Background data quality report

Smoking, Drinking and Drug Use among Young People in England
2016

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All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority’s regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

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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 stop smoking services.
Introduction

This document constitutes a background quality report for *Smoking, Drinking and Drug Use Amongst Younger People in England* (SDD). The statistics included in this release are the latest available figures at the time of publication.

Background

Context

This is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people aged 11 to 15 who smoke, drink alcohol or take illicit drugs. As well as providing prevalence rates it also provides information on sources of cigarettes, alcohol and illicit drugs as well as attitudes towards their use.


Purpose of document

This paper aims to provide users with an evidence based assessment of quality of the statistical output included in this report.

It reports against those of the nine European Statistical System (ESS) quality dimensions and principles¹ appropriate to this output. In doing so, this meets NHS Digital’s obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics², particularly Principle 4, Practice 2 which states:

“Ensure that official statistics are produced to a level of quality that meets users’ needs and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors and other aspects of the European Statistical System definition of quality”

¹ 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.

Assessment of statistics against quality dimensions and principles

Relevance

This dimension covers the degree to which the statistical product meets user needs in both coverage and content.

Towards a smoke-free generation: tobacco control plan for England mentions SDD as the source of information on children smoking and one of the objectives stated in the plan is to “reduce the number of 15 year olds who regularly smoke from 8% to 3% or less”. Progress against this objective will be measured by this survey.

It is also used to monitor indicator 2.09 at national level in the Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/.

The report covers England only.

Accuracy and reliability

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

As the data are based on a sample (rather than a census) of pupils, the estimates are subject to sampling error. Appendix B details how to calculate sampling errors for this survey, and the excel tables include true standard errors and design effects calculated for key survey estimates.

In general, attention is drawn to differences between estimates only when they are significant at the 95% confidence level, thus indicating that there is less than 5% probability that the observed difference could be due to random sampling variation when no difference occurred in the population from which the sample is drawn.

The limitations of the survey estimates are discussed in appendix B.

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.

The survey relates to the academic autumn term of 2016. However, fieldwork was extended into January 2017 as the response rate was low by the end of 2016. This is discussed more fully in appendix B.

These publications have not suffered any delay to their pre-announced release date and are published within 9 months of the end of the period which they refer to. However the SDD report is usually published in July but has been published later this year due to the extended fieldwork.

The section on coherence and comparability explains how the survey mode by which these questions are asked can influence how a pupil may answer them.
The survey asks about awareness and usage of a fictional drug called Semeron. Responses to these questions provide a guide as to how much pupils are over-estimating so it is reassuring to see that in the 2016 survey only 20 pupils (0.17% of the 12,051 respondents) admitted to taking Semeron which is in line with previous surveys and suggests that only a tiny minority of pupils maybe falsely admitting to drugs use. However, 1,460 pupils (12%) said they had heard of Semeron which suggests awareness of drugs could be over-estimated. Hence the majority of the tables in this report focus on drug usage rather than drug awareness.

**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.*

All reports are accessible on the NHS Digital website as PDF documents. All tables in the report are provided in Excel format. These documents are available at [http://digital.nhs.uk/pubs/sdd16](http://digital.nhs.uk/pubs/sdd16). The respondent level file on which this publication is based will become available on the [UK Data Archive](https://ukdataservice.ac.uk). The publication may be requested in large print or other formats through the NHS Digital’s contact centre: [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk) (please include ‘SDD’ in the subject line).

NHS Digital has produced SDD reports since 2004. Prior to this the Department of Health produced these reports. The DH reports are available [here](http://digital.nhs.uk/pubs/sdd16).

**Coherence and comparability**

*Coherence is the degree to which data which have been derived from different sources or methods but refer to the same topic are similar. Comparability is the degree to which data can be compared over time and domain.*

The first survey in the series, carried out in 1982, measured the prevalence of smoking among pupils and described their smoking behaviour. Trends in smoking were monitored by similar surveys carried out every two years. Questions on alcohol consumption were added to the survey in 1988. 1998 survey was the first to include questions on the prevalence of drug use.

The question which is used to define drinking prevalence was changed for this survey making estimates not comparable with previous years. More information on this is available in appendices A and B.

The mode used to collect survey data on smoking, drinking and use of illicit drugs can affect how pupils may answer the questions. For example they may be more willing to admit to admitting to some of these behaviours in surveys conducted away from the pupils home. Previous analysis has shown SDD to provide the most accurate measures of undertaking in risky behaviours as it is conducted away from the home environment. More information is available in section A8 of *Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014.*
There is information on comparisons with other sources at the end of chapters 2, 6 and 9.

**Trade-offs between output quality components**

*This dimension describes the extent to which different aspects of quality are balanced against each other.*

Partaking in smoking, drinking alcohol or taking illicit drugs is self-reported by the pupil and therefore may be susceptible to “satisficing” where they give an answer which is more socially acceptable, i.e. to say they don’t do any of these things. Similarly they may be influenced to say they do partake in these behaviours in order to impress their peers.

Analysis of data from Health Survey for England showed that examining cotinine levels in saliva can lead to higher estimates of smoking prevalence amongst children than self-reported data. See the topic report on children’s smoking in the 2016 survey. However, this is a costly way to collect this information and difficult to carry out in schools within the time they are able to allocate to completion of the survey.

**Assessment of user needs and perceptions**

*This dimension covers the processes for finding out about users and uses and their views on the statistical products.*

The survey methodology, questionnaire and content of the report is discussed and agreed with a steering group which contains representatives from NHS Digital, Department of Health, Public Health England, Home Office, Department for Education, Local Government Association and a Local Authority as well as the contractor carrying out the survey.

The content of the survey and report are often consulted on with the most recent SDD consultation taking place in November 2015 and the results fed into the design of the 2016 survey.

The style of the report was also part of a wider consultation on outputs from NHS Digital. The proposal for SDD was in section A8.

NHS Digital is keen to gain a better understanding of the users of this publication and of their needs; feedback is welcome and may be sent to enquiries@digital.nhs.uk (please include ‘Smoking, Drinking and Drugs Survey’ in the subject line).

**Performance, cost and respondent burden**

*This dimension describes the effectiveness, efficiency and economy of the statistical output.*

Data were collected from pupils using a self-completion paper questionnaire. These were usually completed during a single school period, generally between 30 and 40 minutes in length. The time taken by individual pupils to complete the questionnaire was not recorded and it is not possible to estimate an average. However, the allotted time was sufficient for almost all pupils to answer the questionnaire in full.

The total cost of developing and running the survey and publishing the report is around £450,000.
Confidentiality, transparency and security

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

No personal/individual level information is received by NHS Digital or contained in the report. The list of schools which take part is maintained by the survey contractor and not known to NHS Digital.

The respondent level file available by the UK Data Archive has does not contain any personally identifiable data and has also undergone disclosure control to mitigate against individuals being identified. It is also only disseminated under an End User Licence which contains terms and conditions on how the data may be stored and used. Specifically these forbid onward sharing of the dataset and attempts to identify individuals.

This report and dissemination of the data via the UK Data Archive are subject to a NHS Digital risk assessment prior to issue which is signed off by the Government Statistical Service Head of Profession for statistics.

The data contained in this publication are National Statistics. The code of practice for official statistics is adhered to from collecting the data to publishing.


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Small Numbers Procedure
