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Announcement of Methodological change to 'NHS Contraceptive Services: England, 2010/11' publication [NS]

This annual report, expected to be published by the NHS Information Centre (NHS IC) on 1st December 2011, primarily presents information on NHS community contraceptive services (family planning clinics and clinics run by voluntary organisations such as Brook Advisory Centres). This has been collected since 1988/89 through the KT31 return, which includes services provided by:

- Trusts in NHS clinics and as domiciliary visits
- Brook Advisory Centres

Information on NHS community contraceptive services excludes services provided in out-patient clinics and those provided by General Practitioners.

A new quarterly collection known as Sexual and Reproductive Health Activity Dataset (SRHAD) started in 2010/11 and it is currently running alongside the KT31 return.

SRHAD is an attendance level return. It is electronic rather than paper-based. Clinics without an IT system to record and extract SRHAD data items will continue to submit KT31 data until they are able to submit SRHAD data. IT system suppliers should be developing their systems and working with Providers to modify the software and validate that the new reports are accurate.

The Department of Health (DH) envisage that all sexual and reproductive health services will be able to submit SRHAD returns by 2012/13, at which point the KT31 will be retired. When national compliance is achieved, the data will be published via quarterly and annual reports.

Changes to the 2010/11 publication

Data for this year has been accepted via either the usual KT31 aggregated collection, or via the SRHAD record level dataset that is currently being implemented by Primary Care Trusts (PCTs), NHS Trusts and Social Enterprises. Organisations have until April 2013 to implement SRHAD, however, as SRHAD offers improvements in the data it collects allowing more detailed analysis, a number of organisations migrated to SRHAD during 2010/11.

For this year's publication we received data from 166 organisations. 137 of these submitted full year data via KT31, 15 submitted full data via SRHAD, and 14 organisations migrated to SRHAD part way through the year and therefore submitted part year KT31 data and part year SRHAD data.

KT31 data and SRHAD data are not collected on the same basis. KT31 is an aggregated dataset, collecting the total number of attendances, and then collecting information by gender, age and reason for attendance based on the first contact only within the financial year. Changes in contraception method for attendees are not captured which is considered one of the limitations of the dataset. SRHAD is a record level dataset that captures all contacts at contraception clinics throughout the year. The same person may appear in the dataset more than once.

KT31 and SRHAD data are not compatible for organisations that returned part year data via each method. KT31 is an aggregated dataset based on first contact, and SRHAD is a record level dataset and so it is impossible to see whether those identified in SRHAD data have already been included in the KT31 data. For these organisations, the SRHAD data returned was grossed up proportionately to provide an estimate of a full year of data (organisations had the opportunity to migrate to SRHAD each quarter, therefore the SRHAD data comprised either 1,2 or 3 quarters data).

In order to analyse SRHAD data for this publication it has been converted, where possible, into KT31 format (publications from 2013/14 will be based on the SRHAD dataset and will utilise the more detailed reporting this should allow) and then grossed up to produce data for the full year.

To convert SRHAD data to KT31 data (for figures based on first contact within the year (not required for total contacts)), a flag was inserted into the data to mark the first contact within the year – this was the first contact for a patient ID within the year. This is subject to accurate IDs being inputted and the same ID being used at each visit. It is recognised that not all clients will give accurate details when attending these clinics and therefore the same client may not always have the same ID within the dataset.

All analyses undertaken on a first contact basis only queried the records flagged as a first contact within the year record.

In order to devise a grossing factor, the 15 organisations that returned full year SRHAD data were analysed to see if there was a pattern (3 Brook organisations were not included in this analysis as it was not clear whether they offered the full range of services and therefore may not be representative). It was thought that the total number of contacts would be roughly the same in each quarter to reflect capacity (and this was proven) but the first contacts within the year would reduce quarterly to reflect that in the first quarter of the year, all attendees would be first contact (for the year) on their first visit in that quarter, but this would reduce as re-attendees in any subsequent quarters would not be registered as a first contact. This was also proven by the analysis which showed a similar pattern for the 14 organisations. The analysis is provided in Annex A to this document. From this analysis, a grossing factor was devised which could be applied depending on in which quarter the organisation migrated to SRHAD.

The SRHAD data for these organisations was converted to KT31 data and then grossed up to produce data for the full year. The SRHAD data are also subject to validation procedures. Being a record level dataset, the validation can be more

detailed than allowed under the KT31 aggregated dataset. For example, if males are recorded against a female contraception, if contraception status is blank but contraception method has been coded etc.

Not all fields that are collected via KT31 are available via SRHAD. Information on Clinic Sessions for people aged under 25 is not available. Also, first contacts for women in relation to Sterilisation and for men in relation to Vasectomy can not be ascertained via SHRAD. The total number of Vasectomy operations carried out in community contraception clinics or outpatient clinics are also not currently available via SRHAD. These figures will be missing from any totals that include first contacts and from the number of Vasectomy operations and Clinic Sessions for people aged under 25 for organisations that returned SRHAD data (29 organisations) and so all these figures will be under-estimated, including the total figures. This will have a minimal effect on any grand totals although will have a greater effect on individual figures for either Sterilisation or Vasectomy (at a local level these figures will be unavailable). In 2009/10, these 29* organisations returned 185 Sterilisation and 237 Vasectomy first contacts, 1,516 Vasectomy operations, and there were 4,533 Clinic Sessions for people aged under 25 and 54,299 total contacts in Young Persons Clinics.
*note these figures are based on 25 organisations as 4 organisations did not submit data in 2009/10.

How data are returned

The KT31 is generally a paper based collection. At the end of the financial year each clinic/service completes an aggregated KT31 paper return and submits it to their organisation where these are all combined and submitted to the NHS Information Centre (NHS IC) electronically via the Omnibus collection system.

The SRHAD data are designed to be entered electronically in the administrative system, and automated (record level) extracts are generated and submitted to the NHS IC. These submissions, whilst being record level, are pseudonymised before being submitted to the NHS IC.

In practice, during this period of transition, we are aware of this not always working as it should in all cases. There are many organisations still returning data to the PCT/Trust for submission to the NHS IC. There are also cases where returning organisations still do not have reliable systems in place and are having to rely on interim solutions. These are expected to have an impact of the robustness and quality of the SRHAD data. This will provide many challenges to ensure compliance and also to improve the data quality. We will continue to work with organisations, with DH, to improve both compliance and quality.

Comparability

Even though the data are collected on a completely different basis, the mapping and subsequent analysis of the SRHAD data are considered to make them comparable to the KT31 data. There are some data that are not available via SRHAD and these do have an effect on the figures presented (including the totals) but these are considered to have a minimal effect on the figures and therefore comparisons over time are possible (although as with all contraception data at present, caution should be exercised).

A few organisations are quoting the migration to SRHAD as reasons why this year's data varies widely from data submitted previously. Some of these seem to support the view that SRHAD has been the driver for improvements in recording and reporting, whilst others have seen a reduction in data quality whilst they fully implement the migration to SRHAD. Known issues with the systems and processes in some organisations may have had an effect on the quality of the SRHAD data. However, there are also known issues with the quality of data submitted via KT31 and so all contraception data should be treated with caution until the full integration of SRHAD.

We will continue to work with organisations to improve the quality of data submitted.

Annex A: SRHAD Grossing Analysis

Spread of first attendances (12 Organisations):

Q1	Q2	Q3	Q4	Total
25.12	29.50	22.97	22.40	100.00
27.99	26.69	23.11	22.21	100.00
35.40	26.40	18.85	19.35	100.00
28.60	27.00	21.34	23.06	100.00
36.88	26.11	18.48	18.53	100.00
40.49	25.93	17.00	16.59	100.00
34.50	26.13	20.26	19.12	100.00
46.74	27.76	12.48	13.02	100.00
36.49	26.45	18.68	18.37	100.00
27.88	21.46	14.98	35.68	100.00
37.15	28.90	17.45	16.50	100.00
31.51	26.16	25.10	17.23	100.00
34.67	26.29	18.75	20.29	100.00

Spread of all attendances:

Q1	Q2	Q3	Q4	Grand Total
19.52	28.09	26.04	26.35	100.00
22.55	25.43	25.58	26.44	100.00
23.62	25.39	24.62	26.37	100.00
22.85	26.02	23.55	27.58	100.00
25.92	26.36	22.34	25.38	100.00
25.82	25.31	22.85	26.02	100.00
26.29	25.84	23.29	24.57	100.00
26.05	26.28	22.36	25.31	100.00
24.74	25.86	23.31	26.09	100.00
20.77	22.59	20.45	36.19	100.00
25.42	26.25	22.40	25.93	100.00
24.28	27.70	27.17	20.85	100.00
24.48	25.88	23.12	26.51	100.00

An ANOVA test was then performed to see whether what looks like differences between the quarters for first attendances are in fact significant differences. We assumed, as our hypothesis, that there were no differences. The test showed that there were.