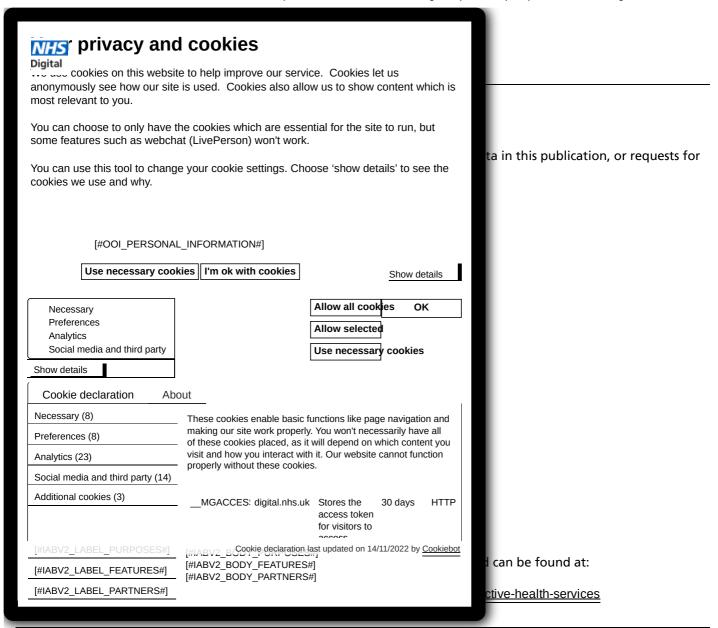
Advisory Group on Contraception (AGC) recommendations to NHS England 2014

Findings from a study by Public Health England on condom distribution schemes (CDS) <u>Condom Distribution Schemes</u>, <u>England 2015/16</u>

Examples of studies/information on the effectiveness of different types of contraception:

https://www.nhs.uk/conditions/contraception/how-effective-contraception/

https://srh.bmj.com/content/familyplanning/32/1/3.full.pdf



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#### **Previous Chapter**

Data quality statement

#### **Next Chapter**

Author, Copyright and Licensing

## **Author, Copyright and Licensing**

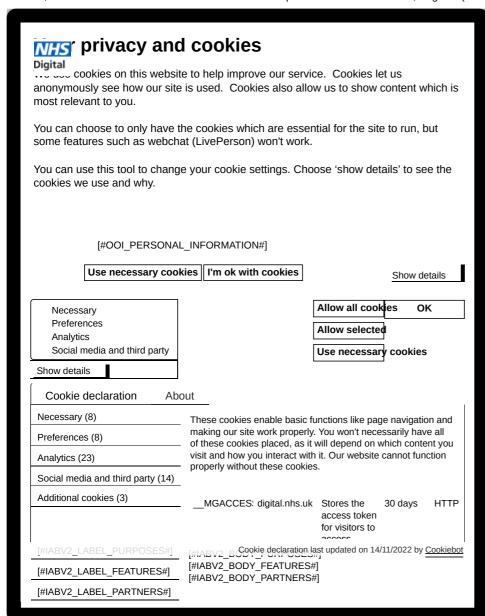
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