Contents

1. Introduction 3
2. Relevance - coverage and content 3
3. Accuracy and reliability 5
4. Timeliness and punctuality 7
5. Coherence and comparability 7
6. Accessibility and clarity 8
7. Confidentiality, transparency and security 8
8. Trade-offs between output quality components 9
9. Assessment of user needs and perceptions 9
10. Performance cost and burden 10
1. **Introduction**

1.1. The annual Sexual and Reproductive Health (SRH) services report primarily presents information on SRH services in England sourced from the Sexual and Reproductive Activity Dataset (SRHAD). It includes national and regional, local authority and provider level analysis.

1.2. SRHAD data is designed to be entered electronically in provider administrative systems, and automated (record level) extracts are generated and submitted to NHS Digital. From January 1st 2015, a 2nd version of SRHAD was introduced which extended the coverage to non-face to face contacts, and added additional data items. By the 2016/17 financial year, all providers were submitting using SRHADv2. Full details of the return and data validations that occur at point of submission, can be found at the following link:


1.3. 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).

1.4. Publication outputs are compiled using a combination of SAS Enterprise Guide, Microsoft Excel, Microsoft PowerPoint and MapInfo.

1.5. Outputs are published to the NHS Digital website.

   [NHS Digital - Sexual and Reproductive Health Services Publications](http://digital.nhs.uk/datacollections/srhad)

2. **Relevance - coverage and content**

2.1. SRHAD covers activity taking place in the community at dedicated SRH services, including activity at non NHS service providers where available. It excludes services provided in out-patient clinics and those provided by General Practitioners as well as contraceptives purchased over the counter at a pharmacy or in other retail settings. It does not provide a count of contraceptive items provided, but a record of activity in relation to contraception and other SRH services. I.e. a person may have a particular main method of contraception recorded, but this does not necessarily mean an item was provided on that contact.

2.2. 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 has changed as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>139</td>
</tr>
<tr>
<td>2015-16</td>
<td>113</td>
</tr>
<tr>
<td>2016-17</td>
<td>103</td>
</tr>
<tr>
<td>2017-18</td>
<td>101</td>
</tr>
</tbody>
</table>

Providers are required to ensure that all the relevant data is recorded.

After this report was originally published in September 2018 it became apparent that some providers of SRH services had not submitted a complete dataset for 2017/18. Work was undertaken to collect this missing data and the report was updated to reflect this in April 2019. The effect was to increase the number of contacts in England by 3% (60,785), with the following providers having submitted additional data:

- London North West University Healthcare Trust (R1K)
- Chelsea and Westminster Hospital NHS Foundation Trust (RQM)
- St Helens and Knowsley Hospital Services NHS Trust (RBN)
- Spectrum Community Health CIC (NL1) (covering Barnsley and Wakefield).

2.3 The report only covers services provided in England, though users of SRH services may be resident outside England.

2.4 SRH services include family planning services, community contraception clinics, integrated GUM and SRH services and young people’s services e.g. Brook advisory centres.

2.5 The statistics provide the most comprehensive source of information regarding SRH services. They are completed on a census basis (i.e. not based on a sample) and are therefore not subject to any inaccuracies that sampling may introduce. They are however subject to some data quality issues which are covered in more detail within this data quality statement. They show the number of people accessing services, and also the total number of contacts with these services.
2.6 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).

2.7 Information is presented by age and gender, and also at regional level and by 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.

2.8 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.

2.9 The information shows why people are attending SRH services and allows comparisons over time (although caution should be exercised due to the data quality issues detailed in the accuracy section of this document and the points raised in the comparability section).

3. **Accuracy and reliability**

3.1 SRHAD data is validated by NHS Digital using automated processes which ensures data adheres to a set of validation rules. The validation rules are classed as either “errors” which must be resolved before the data will be accepted, or “warnings” which highlight potential errors for the submitting organisation to investigate before they confirm the data as being final. Issues with the data are queried with the submitting organisation although there may be valid reasons for the data, and organisations have the opportunity to explain any such reasons.
3.2 The purpose of the validation is to ensure that the data are robust and presented appropriately with caveats and footnotes to aid interpretation where necessary.

3.3 Details of the validations are shown within the SRHAD Technical Guidance document which can be found at the following link:


3.4 Analyses based on the number of individuals using SRH services within each financial year, requires accurate local patient IDs being inputted and the same ID being used for each contact. It is recognised that not all clients will give accurate details when contacting these services and therefore the same client may be counted more than once. As local patient IDs are only unique to each service provider, this methodology only allows us to identify multiple contacts with the same service provider. A person attending different service providers will be counted as a different person.

It can also be difficult to track patients over time when the provider supplying the service changes even if the clinic remains in the same location. This is because patient IDs issued under the old contract are often not continued by a new provider. However, this is unlikely to effect analysis in this report as providers rarely change mid-financial year.

3.5 Changes in how services are delivered can affect local time series data – the number of providers that return SRHAD data 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 – the data in tables 15A, 16A, 17A, 18A and 19A are presented according to the returning provider each year, so changes in responsibility will need to be considered when interpreting local results.

3.6 LA of residence was added to the collection as a mandatory field in SRHAD v2.

In 3.8 per cent of records (68,774) the LA of residence has been recorded as unknown.

3.7 The following data known quality issues should be considered when using the data:
The Whittington Hospital NHS Trust (RKE) stopped providing services in June 2017, but no data was provided for the period prior to this (April to June).

Liverpool Community Health NHS Trust (RY1) incorrectly recorded all contacts (around 44 thousand) as having taken place at the patient’s home (code A01). These should have been recorded as having taken place at a health centre (B01).

3.8 Table 21 in the Excel data tables shows a number of data quality measures by service provider, with RAG 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.

4. **Timeliness and punctuality**

4.1 The data are collected following the end of the financial year (1st April to 31st March) by NHS Digital. The final annual dataset is passed to the Lifestyles 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.

5. **Coherence and comparability**

5.1 Between 2010/11 and 2014/15 providers of SRH services data transitioned from submitting via an aggregated collection called the KT31 to SRHAD. However, the SRHAD data can be aggregated to produce analyses which are comparable to KT31 data thus making the time series presented in this report consistent over time (subject to the other points which follow in this section).

5.2 From 2015/16, the SRHAD v2 collection extended the coverage to include non-face to face contacts, identified via a new ‘consultation medium’ field.

All analyses include the non-face to face contacts but it is very unlikely they are affecting any comparisons over time as they only represent a small proportion of total contacts.

5.3 For analysis of a woman’s main method of contraception, a woman contacting the same service multiple times during the year is only counted once. From 2014/15 the methodology used to determine the choice of contact was revised from being based on a person’s first contact in the year (see appendix C for details).
This change in methodology created a break in the time series, meaning that the data from 2014/15 is not directly comparable with previous data. However, the methodological change is not considered to have effected general trends over time e.g the rate of increase in the use of Long Acting Reversible Contraceptives (LARCs) from year to year.

For 2014/15 analysis of main contraception is presented for both methodologies so that the impact of the change can be observed. The new methodology increased the percentage of women reported as using LARCs as their main method by 4.2 percentage points, and a corresponding fall in those reported with a user dependent main method.


5.4 Prescribing data is collected on a different basis to SRHAD and so the datasets can’t 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.

6. **Accessibility and clarity**

6.1 The tables are made available as standalone Microsoft Excel workbooks. In order to meet the Government’s transparency agenda and to facilitate re-use of the data, the data has also been made available as a record level file. However, in order to ensure that this is non-disclosive, it was necessary to remove, aggregate or alter some fields. More details can be found in appendix A and the guidance document which accompanies the record level file.

7. **Confidentiality, transparency and security**

7.1 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:
7.2 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. Also as explained previously, some fields have been removed from the record level extract while others have been aggregated or altered.

8. Trade-offs between output quality components

8.1 As mentioned previously, a patient would appear in the dataset as more than one person if they contacted clinics at different service providers. This is a necessary trade-off due to the absence of NHS number in the collection.

9. Assessment of user needs and perceptions

9.1 User needs are assessed in a number of ways:

- The NHS digital lifestyles team are members of the Contraceptive and Reproductive Health Data Advisory Group which meets each year. It includes representatives from specialised sexual health services, Local Authority sexual health service commissioners, sexual health academics and members of the sexual health team at Public Health England (PHE). As part of this group, NHS digital outputs are discussed and feedback and advice obtained as to their suitability and usefulness.

- User feedback is collected via NHS digital online feedback forms linked to the publication page.

- Adhoc requests for SRH services data received during the year inform the content of published tables during the design of development stage of the publication each year.

- Full user consultation exercises are occasionally required when there are plans to make significant changes to the content of outputs. Such a consultation was run in 2014 prior to updating the publication outputs for 2014/15.
- This report was also part of a wider consultation on all NHS Digital publications in 2016

9.2 A list of known users and uses of the data is included in appendix D.

10. Performance cost and burden

10.1 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 only collected annually which should have reduced the burden.

10.2 The cost to NHS Digital of collecting, validating, processing and disseminating the data was estimated to be around £60,000 during 2017/18.