hscic Health & Social Care Information Centre

NHS Contraceptive Services: England

Consultation Review - Outcome

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Background

Between January and March 2012, the Health and Social Care Information Centre consulted on the annual NHS Contraceptive Services: England publication and also on a new quarterly attendance level collection known as the Sexual and Reproductive Health Activity Dataset (SRHAD) which started in 2010/11. The consultation was conducted in accordance with the Code of Practice for Official Statistics and is available via the following link:

http://www.ic.nhs.uk/article/2148/NHS-contraceptive-services-England-Consultation-review

The consultation sought to engage with users to develop a further understanding of the users and uses of the reports and also encouraged views on the methodologies used within the reports. It also contained, in broad terms, a proposal on how to best present the newly collected SRHAD data in future versions of the report so that it is exploited to its full potential. Users were invited to let us know what analyses they would like to see in future reports and for what purpose.

The consultation closed on 23 March 2012. We received four responses to the consultation. We thank all respondents for their helpful comments and anybody that contributed to this consultation. Details of the respondents are contained in Annex A.

Proposal and Outcome

Feedback was received on all points of the consultation. This is summarised below. Some comments are relevant across several points of the consultation in which case they are recorded beneath one and mentioned beneath others.

1. *In order to improve our understanding of the users and uses of these statistics, please tell us how you currently use the publications and for what purposes.*
    - *Include details of which sections you find most useful, and which are less so.*

The following uses of the data were identified:

- Overall these data provide a useful insight into prescribing and patient choices in community contraceptive clinics.
- A driver for the improvement of safety, quality and efficiency of services and in improving outcomes for patients and service users.
- Benchmarking between providers, encouraging services to learn from good practice and improving their existing practices
- Enabling commissioners to make informed decisions about how they design services and who they commission them from, for example information on demand for services
- Enabling policymakers to better understand the impact of national and local sexual health policies and monitoring the delivery of outcomes
- Enabling patient and professional groups to evaluate local variations in services and identify where there may be issues related to patient choice and information
- Comparison of trends across different districts of England.
- Comparison of data over recent years to see trends in methods used in community sexual reproductive health clinics
- Partly feeds into workforce planning.

2. *Do you have any comments on the existing publication to assist us in improving the relevance and usefulness?*

All respondents highlighted the limitations in the coverage of the data, that KT31, and SRHAD, only collect data from contraceptive clinics and do not include activity in GP surgeries, pharmacies and other settings. One respondent highlighted that although prescribing data and Hospital Episode Statistics (HES) are used as a source for other provisions of contraception, there is no cross-linking to community Sexual and Reproductive Health (SRH) services. They commented that a proportion of women will be attending both settings, for example when referred by a GP for more specialist advice, or very frequently when a woman says she is unable to access appointments at her GP for continuation of a method which is running out.

One respondent highlighted the lack of information on contraception provided to young people under schemes not covered by KT31 clinics. Obvious examples are emergency contraception provided under patient group directives either at pharmacies or at schools.

One respondent stated that the data on sterilisation and vasectomies is not really useful unless it includes all procedures regardless of where they are done e.g. in patient, community clinic, not for profit organisation, private. They understood that there may be limitations in gathering data from private providers, but believed it was important that all NHS provision was covered. One respondent observed that the annual reports do not always make clear exactly what data is reported and what is not. Another respondent commented that the General household surveys and later Contraceptive and Sexual Health reports did give a good snapshot across the country and the discontinuation of these was a matter for concern.

Another limitation of the reported data highlighted by respondents was that the KT31 return only records contraceptives prescribed at first contact and so does not record changes to contraceptive methods. One respondent stated that it was essential that information is collected about women switching their contraceptive method. SRHAD data records information on all contacts, so moving to all data being collected in this way was described as a priority by one respondent. This is discussed further below.

3. *In order to maximise the potential of the SRHAD data (see Annex A of* NHS Contraceptive Services: England, Consultation Review*), please let us know what analyses you would like to see in future reports and for what purpose.*
   For example,
   - *please indicate the level of aggregation, the precision, and the frequency of the data (annually or quarterly).*
   - *please indicate whether the analyses should be based on first contact or all contacts; and the main method of contraception or all methods.*
   - *please indicate how the data should be broken down for presentation.*

The current intention is to maintain most (if not all) of the tables provided in the latest publication (based on first contacts), and in addition to produce similar information (by age and gender) utilising the additional items contained within the SRHAD dataset. For example: information based on primary and secondary methods of contraception, to provide similar information based on all contacts (not just first contacts), information based on all reasons for attending, and to provide information by Local Authority.

General points

One respondent observed that SRHAD guidance is much better than KT31 but still not always absolute. They believed that guidance should be absolute to ensure consistency, and should not allow for 'interpretation'. Similarly, another respondent stated that there is still some lack of clarity about what constitutes a 'new' method at first visit to SRH services. For example, if a client let her GP-provided method over-run, how long must she be off the pill for her to be restarting and what if she used condoms once in between?

Limitations of SRHAD

Several limitations of SRHAD were raised by respondents. One stated that although it records secondary methods it does not record why the 2nd method is being used; for example: medical reasons to try to improve continuance of main method where additional Combined Oral Contraceptive (COC) is given to control bleeding problems, control of dysmenorrhoea induced by Intra-Uterine Devices (IUD), or bridging method to provide immediate cover when new method is instigated.

One respondent requested that for future development a code would be useful for deliberate ceasing of contraceptive methods in order to conceive. Removal of IUD/Intra-Uterine System (IUS)/implant can be coded but no evidence as to reason if no method is provided or discussed. Other codes may also be useful, for example rubella screening.

It was raised that SRHAD only reported face to face consultations. Failing to capture telephone consultations misses out a significant proportion of work and may cause services

to encourage patients to attend clinics where they may wait in queues, which goes against the ethos of working with patients to value their time.

One user highlighted that it did not appear that SRHAD collects information sufficient to report the number of young person's contraceptive clinics or the number of contacts at such clinics. They described this as a very useful measure of how different areas are providing sexual health services and it would be very useful for this data to continue to be provided at Primary Care Trust and/or local authority level. Although another respondent stated that The loss on 'Clinics for <25s' is not important as what is relevant is what age the people attending are and what proportion are under 25 or more importantly teenagers. Whether they attend a clinic just labelled by age or a mixed one is not the issue.

As discussed above, SRHAD does not cover all provision of contraceptive services. Specific suggestions of other data sets that should be reported on with SRHAD are discussed below.

Level of Aggregation, Precision, and Frequency of the Data

There was some desire from the respondents for quarterly reports, although his was not universal, with others stating that annual data was sufficient as the data did not vary to a large extent by quarter.

All respondents commented on the importance of local and regional level data. The importance of local authority level reporting was identified as a key element of this due to the change in responsibility for commissioning sexual health services. One respondent requested that data be reported by both commissioner and provider and another asked that data be reported at the most granular level possible.

First Contact or All Contacts, Main or All Methods of Contraception

Three respondents explicitly stated that reports should not be based on first contact. One described it as an artificial concept that should be disposed of. The final respondent did not comment on first vs. all contacts, but they did state that data should be comparative over time with the previous data, at least until a sufficient time series has been built up.

The usefulness of time series in the data was also raised by other respondents. With regards to times series one respondent commented that they were aware that KT31 could grossly underestimate the number of users and that SRHAD will be able to compare much better the number of insertions and removals which will make for better comparisons between services and enable us to show how they compare from the point of view of accessibility to Long Acting Reversible Contraceptive (LARC) and overall usage. Another respondent also expected LARC numbers to increase when changing to reporting all contacts, but that in future the trends would be very useful as they understood that most are fitted in community clinics.

Breaking Down of Data for Presentation

All respondents mentioned the usefulness of breaking the data down by age. One requested that the age bands be extended from ‘35 and over’ to ‘35-45’ and ‘45 and over’. Other requests were for ethnic group analysis and rate of access by population.

Reporting by main method of contraception and additional methods was also requested and it was specifically asked that the number of insertions, renewals and removals of IUD/IUS and implants should be identified.

It was requested that where possible some idea of how many people change from year to year or stay on the same method should be reported. A limitation of this was highlighted in that it will only be for people who continue at the same clinic, and will not capture the full picture for people who use services in other settings such as GP surgeries and pharmacies.

One respondent commented that emergency contraceptive figures are useful as they give some idea of unmet need for on-going contraception, though the data from SRHAD is of limited use as it does not capture all activity nationally and so may not be representative of wider provision. They stated that those accessing community clinics for this are only a small proportion of the whole. Each occasion is a potential opportunity for starting longer term contraception which may or not be taken, but with no idea of real EC usage rates it is difficult to know what is happening.

4. *Are there any potential uses for the SRHAD dataset for secondary analyses (subject to appropriate confidentiality controls)*

The link between SRHAD and the Genitourinary Medicine Clinic Activity Dataset (GUMCAD) was commented on by respondents. One stated that combining or at least parallel reporting of SRHAD and GUMCAD will be vital so that all the work can be recognised. GUMCAD collects data on diagnoses of sexually transmitted infections (STIs) and other services provided by all genitourinary medicine (GUM) clinics in England. GUMCAD is collected by Public Health England (formally by the Health Protection Agency). Further information can be found here.

One respondent stated that the split into SRHAD and GUMCAD will now mean there is no way of knowing how many people or visits a service had as any patient receiving both STI and Contraceptive services will appear on both sets of statistics. (Although we believe this can be addressed by improvements to the guidance documents made available to users.)

One respondent stated that it would be an interesting aid to commissioning if it could be linked to local termination of pregnancy rates for the population served (however as services are open-access, this would not necessarily indicate resident population).

Summary and Next Steps

Thank you for all your comments and interest in these statistical publications. All comments will be considered when producing future publications. Further comments can be submitted at any time to the Health and Social Care Information Centre using the feedback forms that accompany each publication – we continually aim to improve the content and relevance of all our work.

The responses have assisted us in understanding how the data are presently used, and also increased our knowledge and understanding of the strengths and limitations of the data.

We have also received comments on how the SRHAD based data should be presented to maximise the usefulness of the data.

Since the consultation was launched, the full migration to SRHAD has been slower than originally anticipated. This has been for a number of reasons which include issues in amending IT systems to accommodate the SRHAD collection and the transfer of responsibility for commissioning services from Primary Care Trusts to Local Authorities. We will be able to consider all these comments more fully once national compliance with SRHAD is achieved and we commence work on the new SRHAD based publication. At present, due to the incompatibility between KT31 and SRHAD, data received via SRHAD has to be converted to KT31 format in order to publish (as KT31 aggregated data cannot be converted to SRHAD).

As more organisations are now submitting SRHAD based returns we are hopeful we will soon be able to publish based on the SRHAD data. We will therefore be undertaking detailed analyses of the SRHAD data to see how the data can be used to meet users' needs.

On 1st April 2013, responsibility for community contraception services was transferred to Public Health England (PHE). The comments received via this consultation will be made available to our colleagues in PHE and we will work with them over the next few months in determining any appropriate actions to ensure the data are accurate and consistent, and to consider the content of the publication.

This work is expected to take place between April and September 2013 and we will provide an update to this document detailing the future publication proposal shortly after. We will attempt to address all comments received.

Annex A: Summary of respondents to the consultation

Advisory Group on Contraception (AGC)	1
Faculty of Sexual and Reproductive Healthcare	1
Nottingham University Business School	1
Liverpool Community Health Sexual Health Services	1

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