Public Health England

NHS Digital

Sexual and Reproductive Health Activity Dataset (SRHAD)

Guidance

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Document Control

Purpose	Document intended to provide guidance to all staff responsible for capturing and entering SRHAD data into systems and reporting to the Information Centre		
Current status	Draft		
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Introduction

The Sexual and Reproductive Health Activity Dataset (SRHAD) is an anonymised, patient- level, electronic collection from sexual and reproductive health (SRH) services.

SRH services provide clinical care for contraception, sexually transmitted infections (STIs) and reproductive health, but also support the public health and social care requirements of their patients. This makes it very difficult to concentrate solely on a clinical record when much time and activity is spent in supporting other aspects of care, e.g. supporting vulnerable young people towards appropriate social care.

The dataset return includes patient demographic details collected at patient registration at their first attendance, and clinical and social care data collected during the patient consultation. These should be appropriately updated at subsequent visits e.g. if GP practice details are incorrect. SRHAD is an electronic dataset, it requires services to employ patient administration software systems that can register patient details and care activities on their contact with the service.

The purpose of SRHAD is to:

- Ensure more relevant and timely collection of electronic data to support local service development.
- Allow monitoring of key policy initiatives such as: increasing access to all methods of contraception, including Long Acting Reversible Contraception (LARC) methods and emergency contraception for women of all ages and their partners; reducing teenage conceptions; reducing rate of unintended pregnancies and modernisation of SRH services.
- Provide appropriate definitions and guidance material to enable a standardised data set from SRH services.
- Support commissioners in understanding which population groups are accessing SRH services and which services they are receiving (including uptake of LARC methods as recommended by NICE) and thus allow for improved long-term commissioning of services.
- Develop, over time, indicators of quality and outcome in service delivery (especially in comparative reports). For instance, the removal and length of use for LARC devices, provision of emergency contraception, the provision of contraception post abortion and referrals to secondary care. Further to this, the dataset can compare attendance rates for selected care and the diversity of young person provision by SRH services including social care referrals.
- Aid in the development of benchmark measures that indicate how services compare in delivering the most appropriate and effective care to patients.
- Reflect current data collection practices and requirements at SRH Services.

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General Practice activity is excluded, except in the following cases:

i) specialist SRH services that undertake activity on GP practice premises
ii) specialist SRH services that sub-contract with GPs to undertake some of these services
iii) GP activity that is already being recorded through SRHAD as part of a network of open-access services

SRHAD is sponsored by the Department of Health, with Public Health England (PHE) acting on behalf of the Department regarding development of the collection. The dataset is collected and validated by NHS Digital. This guidance focuses on the items needed only for SRHAD but this dataset is complimentary to the Genitourinary Medicine Clinic Activity Dataset (GUMCADv2), which collects data on STIs from GUM clinics and other commissioned Level 2 Sexual Health Services (ISB 0139):

http://www.isb.nhs.uk/library/standard/118

SRHAD received full operational approval from the Information Standards Board in 2009. The Data Set Change Notice (DSCN) relating to this and the Information Standards Notices for subsequent amendments can be found under:

http://digital.nhs.uk/datacollections/srhad

This document is intended for front line staff of SRH services responsible for the collection and recording of data on contraceptive and SRH care activities which are used to generate the SRHAD, and for staff responsible for reporting the data to NHS Digital.

This document will provide detailed guidance on how to collect and record each data item.

It also provides technical specifications for the SRHAD submission including file format/structure (appendicies 1 and 2), coding (appendix 3), and validation rules (appendix 4).

Data Extract Specification

Scope of the data collection

Each SRH service will be required to generate an annual data extract of one attendance record per contact with the service, (including external contacts, i.e. where an individual patient receives care outside the clinic setting, in his or her own home or other location). An attendance for SRHAD purposes is classified as requiring clinical time, and this can be via face to face, telephone or telemedicine web consultations.

Time period

The SRHAD return covers one financial year (April of the current year to March of the following year). SRHAD was implemented from 01 April 2010.

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Frequency

SRHAD return to be run annually by the SRH service, no later than 6 weeks after the end of the financial year.

Data items and formats

All data items included in SRHAD and their related coding and formatting required are summarised in Appendices 1 and 2. Local codes can be created and used if further breakdowns of SRHAD data item categories are required locally. However, these codes must be mapped or aggregated to a SRHAD specified coding option prior to submission.

More detailed descriptions of each data item are provided in section 4 (Recording SRHAD data items).

Transmission

Electronic files will be transmitted to NHS Digital. SRHAD returns should be submitted through the secure NHS Digital gateway which enables organisations to upload SRHAD CSV files from identified users in a reliable manner across the internet and have the files validated. Further guidance on the transfer process from NHS Digital can be found here: http://.digital.nhs.uk/datacollections/srhad

Overlap with GUMCADv2

The Genitourinary Medicine Clinic Activity Dataset (GUMCADv2) collects information on sexually transmitted infections (STIs) and related care from Level 3 GUM clinics and commissioned Level 2 Sexual Health services. GUMCADv2 is submitted to PHE as described here:

https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2

Integrated (SRH and STI*) services have a mandatory obligation to provide both the GUMCADv2 and SRHAD reports.

**Level 2 (non-GUM) or Level 3 (GUM) STI services*

Shared data items

Some data items in SRHAD overlap with data items in GUMCADv2 e.g. ‘Gender’. The table below provides a summary of the data items shared between SRHAD and GUMCADv2 - both reports use the same NHS Data Dictionary terminology and coding.

Integrated services are not expected to complete these data items twice in the patient software systems (PSSs), but to continue recording the information in the normal way (PSSs will automatically ensure the data items are included in both the SRHAD and GUMCADv2 reports).

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GUMCADv2 and SRHAD Shared Data Items

Data Items	GUMCADv2*	SRHAD†
Patient Registration/Clinic Information		
Organisation ID		✓
Clinic ID	✓	✓
Patient ID	✓	✓
Gender	✓	✓
Age	✓	✓
Ethnicity	✓	✓
Country of Birth	✓	
LA of Residence	✓	✓
LSOA of Residence	✓	✓
GP Practice Code		✓
Attendance Information		
First Attendance	✓	
Date of Attendance	✓	✓
Initial Contact		✓
Location Type		✓
Clinical Details		
Sexual Orientation	✓	
Episode Activity (SHHAPT or READ code)	✓	
Contraception Method Status		✓
Contraception Main Method		✓
Contraception Other Method (1&2)		✓
Contraception Method Post Coital (1&2)		✓
SRH Care Activity		✓
Consultation Medium Used		✓

**Reported to PHE by all commissioned Level 2 (non-GUM) or Level 3 (GUM) sexual health services*
†Reported to NHS Digital by all sexual and reproductive health services

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Shared Episode Activity

Some episode activity collected in GUMCADv2 overlaps with care activity collected in SRHAD e.g. sexual assault (see table below).

GUMCADv2 and SRHAD Shared Episode Activity

SHHAPT Code	SHHAPT Description	SRHAD Data Items	SRHAD Description
40	Sexual assault - Acute	SRH Care Activity: 40	Sexual assault - Acute
41	Sexual assault - Non-acute	SRH Care Activity: 41	Sexual assault – Non-acute
P3*	Contraception	Contraception Method Status, Contraception Main Method, Contraception Other Method, Contraception Method Post Coital.	SRHAD contraception related data items
P4	Cervical cytology performed	SRH Care Activity:11	Cervical Screening
SRH*	SRH patient only	*All* Contraception related items and SRH Care Activity	Attendances related to SRH care only i.e. no STI related care provided
All SHHAPT codes	Attendances related to STI care only i.e. no SRH related care provided	SRH Care Activity: 34	STI related care

**These SHHAPT codes relate to multiple care activities in SRHAD.*

The episode activity coding required in SRHAD may not be the same as the equivalent care activity coding in GUMCADv2. Please speak to your software provider to determine if separate coding is required for SRHAD and GUMCADv2 in order for the shared activity to appear in both reports i.e. it may need to be coded twice in your PSS.

Recording SRHAD Data Items

The guidance is broken down into sections that follow service business process with high output and traditional activities reflected in order of magnitude. For each data item a description, validation rules and question & answer section is included.

This guidance includes the patient's understanding of information requested and assurance regarding how information is used and managed.

The recording guidance for SRHAD data items breaks down into the following sections:

- Recording patient registration data
- Recording attendance data
- Recording contraception care data
- Recording sexual and reproductive healthcare activities
- Other guidance

SRHAD data items are denoted in square brackets [ ], e.g. [Patient ID].
The table in appendix 1 also provides a summary list of fields and coding guidance.

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Recording patient registration data

In order to collect and report the new dataset, SRH services require an IT system that provides a patient administration and appointment tracking facility.

Each patient who attends the service will need to be registered and details recorded on the IT system. This includes the generation of a local unique patient identifier. An example registration form is included (Appendix 5) to highlight the data that is required.

If a patient's demographic details (e.g. gender, LSOA of Residence, GP practice etc.) are changed during a given month, the most recent entry must be allocated to the record being transmitted.

To generate the SRHAD return, a SRH service will need to provide data for the following:

- [Organisation ID] Organisation code of service
- [Clinic ID] Site Code of treatment
- [Patient ID] Unique Local Patient ID used to identify a patient
- [Gender] Self-declared gender of a person, or inferred by observation for those unable to declare
- [Age] Age at attendance date in years
- [Ethnicity] Patient's ethnic category
- [LSOA of Residence] Lower Layer Super Output Area of residence of the patient
- [Local Authority] Local Authority of residence
- [GP Practice Code] General Practitioner Practice Code where patient is registered
- [Attendance Date] Date of Attendance

[Organisation ID]

Each NHS service or Trust utilises a unique code that distinguishes one service from another. A list of national Organisation Codes is available from Organisation Data Service (ODS) formerly known as the National Administration Code Service (NACS). Please contact ODS directly if you do not know your Organisation ID (http://odsportal.hscic.gov.uk/).

Validation rules:

1. The 3 digit code must be a valid and current ODS service provider (NHS or independent) (Will allow valid 5 digit codes from 1 April 2020)

[Clinic ID)]

[Clinic ID] is used in conjunction with [Organisation ID] to identify the site within an organisation where treatment took place i.e. the clinic site. These codes are also available from ODS.

Validation rules:

1. The 5 digit code must be a valid and current ODS site of treatment (NHS or independent)

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[Patient ID]

Unique local patient ID used to identify a patient. Most systems will automatically generate a unique patient Identifier number at patient's initial registration. Some patients may not provide all these details. This should not prevent them being registered and accessing the service. If all these details are not collected at the first attendance, it may be possible to collect some further information at subsequent patient attendances.

Validation rules:

1. No patient identifiers used as Patient ID's e.g. data of birth, postcode, name, NHS number

[Gender]

Gender should be specified by the patient. 'Indeterminate (unable to be classified as either male of female)' should be recorded where gender cannot be classified as either male or female. If the gender is not known code X can be used.

[Age]

Age at attendance date in years calculated from date of birth. Date of birth allows the system to generate the age of the patient at attendance. Age at the date of attendance is required for SRHAD return. The date of birth is recorded locally and only age at attendance is included in SRHAD.

Validation rules:

1. Age cannot be 0 or blank. (use the code 999 if the date of birth is not stated / not known)

2. Age cannot increase or decrease by more than one year between attendances in the annual reporting period.

3. Ages between 1 and 10, and over 80 will be flagged as warnings

[Ethnicity]

Ethnicity should be specified by the patient from a standard list (http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/end/ethnic_category_code_de.asp?shownav=1). 'Not stated' should be recorded where the patient does not provide the information.

[LSOA of Residence] and [LA of Residence]

SRH services record patient's addresses including postcodes at registration and should update these on subsequent visits. These postcodes do not flow through SRHAD due to confidentiality issues, instead, the postcodes are mapped to their corresponding Lower Layer Super Output Area (Person Residence) code (or equivalent – as defined by ONS) using the NHS Postcode Directory Gridlink® file. The mapped LSOA information should then be included in SRHAD. The mapping should be automatically done within your software system when a SRHAD extract is generated. Please contact your software supplier if this is not done.

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Records where the patient's postcode has not been provided to generate [LSOA of residence] should be allocated to 'not known' and coded "X99999999". Postcodes outside the UK (overseas visitors) should be allocated to 'not applicable' and coded "X99999998"

Validation rules:
1. The code must be a valid and current ONS English/Welsh LSOA, Scottish data zone, Northern Ireland SOA, or Channel Island/Isle of Man LSOA. Old codes will be flagged as warnings.

[LA of Residence]

SRH services record patient's addresses including postcodes at registration and should update these on subsequent visits. These postcodes do not flow through SRHAD due to confidentiality issues; instead, the postcodes should be mapped to their corresponding Local Goverment Geography Area Code (Local Authority District) http://odsportal.hscic.gov.uk/?Length=6n within the software using the NHS Postcode Directory Gridlink® file. The mapped LA information should then be included in SRHAD. The mapping should be automatically done within your software system when a SRHAD extract is generated. Please contact your software supplier if this is not done.

Records where the patient's postcode has not been provided to generate [LA of residence] should be allocated to 'not known' and coded "X99999999". Postcodes outside the UK (overseas visitors) should be allocated to 'not applicable' and coded "X99999998" .

Validation rules:
1. The code must be a valid and current ONS LA. Old 8 digit Northern Ireland codes are being permitted for a temporary period.

[GP Practice Code]

[GP Practice Code] is the code for the practice at which the patient is registered with their General Practitioner. This data item is system generated from the patient's GP details recorded at registration and should be updated on subsequent visits.

- V81997 should be used when a PATIENT presents, who is not currently registered at a GP Practice, but is eligible to be registered should they wish to.

- V81998 should be used where a PATIENT should not have a registered GP Practice, due for instance to them having only recently entered the country.

- V81999 should be used where it is not possible to determine a PATIENT's registered GP Practice code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the PATIENT cannot communicate and is unidentified).

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Validation rules:

1. The 6 digit code must be a valid and current ODS GP practice code. Old codes will be flagged as warnings.

2. An error will result if an incorrect code is entered.

Recording attendance information

The SRHAD dataset covers only face-to-face and non-face-to-face contacts with the service that requires clinical time. This can be in the clinic setting, in the patient's home or at an alternative location. Attendance data, including an initial contact indicator and attendance date, are required for commissioning as a marker of clinic activity.

[Attendance Date]

This is the date the patient attends their appointment with the service or the date they are attended on, in their home or other location.

Validation rules:
1. The attendance date must fall within the current collection year.

[Initial Contact]

This is recorded at the patient's first ever registration at this service; the options for this item is 'Yes' or 'No'. It allows commissioners to record new patients to the service and is particularly required in community services where many patients receive on going care.

Validation rules:
1. Where the same patient contacts the same service more than once during the year, only the first contact recorded can have an initial contact of "Yes" (though all contacts can be recorded as "No" if applicable).

[Consultation Medium Used]

Identifies the communication mechanism used to relay information between the care professional and the person who is the subject of consultation. [Consultation Medium Used] was introduced to the dataset from 1st January 2015. The following options can be selected:

- 01 = Face to Face
- 02 = Telephone
- 03 = Telemedicine Web Camera
- 04 = Talk Type for Person Unable to Speak
- 05 = Email
- 06 = Short Message Service (SMS) – Text Messaging
- 98 = Other

Validation rules:
1. Where the consultation medium is recorded as a non-face-to-face code (02 to 98) then the location code should not be B01 (health centre).

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[Location Type]

This is the location where the patient is seen by the service. The following options can be selected:

- A01 = Patient's Home
- B01 = Health Centre
- L99 = Educational Premises
- M01 = Prison
- N01 = Street or Other Public Space
- X01 = Other

Validation rules:
1. Where the location is recorded as health centre (B01) then the consultation medium code should not be non-face-to-face (02 to 98).

Recording contraception care

All contraception consultations, advice, administration, maintenance and changes in method are recorded in the following fields.

[Contraception Method Status]

[Contraception Main Method]

[Contraception Other Method (1 & 2)]

[Contraception Method Post Coital (1 & 2)]

Whenever the reason for the patient's attendance at the service is related to contraception care or advice on contraception methods then it must be recorded here.

Record contraception data only at the attendance where the contraception intervention occurs. An intervention is where the patient attended the clinic (or was attended to in the home/other location) for the purpose of changing, maintaining, supporting or initiating their method of contraception, e.g. having their device adjusted or checked, obtaining a repeat prescription, receiving combined oral pill to control bleeding with an implant, receiving advice on contraception methods.

For example, if a patient attends a clinic, for colposcopy treatment and as part of the consultation the clinician notes the patient main method of contraception, do not record here if no intervention in relation to the maintaining, changing or administrating main/other contraception method occurred during this consultation. However, if advice is given on contraception at this consultation then contraception advice can be recorded

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[Contraception Main Method] is recorded at ***every attendance*** where an intervention into the ***Main Method of contraception*** occurs or if there is an intervention into either of the contraception other method fields. For example, where the clinic issues the patient with a new Main Method of contraception, where a Main Method is changed from a previous Main Method (record only the 'newest' Main Method.) or where a current Main Method is being maintained, e.g. repeat pills or adjustment to an IUD. [**Contraception Main Method] needs to be recorded even if it is only for a repeat of the auxiliary method.**

All emergency contraception, whether an emergency main method or not, needs to be recorded in the Contraception Method Post Coital only.

If the patient receives more than one method of contraception , i.e. a method to support their Main Method then record up to two extra methods if applicable in [Contraception Other Method] fields.

If the patient only receives advice on contraception or has a consultation prior to obtaining any contraception method then record here using [Contraception Method Status] only.

Figure 1 provides a handy tool to clarify how the contraception data items should be recorded.

Please note:

- Sterilisation and Vasectomy are now recorded in [SRH Care Activity] fields as they are permanent contraception methods.
- All IUD, IUS and Implant removals are also recorded in [SRH Care Activity] fields as devices can be removed without changing the main method of contraception or a device can be fitted for non-contraception purposes and its removal may need to be recorded independently.

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[Contraception Method Status]

Record here where:

Code	Description
1	**New** is where the patient is not currently using a main method of contraception and who **receives** a method following the consultation for the first time or **receives** a method for the first time after a time lapse of one month or greater.
2	**Change** is where a patient changes from one main method of contraception to another, regardless of where the main method currently in use was obtained, e.g. GP or another SRH service. Only the new method is recorded in the [Contraception Main Method] field. This is where the actual method changes and not merely where a device is changed.
3	**Maintain** is where the patient receives care by attending the service (or are seen by the service at another location) with respect to their current main method of contraception (e.g. a repeat supply of pills or adjustment of a long acting contraception method) regardless, of where the current method was first obtained, e.g. GP or another SRH service.
4	**Pre Contraception Consultation/ Contraception Advice only** is where the patient receives an initial consultation on contraception prior to receiving a method or where the patient receives advice on the range of methods of contraception available, etc. ***without (yet) receiving a non-emergency method of contraception..***

[Contraception Main Method]

Record here the main method of contraception that the patient receives during their attendance from the service (or the main method the patient is maintaining under the service's care).

Available options:

01 = Injectable Contraception

02 = Implant

03 = IUD

04 = IUS

05 = Vaginal Ring

06 = Contraception Patch

07 = Combined Pill

08 = Progestogen only Pill

09 = Cap/Diaphragm

10 = Spermicides

11 = Natural Family planning

12 = Condom (Male)

13 = Condom (Female

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[Contraception Other Method] (1 & 2)

Record here where the patient receives either one or two auxiliary methods of contraception to support their main method. For example, contraception pills to support a long acting main method or contraception pills and condoms to support an IUS. The same options as [Contraception Main Method] listed above apply.

[Contraception Method Post Coital] (1 & 2)

Record here ***all emergency contraception*** administered to the patient. If both are given on the same day record other option in secondary [Contraception Method Post Coital] field.

1 = Emergency Oral

2 = Emergency IUD

Validation rules:

1. If the patient is receiving, maintaining or changing a Main Method of contraception then the Main Method must always be recorded at every attendance and if the Main Method is recorded then [Contraception Method Status] must be 1, 2 or 3.

2. If [Contraception Other Method] is recorded then [Contraception Main Method] must also be recorded.

3. If [Contraception Method Status] is recorded as 4 then [Contraception Main Method] must be left blank. If the patient is consulting on contraception methods or is obtaining advice on methods but has not yet received their method from this service then no Main Method should be recorded here.

4. If the patient is in receipt of emergency contraception only and it is not in support of a Main Method of contraception, then this is recorded only under [Contraception Method Post Coital]. If the emergency contraception is in support of a Main Method, or is to be used as an ongoing main method (for emergency IUDs) then the Main Method and [Contraception Method Status] must also be recorded.

5. When Contraception Main Method is 03 (IUD) or 04 (IUS) then SRH Care Activity cannot be 22 (IUS insertion (non-contraception)) or 23 (IUS check (non-contraception)). CMM codes 03 & 04 should only be used when the IUS / IUD is being used as a method of contraception

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If a patient has an IUD which was fitted by another service, what do I record when I give the patient advice on possible alternative methods of contraception?

3 – Maintain, as the patient is already using an IUD as contraception. Advice is presumed as been given at every consultation where required.

How do I record that the patient needs advice before deciding to switch from their Main Method of contraception?

This is a consultation re the current method of contraception: therefore record [Contraception Main Method] with the current Contraception Main Method and update [Contraception Method Status] = 3. (Consultation on possible change of a current method including advice is recorded as maintenance of a current method)

How do I record when the patient is switching from one Main method to another Main method of contraception?

Record the new [Contraception Main Method] and [Contraception Method Status] = 2

How do I record that the patient is maintaining their Main method but we need to change their IUS device?

Record their current [Contraception Main Method] and update [Contraception Method Status] = 3 (i.e. maintenance of their Main Method) then record [SRH Care Activity] = 20 (IUS removal)**.** This allows us to count the number of attendances related to a Main Method of contraception and also to record independently the number of devices removed. It also allows us to record the time interval between device insertion and removal once continuous data sets are flowing to NHS Digital

Do IUD, IUS or Implant 'checks' count as an intervention although the actual device may not be removed or replaced?

Any checking of a current method of contraception should be recorded in [Contraception Main Method] and [Contraception Method Status] = 3 as this counts as a consultation on the patients contraception care, i.e. an intervention.

How do I record if a method problem is addressed (e.g. bleeding problems on the injection, Emergency Hormonal Post Coital Contraception given following missed pills, or EHPCC given following LARC previously administered but not yet active) yet repeat supplies of the Contraception Main Method of contraception are not required or administered.?

Record here as a maintenance of a main contraception method using [Contraception Main Method] and [Contraception Method Status] = 3 also record any emergency contraception in [Contraception Method Post Coital] and any supporting method in [Contraception Other Method].

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If contraception is given to support a Main Method (e.g. given COC to control bleeding problems seen with Implant use) do we still record this as a 'Maintain' under this category? In these circumstances, the actual Implant may or may not be physically checked, as the reason is commonly (but not always) a simple hormonal side effect?

Record 'implant' using [Contraception Main Method] = 02 and 'combined pill' in [Contraception Other Method] = 07 and [Contraception Method Status] = 3. Although the Main Method has not actually been adjusted the purpose of the consultation is the maintenance of the current Main Method of contraception.

How do we record if an emergency IUD is fitted that is also to be used as the ongoing Main Method. Would we also record under these categories?

The NHS data dictionary has separated emergency and Main Method of contraception into two different fields and therefore if emergency contraception is given to a patient (whether as a Main Method or not) it will need to be recorded in the [Contraception Method Post Coital] field. If the patient receives an emergency IUD that also continues as the Main Method of contraception, record both emergency IUD in [Contraception Method Post Coital] and in [Contraception Main Method].

How do we record where repeat supplies of spermicide are given to support diaphragm users but a new diaphragm is not also needed or given?

Record 'Diaphragm' using [Contraception Main Method] = 09 and 'Spermicide' in [Contraception Other Method] = 10 and [Contraception Method Status] = 3.

If condoms are issued primarily to protect against Sexually Transmitted Infections, when another Main Method of contraception is in use do we still record condom supply under [Contraception Other Method]?

Record [Contraception Other Method] = 12 if male condoms are a supporting method of contraception. If condoms are provided on reception or through vending machines then this is not part of a clinical consultation and should not be recorded through SRHAD.

If condoms are supplied to prevent both unintended pregnancy and STIs, record [Contraception Other Method] = 12.

If the purpose of condoms is to support STI prevention but not to protect against unintended pregnancy and they are given to the patient with appropriate advice, then record using 'Sexual Health Advice' under [SRH Care Activity] field.

How do we record where emergency hormonal contraception is given to the patient for future use?

Record all emergency contraception in [Contraception Method Post Coital] whether given for future use or not as all constitutes activity and cost to the service.

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How do you record a patient who comes for an auxiliary method of contraception but not their Main Method?

A: In the Contraception Method Status enter 3 (maintain), in Contraception Main Method enter the code for their Main Method e.g. 07 (combined pill) and in Contraception Other Method enter the auxiliary method e.g. 12 (male condom).

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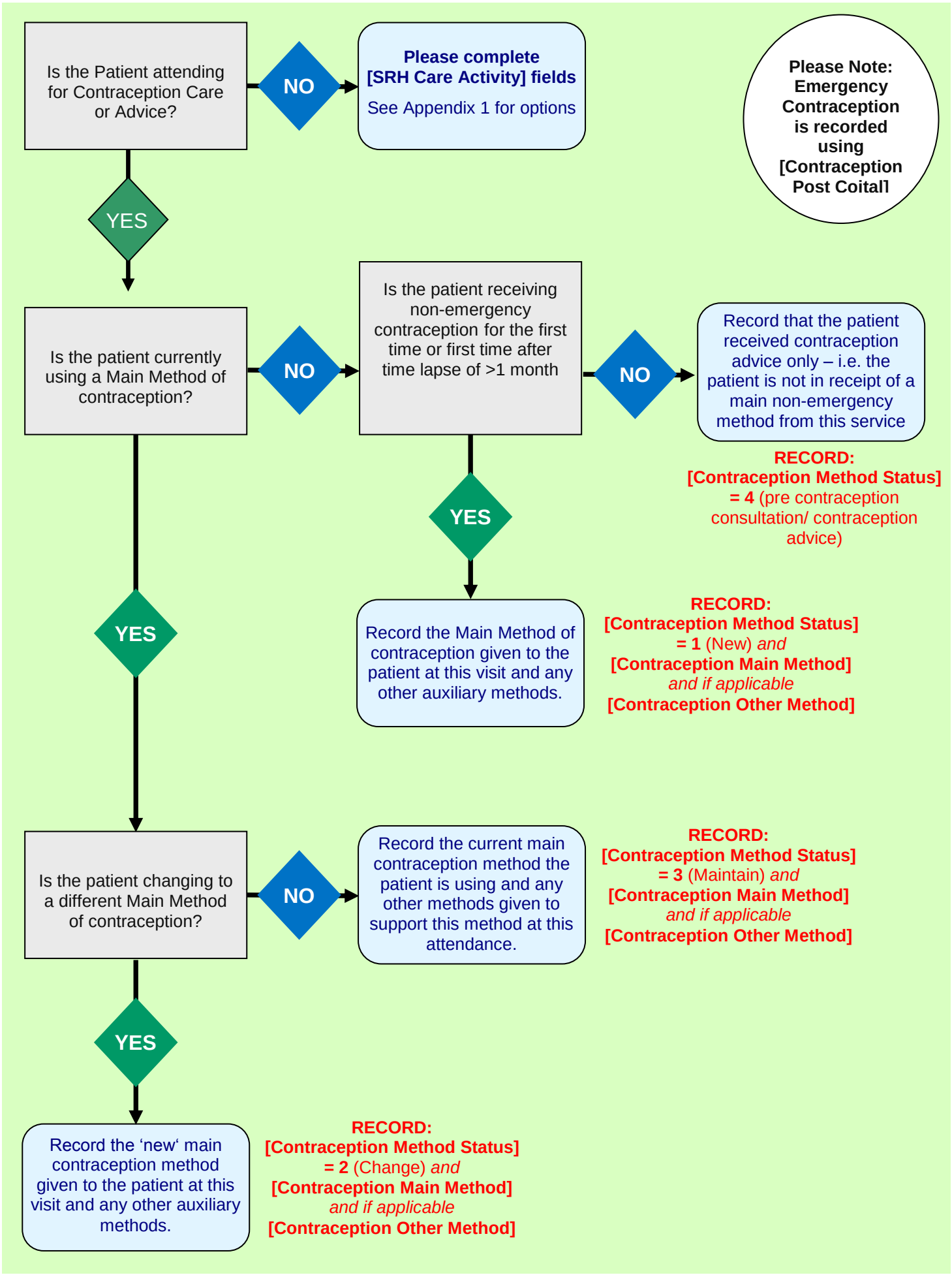
Figure 1. Contraception care data capture flow diagram



Recording sexual and reproductive healthcare activities

Other sexual and reproductive health care activity can be recorded under data item SRH Care Activity. Where patients were seen for contraception purposes and for an SRH Care activity, all attendance activities should be recorded for SRHAD. Up to six codes can be entered per patient, but must be entered consecutively with no gaps.

1. Sexual Health Advice

SRH services provide public and sexual health advice as part of the clinical care of their patients. In most instances this advice is an inherent part of the treatment or care given to the patient and is thus not recorded here, e.g. advice given during an abortion assessment or advice given during a psychosexual therapy session. However where the patient receives advice only (with the offer of condoms for safer sex) and it is not an inherent part of another activity listed under [SRH Care Activity] field record here under 'sexual health advice'.

The **exception** to this is where the patient receives advice on pregnancy options (including advice on termination & miscarriage) **then** 'Pregnancy Advice and/or Options Information' ([SRH Care Activity] = 03) is recorded and where the patient received advice on contraception care and methods then [Contraception Method Status] = 4 is updated. This enables us to distinguish where advice is specifically related to pregnancy or contraception, which covers the majority of activities at most SRH services.

In order to limit the quantity of options available as part of SRHAD it is not necessary for national reporting to distinguish all aspects of advice given to the patient. Therefore, we have included the option 'sexual health advice' to cover all other advice options where this advice is not an inherent part of their care as recorded under another activity. A service may wish to locally sub divide 'sexual health advice' into specific advice options which should all then be mapped to this options 'sexual health advice' for reporting through SRHAD.

Questions & Answers

What if I advise the patient on contraception methods available and then they choose a method. How do I record that I gave them advice?

This is part of the contraception consultation and therefore inherent when [Contraception Main Method] is recorded. (Contraception advice is recorded where no method is provided).

What if I give advice on contraception methods during cervical screening?

As this is contraception advice (without administering a contraception method) then it is recorded using [Contraception Method Status] = 4.

What if I give advice related to the menopause. How do I record this?

If this advice is inherent and part of 'Menopause Management and Treatment' then 'Menopause Management and Treatment' ([SRH Care Activity] = 24) is recorded. However if

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the patient receives merely general advice on the menopause without commencing any treatment then record under 'sexual health advice' ([SRH Care Activity] = 01).

What if I give advice related to sexual dysfunction. How do I record this?

If this is part of the psychosexual treatment of the patient then it should be recorded under 'psychosexual therapy' ([SRH Care Activity] = 12) and be provided by a trained counsellor. Otherwise, if this is general sexual dysfunctional advice and is not included as part of the patients sexual dysfunction care then record under 'sexual health advice' ([SRH Care Activity] = 01).

If I refer a patient to another service for colposcopy care how do I record that I have given this patient advice regarding their treatment as part of the referral process?

For colposcopy, abortion, sterilisation, vasectomy and psychosexual referrals advice is an inherent part of the referral and does not need to be recorded separately.

2. Pregnancy Test

SRH services administer pregnancy testing at their services and provide patients with pregnancy test equipment on departure. This option will record all instances where pregnancy testing was part of the clinic's activity.

This option can be recorded with up to five other care activities and contraception methods on SRHAD. In many instances this is recorded along with 'Pregnancy Advice and/or Options Information' advice' ([SRH Care Activity] = 03) as the patient may have used the service to confirm pregnancy and then proceeded to discuss options.

3. Pregnancy Advice and/or Options

Where the patient is confirmed pregnant (and usually recorded under the option 'pregnancy test') and the patient requires advice and detailed discussion on options available. This can include a discussion on the option around termination and advice where the patient may have suffered a miscarriage.

Questions & Answers

Why is there the option 'Pregnancy Advice and/or Pregnancy Options Information', and an option 'Pre Abortion Counselling' and 'Abortion Assessment'?

'Pregnancy Advice and/or Pregnancy Options Information' relate to general advice about the pregnancy and various options are discussed while 'Pre Abortion Counselling' is counselling by a trained counsellor that is part of the pre abortion care of the patient. Abortion assessment includes a clinical assessment of the patient prior to abortion along with patient consent.

4. Abortion Assessment

This option allows for the recording of a clinical abortion assessment at SRH services and includes a clinical assessment of a patient considering termination of pregnancy. It includes assessment of gestation, medical history and social circumstances, a detailed discussion of

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the options available, their appropriateness and (usually) obtaining informed consent for any chosen procedure.

Questions & Answers

How does an Abortion Assessment differ from option 3 'Pregnancy Advice and or Pregnancy Options Information'?

An Abortion Assessment includes a clinical assessment while Pregnancy Advice and/or Options' are a more general consultation pre the decision to begin an abortion clinical assessment.

Only record 'Abortion Assessment' where the patient receives a clinical assessment. Separately record a scan using option 27 'Ultra Sound Scan'.

5. Pre Abortion Counselling

This option includes counselling given pre abortion by a trained counsellor.

Questions & Answers

We specifically employ a trained counsellor (non-clinician) who runs a separate dedicated (pre and post termination) counselling clinic on psychological and emotional issues surrounding termination. Should we use this code in this instance, or another one?

Record all instance of pre abortion counselling if given by a trained counsellor here – otherwise if general advice on options given by a clinician record under Pregnancy Advice and/or Options' ([SRH Care Activity] = 03).

6. Abortion Medical Procedure & 7. Abortion Surgical Procedure

Record every attendance that the patient has with the service in relation to their abortion procedure. Surgical and medical abortion procedures need to be recorded separately.

Questions & Answers

Most of our patients have a medical abortion, which involves more than one attendance. How do I record this?

Record abortion medical procedure at every attendance relating to the procedure.

Validation Rule

Record either 'Abortion Surgical Procedure' or 'Abortion Medical Procedure'. Do not record both for the same patient at the same attendance.

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8. Abortion Aftercare

If after the abortion procedure, the patient attends at the service for aftercare record here for each aftercare attendance.

Questions & Answers

What if after the abortion procedure the patient attends at the service for aftercare including contraception advice and post abortion counselling – how do I record this?

Record abortion aftercare for post abortion care ([SRH Care Activity] = 08) and record post abortion counselling if offered by a trained counsellor ([SRH Care Activity] = 10) and record [Contraception Method Status] = 4 if advice is given on contraception (or record a [Contraception Main Method] option if a method of contraception is administered to the patient.

9. Abortion Referral (with Advice)

Record here where the patient is referred to an abortion service including any advice given to the patient about their abortion care.

Questions & Answers

How do I record where I gave the patient advice on their pregnancy and options available and then refer for abortion to another provider

Record both the option 'Pregnancy Advice and/or Options' ([SRH Care Activity] = 03) and Abortion Referral (with advice) ([SRH Care Activity] = 09).

Validation Rule

Record only 'Abortion Referral' ([SRH Care Activity] = 09) **OR** 'Abortion Medical/Surgical Procedure' ([SRH Care Activity] = 06/07). Do not record both for the same patient at the same attendance.

10. Post Abortion Counselling

This option includes counselling given post abortion by a trained counsellor.

Questions & Answers

How do I record that a patient returns to our service after their abortion at another NHS service for advice and contraception care which is not offered by a trained counsellor?

Record using 'Abortion Aftercare' ([SRH Care Activity] = 08) and record contraception using [Contraception Main Method] and [Contraception Method Status].

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11. Cervical Screening

Record here all instances of cervical screening including smear test and cytology.

12. Psychosexual Therapy

This option is recorded for all attendances where psychosexual therapy is provided by a trained counsellor. It includes the initial consultation with the patient on starting therapy.

Validation Rule

Record either 'Psychosexual therapy' **OR** 'Psychosexual referral'([SRH Care Activity] = 13) but not both at the same attendance.

13. Psychosexual Referral (with Advice)

Record here all referrals to a psychosexual service provide by a trained counsellor.

Validation Rule

Record either 'Psychosexual therapy' ([SRH Care Activity] = 12) **OR** 'Psychosexual referral' but not both at the same attendance.

A warning will be generated if SRHCA 12 (Psychosexual Therapy) and 13 (Psychosexual referral (with advice) appear in the same record on the same day. They should not appear on the same record as they don't usually happen on the same day.

14. Sterilisation/Vasectomy Assessment

Record here every attendance where the patient attends for an assessment pre sterilisation/vasectomy procedure.

15. Sterilisation/Vasectomy Treatment (including procedure)

Record here every attendance where the patient attends for sterilisation or vasectomy procedure.

16. Sterilisation/Vasectomy Aftercare

Record here every attendance where the patient attends for sterilisation or vasectomy aftercare.

17. Sterilisation/Vasectomy Referral (including advice)

Record here where the patient is referred to another service for a sterilisation or vasectomy procedure.

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Validation Rules

1. Record 'Sterilisation/vasectomy treatment' ([SRH Care Activity] = 15) **OR** 'Sterilisation /vasectomy referral' ([SRH Care Activity] = 17) but not both at the same attendance.

2. Record 'Sterilisation/vasectomy treatment' ([SRH Care Activity] = 15) **OR** 'Sterilisation /vasectomy aftercare' ([SRH Care Activity] = 16) but not both at the same attendance.

18. PMS Treatment

Record this option for every attendance where the patient receives treatment and care for PMS and or PMT. This includes consultation, clinical care and all therapies.

19. Implant Removal, 20. IUS Removal & 21. IUD Removal

Record here all instances where an IUS, IUD or Implant device is removed.

22. IUS insertion (non contraception) & 23. IUS check (non contraception)

Record here all IUS insertions or where the patient attends to check their IUS **and** where the IUS is for non-contraception reasons.

Questions & Answers

How do I record other, non-IUS methods of contraception which are given for non-contraception purposes (and not for menopause management)?

Record using "Other Gynaecology Treatment and Care" ([SRH Care Activity] = 29).

If the IUS insertion is to support a Contraception Main Method then record under [Contraception Other Method] = 04. However if the IUS is for menorrhagia purposes only including to support menopause treatment and care then record here.

24. Menopause Management and Treatment (excluding IUS insertion/check)

Record this option for every attendance where the patient receives treatment and care for Menopause. This includes consultation, clinical care and all therapies.

25. Colposcopy Treatment

Record this option for every attendance where the patient receives colposcopy treatment.

Validation Rule

1.A warning will be generated if SRH Care Activity 25 (Colposcopy Treatment) and 26 (Colposcopy referral (with advice) are recorded together for the same patient. They should not appear on the same record as they don't usually happen on the same day.

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26. Colposcopy Referral

Record this option for every attendance where the patient is referred to another service for colposcopy treatment and care.

27. Ultra Sound Scan

All ultra sound scans given to the patient are recorded using this option.

28. Sub Fertility Treatment and Care

Record this option for every attendance where patient receives sub fertility treatment and/or care including a consultation, blood test for sub fertility purposes and semen analysis. Record all ultra sound scans using option '27 = Ultra Sound Scan'.

29. Other Gynaecology Treatment and Care

Record this option for every attendance where patient receives gynaecology treatment not covered under cervical screening, colposcopy and sub fertility care. This includes gynaecology consultation, investigation (vaginal or pelvic examination) and treatment.

30. Alcohol Brief Intervention

Record here for every attendance where the service provides the patient with a brief alcohol intervention as set out in Public Health England's Alcohol Learning Resources. Please see Identification Tools, Structured Brief Advice Tool and Clarifying Brief Interventions resources at the following link:

https://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/

31. Safeguarding Children Referral

Where there is a possibility that children who attend SRH services are being abused either physically, sexually or emotionally and where services complete the necessary local agreed safeguarding procedures and referral forms then record here for all attendances that include a safe guarding children referral. Please see the following link for more information on safeguarding children.

http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren

32. CAF (Common Assessment Framework) Referral

This option relates to additional needs of children and young people and can include CAF, SEND (Special Education Needs and Disabilities) support or EHC (Education, Health and Care) plan related referrals. You may wish to adjust local labelling of this option if relevant. The Framework was originally set out by the Department for Children, Schools and Families

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and the CAF approach is still operating in many areas. Please see the following archived links for information on the CAF forms and standards:

http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFES-0337-2006

http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/caf-practitioner-guide.pdf

Updated guidance regarding SEND and EHC assessments and plans can be found here:

https://www.gov.uk/children-with-special-educational-needs/overview

33. Other Referrals

Record here for all other referrals from the service not included above. These include referrals to GUM clinics, Primary care, Gynaecology departments and other outpatient services.

Questions & Answers (Options 11 to 33)

Where do I record treatment on erectile dysfunction?

If the treatment includes psychosexual therapy then record ([SRH Care Activity] = 12). However, if the treatment is the administration of appropriate drugs record locally but do not include on SRHAD which does not collect drug data.

34. STI Related Care

Record here any sexually transmitted infections related attendances, such as chlamydia tests. If your service also submits GUMCADv2, the detail of the STI care will be recorded within the GUMCAD return.

35. Complex Long- Acting Reversible Contraception procedures

Complex Implant procedures:

- Removal of deep or impalpable implant
- Removal/Insertion of Implant where a previously attempted procedure of removal/Insertion had failed
- Removal of implants not licensed in UK (e.g. Norplant/Jadelle)

Complex IUD/IUS procedures:

- IUD/IUS removal where previous attempt at removal has failed
- IUD/IUS removal with missing threads
- IUD/IUS insertion where previous attempt at insertion has failed
- IUD/IUS insertion in the presence of genital tract

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- anatomical abnormality (fibroids distorting uterine cavity, congenital uterine anomalies, cervical scarring due to previous cervical surgery, uterine scarring from previous multiple caesarean sections or myomectomy)
- IUD or IUS insertion in the presence of complicating medical conditions (heart disease, epilepsy, anticoagulant therapy, extreme anxiety, learning disability)
- Gynefix insertions

36. Complex Contraception

Contraceptive assessment and development of contraception plan in women with co-existent UKMEC 3 or 4 conditions requiring specialist input. This only applies to contraindications to the contraceptive method being considered, thus cardiovascular disease would come under this category for a woman wanting combined hormonal contraception, but not for a woman wanting an IUD unless she was so ill as to make the possible insertion difficult or hazardous. UKMEC 3/4 is as defined in the UKMEC guidance on the FSRH website.

Management of major complications or intractable side-effects due to contraception requiring specialist input. This does not apply to situations involving dealing with minor side effects due to contraception. It involves conditions that require liaising with other specialists or needing specialist intervention.

37. Medical Gynaecology

Specialist gynaecological investigation (Pelvic ultrasound scan and/or endometrial biopsy and/or hormonal profile) AND management of abnormal uterine bleeding (HMB, IMB, PCB, oligo/amenorrhea and persistent bleeding problems in women using contraception). This code should not be used for short term bleeding (3 months or less) nor for basic investigations such as infection screening or cervical cytology. Where ultrasound is performed in the clinic it should be recorded as SRH care activity code 27 in addition to the 37 code.

Specialist investigation (e.g. pelvic ultrasound) and management of persistent pelvic pain (includes dysmenorrhea, deep dyspareunia). This code should not be used for initial assessment of pelvic pain symptoms with a detailed history taking, abdomino-pelvic examination and basic investigations such as infection screening. This should also not be used for initial management of pelvic pain such as treatment of pelvic inflammatory disease (PID), use of Mefenamic acid or combined oral contraceptive (COC) for dysmenorrhea. Where ultrasound is performed in the clinic it should be recorded as SRH care activity code 27 in addition the 37 code.

38. Care of Prostatis

Investigation and treatment of acute or chronic prostatitis which requires 28 days of antibiotic treatment +/- specialist input and investigations.

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39. Genital Dermatoses

Investigation and treatment of genital dermatoses which require more senior clinical input e.g. lichen sclerosis, lichen planus, eczema and psoriasis. This code should be used for patients undergoing skin biopsy and those requiring longer courses of treatment (e.g. with topical steroids). This code should also be used for those patients with recalcitrant or difficult to treat genital warts (requiring treatment / follow-up > 12 weeks) or those requiring more specialist therapies e.g. hyfrecation. This code should not be used for 'simple' skin rashes e.g. those treated empirically on the first visit with Canesten HC. This code should only be used in patients with genital warts whose treatment requires specialist input and is lasting longer than 12 weeks.

40. Sexual Assault (acute presentation)

Record attendances for sexual assault where the time between incident and medical examination is within 7 days.

41. Sexual Assault (non-acute presentation)

Record attendances for sexual assault where the time between incident and medical examination is greater than 7 days.

Other Guidance

Supportive arrangements should be made where necessary for patients who do not have English as a first language, or who are visually impaired or have other disabilities that may affect their ability to complete a registration form e.g. literacy.

Patients should be made aware that the questions on the registration form and at consultation are designed to help manage their care, and there is also the added benefit that information collected from everyone who attends can be used to help improve services in future.

Clinics should be aware that some patients will have questions regarding these items.

How NHS Digital and PHE use the data

Purpose of the SRHAD return

The SRHAD data are collected and analysed to monitor contraception uptake of people attending SRH services, to understand community sexual health services provided to patients both nationally and locally, to support commissioning of community sexual health services, to reflect and standardise current local data collection practices, to develop over time indicators of quality and outcome in sexual health delivery, to benchmark services, to support the delivery of public health and inform sexual health policy development.

For example, the data can be used to identify (1) the number of women attending SRH services who switch to Long Acting Reversible Contraceptive (LARC) methods year on year, (2) the increase in the number of young people receiving contraception advice and care post

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termination or (3) the number of women who report failure in contraception methods either through the need for emergency contraception, pregnancy advice or abortion procedures/referrals.

This information is used to inform the public health response by:

- Improving the planning and management of services.
- Developing, adapting and refining interventions.
- Monitoring the effectiveness of sexual health policies.

Types of output

PHE and NHS Digital are undertaking detailed analyses of the SRHAD data received to see how it can be used to create outputs that best meet users' needs. An expert advisory group has been set up to inform the process. Outputs will be made available to stakeholders and national data will be available on the NHS Digital and PHE websites. For example:

- NHSDigital's 2015/16 report is available at: http://www.content.digital.nhs.uk/catalogue/PUB21969.
- PHE provides local authority level indicators in the Sexual and Reproductive Health Profiles available at: http://fingertips.phe.org.uk/profile/sexualhealth.
- PHE also provides further analyses in Local Authority HIV, Sexual and Reproductive Health Epidemiology Reports (LASERs). Local Authorities can obtain these reports from their PHE Centre; contact details are available here: https://www.gov.uk/guidance/contacts-phe-regions-and-local-centres.

Confidentiality and anonymity

Data items

SRHAD includes local patient identifier (which is a 'pseudonymised' local clinic identifier code), age and ethnicity of the patient, LSOA of Residence and LA of residence. No information that can identify an individual patient will flow from SRH clinics as part of this dataset. The full dataset is described in Appendix 1.

NHS Digital and PHE will have no access to the original record or the capability to link backwards to the clinic of origin to identify patients. The local patient identifier is removed and replaced with a pseudo identifier before the data is shared with PHE.

As the local patient identifier is unique to the SRH service only, it cannot be used by NHS Digital to link to other patient level records from other sources.

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Patient consent

Where patients express concern regarding supplying their data and it being reported to NHS Digital please;

- Explain the uses of the data i.e. what they are consenting to, which is to allow information to be recorded and reported to improve the services and to protect public health. This will reassure the vast majority of patients. When necessary, patients should be reassured that their personal data are held in strict confidence and that no personally identifiable information will be reported outside the service.

- If there are still on-going concerns, some systems allow for the use of aliases. Whilst this is not ideal it is preferable to not recording the data at all. This should then allow for the reporting of data for these patients.

Sexual Health patients will largely consent to the collection of data once they are assured that their details are kept secure on the local IT system and that only pseudonymised data is shared for the purposes of public health. GUM services now routinely collect patient postcode and other demographic details but only transmit pseudonymised patient details to PHE.

NHS Digital Information Governance Processes

NHS Digital is committed to ensure that it maintains a comprehensive range of security policies and procedures, aimed at providing staff members with 'best practice' guidance on how to help protect NHS Digital from the dangers of disclosure, inaccuracy, incompleteness or unavailability of its information. In addition NHS Digital ensures that where any data is shared with a third party organisation robust Data Sharing Agreements are put in place to ensure that Information Governance Standards are adhered to. The Data Sharing Agreements have terms and conditions which specifically forbid reidentification. Further information on what to expect when NHS Digital collects personal information is provided in the Privacy Notice: https://digital.nhs.uk/article/236/Privacy-and-cookies.

PHE information governance processes

PHE receives an annual copy of the SRHAD database from NHS Digital through a secure file transfer process, and processes this according to the data sharing agreement with NHS Digital. This includes not sharing SRHAD data with third parties. PHE also maintains a comprehensive range of data security processes. Further information on how PHE deals with data is provided in the Fair Processing Notice: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/421854/PHE_fair_processing_notice.pdf

NHS Digital's submission process

The submission platform (SDCS) deployed to collect SRHAD extracts from services is a secure method of online data transfer that allows encrypted files to be uploaded by named and registered individuals. These files will be processed as they arrive to get them into NHS Digital's Data Management Environment.

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To access the web based SDCS system, users need to register with NHS Digital to get a Single-Sign-On account. When submitting data, a user name and password are required to validate a user's identity.

The SDCS system only accepts text files in a .csv format

SRHAD support – contact us

For queries regarding collection or submission of data please contact Data Collections Team at NHS Digital:

data.collections@nhs.net

For suggestions regarding further development of the dataset please contact the Risk Factors Intelligence Team's Chief Knowledge Officer at Public Health England:

srhad@phe.gov.uk

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Appendix 1. Format of SRHAD return

Position*	Field Name	Description	NHS Data Dictionary Data Element	Variable Length (maximum)≠	Example±
1	Organisation ID	Organisation Code of the Service	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	AN(3)**	RVY
2	Clinic ID	Clinic (service) ID code	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	AN(5)**	RVY39
3	Patient ID	Local patient ID used to identify a patient	LOCAL PATIENT IDENTIFIER	AN(10)	AL000245
4	Gender	Gender	PERSON STATED GENDER	AN(1)	1
5	Age	Age at attendance date in years	AGE AT ATTENDANCE DATE	N(3)	16
6	Ethnicity	Patient's ethnic category	ETHNIC CATEGORY CODE	AN(2)	A
7	LSOA of Residence	Lower layer super output area of residence of the patient	LOWER LAYER SUPER OUTPUT AREA (PERSON RESIDENCE)	AN(9)	E01032365
8	LA of Residence	Local Authority (LA) of patient residence	ONS LOCAL GOVERNMENT GEOGRAPHY AREA CODE (LOCAL AUTHORITY DISTRICT).	MIN AN(3) MAX AN(9)	E07000243
9	GP Practice Code	It is the CODE of the GP Practice that the patient is registered with.	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	AN(6)	V81997
10	Date of Attendance	Date of Attendance	ATTENDANCE DATE	AN(10) CCYY-MM-DD	1981-11-18
11	Initial Contact	The patients first ever contact with this service	INITIAL CONTACT INDICATOR	AN(1)	Y
12	Consultation Medium Used	Identifies the communication mechanism used to relay information between the care professional and the person who is the subject of consultation.	CONSULTATION MEDIUM USED	AN(2)	01
13	Location Type	Where the patient consultation/treatment took place	ACTIVITY LOCATION TYPE CODE	AN(3)	B01
14	Contraception Method Status	Type of Contraception Consultation	CONTRACEPTION METHOD STATUS	AN(1)	1

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Position*	Field Name	Description	NHS Data Dictionary Data Element	Variable Length (maximum)≠	Example±
15	Contraception Main Method	Main method of contraception of the patient	CONTRACEPTION PRINCIPAL METHOD	AN(2)	12
16	Contraception Other Method 1	Supporting contraception method	CONTRACEPTION OTHER METHOD	AN(2)	13
17	Contraception Other Method 2	Supporting contraception method	CONTRACEPTION OTHER METHOD	AN(2)	07
18	Contraception Method Post Coital 1	Emergency Contraception	CONTRACEPTION METHOD POST COITAL	AN(1)	1
19	Contraception Method Post Coital 2	Emergency Contraception	CONTRACEPTION METHOD POST COITAL	AN(1)	2
20	SRH Care Activity 1	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	36
21	SRH Care Activity 2	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	35
22	SRH Care Activity 3	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	36
23	SRH Care Activity 4	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	11
24	SRH Care Activity 5	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	20
25	SRH Care Activity 6	Sexual & Reproductive Health Care Activity received by patient	SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY	AN(2)	22

*****Refers to the horizontal position of the field within CSV format

≠AN = Alpha-numeric, N = Numeric, A = Character. Number in brackets denotes the string length.

±Example of field content, also used to illustrate extract format expected (see Appendix 1)

**NHS Data Dictionary has additional format lengths for this variable, however only the format length stated in the table above is accepted for the SRHAD extract.

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Appendix 2. Example of CSV format for SRHAD return

For one row of data:

Organisation ID, Clinic ID, Patient ID, Gender, Age, Ethnicity, LSOA of Residence, LA of Residence, GP Practice Code, Date of Attendance, Initial Contact, Consultation Medium Used, Location Type, Contraception Method Status, Contraception Main Method, Contraception Other Method 1, Contraception Other Method 2, Contraception Method Post Coital 1, Contraception Method Post Coital 2, SRH Care Activity 1, SRH Care Activity 2, SRH Care Activity 3, SRH Care Activity 4, SRH Care Activity 5, SRH Care Activity 6

RVY,RVY39,AL000245,1,16,A,E01032365,E07000243,V81997,18/11/1981,Y,1,B01,1,12,13,7,1,2,36,35,36,11,20,22

NB. There should be 25 fields contained in the CSV output. If a field is not applicable leave this blank, do not complete with NULL, “0” or any other characters. The file will fail to upload if 25 fields are not included.

Only the following fields can be left blank:

- Contraception Method Status
- Contraception Main Method
- Contraception Other Method 1 & 2
- Contraception Method Post Coital 1 & 2
- SRH Care Activity (1 to 6)

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Appendix 3. Coding specification for SRHAD

Patient Registration Information (*Record for every contact)*						
Field Name	**Code Options**				**Format**	**Notes**
Organisation ID	ODS code to identify service provider http://odsportal.hscic.gov.uk/ (From 01/04/2020 new codes will be 5 characters)				Mandatory Length an3	This must be a valid code issued by the ODS If you do not know your Organisation Identifier code, contact Exeter.helpdesk@nhs.net If you do not know your Organisation Site Identifier code, contact Exeter.helpdesk@nhs.net
Clinic ID	ODS code to identify clinic or site http://odsportal.hscic.gov.uk/				Mandatory Length an5	
Patient ID	Local patient ID used to uniquely identify a patient within a SRH service.				Mandatory Length an10 (max)	Local patient Identifier or can be assigned automatically by the IT system. This field MUST NOT contain any information which could directly identify the patient such as NHS Number, name, address, postcode or date of birth. A warning will result if an NHS number is used. An error will result if a date or postcode format is used.
Gender	**1**	Male	9	Indeterminate (unable to be classified as male or female)	Mandatory Length an1	A self-defined classification of the current sex of a person, or inferred by observation for those unable to declare their gender. Some contraception codes, main methods and SRH Care Activities are gender specific. For Transgender patients code 9.
	2	Female	X	Not Known		
Age	Enter date of birth and the software system will generate their age at attendance. Age at attendance date in years.				Mandatory Length an3	Not known = 999 A warning will result for patients under 11 and over 80. An error will result if patient is recorded as zero or blank

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Field Name	Code Options		Format	Notes
Ethnicity	**White** A British B Irish C Any other White background **Mixed** D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background **Asian or Asian British** H Indian J Pakistani K Bangladeshi L Any other Asian background	**Black or Black British** M Caribbean N African P Any other Black background Other Ethnic Groups R Chinese S Any other ethnic group Z Not stated 99 Unknown	Mandatory Length an2	Patients select their own ethnic category. Ethnicity should not be defined by clinic staff. National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known
Lower Super Output Area (LSOA) of Residence	England codes begin with E01 Wales codes begin with W01 Scotland codes begin with S01 Northern Ireland codes begin with 95	L99999999 = Channel Islands M99999999 = Isle of Man X99999998 = Outside the UK X99999999 = Not known Please note that all LSOA codes are 9 digits except Northern Ireland which are 8 digits	Mandatory Length an9	LSOA of residence should be generated from patient postcode. The latest postcode mapping file (postcode directory is available from the Office for National Statistics at https://data.gov.uk/dataset/national-statistics-postcode-lookup-uk

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Field Name	Code Options				Format	Notes
Local Authority (LA) of Residence	There is an LA for each postcode in the UK (or equivalent – as defined by ONS). Records where the patient's postcode has not been provided to generate LA of residence should be allocated to 'not known' and coded "X99999999". Postcodes outside the UK (overseas visitors) should be allocated to 'not applicable' and coded as "X99999998" LA codes are 9 digits except Northern Ireland (DCA) which were recently updated from 3 digits to 9 digits. 3 digit Northern Ireland codes are still accepted until further notice or update from NHS Data Dictionary				Mandatory Length min an3 / max an9	LA of residence should be generated from patient postcode. The latest postcode mapping file (postcode directory is available from the Office for National Statistics at https://data.gov.uk/dataset/national-statistics-postcode-lookup-uk
GP Practice Code	http://odsportal.hscic.gov.uk/		Enter the patient's registered GP details; the system≠ should generate the GP Practice code.		Mandatory Length an6	Your system supplier is responsible for keeping the list of codes up to date in your system. A warning will result if an inactive code is entered. An error will result if an incorrect code is entered.
Attendance Information *(Record for every contact)*						
Date of Attendance	CCYY-MM-DD e.g. 2016-11-18				Mandatory Length an10	Enter date patient attended/received service. The date entered must be within the reporting year
Initial Contact	**Y**	Yes	**N**	No	Mandatory Length a1	Identifies patient's first ever contact at this service. Any subsequent visits (regardless of time gap) should be coded as N. Dates of attendance are used in the validation for this field. Initial Contact can only be 'Yes' on an individual patient's first record. All subsequent records must be recorded as 'No'.

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Field Name	Code Options				Format	Notes
Consultation Medium Used	**01**	Face to face communication	**05**	Email	Mandatory Length n2	Telephone contacts solely for informing PATIENTS of results are excluded. Identifies the communication mechanism used to relay information between the care professional and the patient. Code 01 must be entered if location type code is B01.
	02	Telephone	**06**	Short Messaging Service (SMS) – Text Messaging		
	03	Telemedicine web camera	**98**	Other		
	04	Talk type for a PERSON unable to speak				
Location Type	**A01**	Patient's Home	**M01**	Prison	Mandatory Length an3	Identifies the physical location where patients are seen using the options shown. Where the consultation medium was not face to face, the location of the patient should be recorded, rather than the location of the care professional.
	B01	Health Centre	**N01**	Street or Other Public Space		
	L99	Educational Premise	**X01**	Other		

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Field Name	Code Options				Format	Notes
Contraception Information - *Whenever the reason for the patient's contact with the service is related to contraception care or advice on contraception methods then it must be recorded here*						
Contraception Method Status	**1**	**New** is where the patient is not currently using a main method of contraception and who receives a method following the consultation for the first time or receives a method for the first time after a time lapse of one month or greater.	**3**	**Maintain** is where the patient receives care by attending the service (or are seen by the service at another location) with respect to their current main method of contraception (e.g. a repeat supply of pills or adjustment of a long acting contraception method) regardless, of where the current method was first obtained, e.g. GP or another SRH service.	Length an1	• **This field can be left blank if there is no contraception activity** • If leaving blank then data **must** be recorded in Contraception Method Post Coital 1 & 2 **OR** in the SRH Care Activity • If entering 1,2, or 3 then data **must** be entered in Contraception Main Method • If entering 4 or left blank, the Contraception Main Method and Other Contraception Method 1 & 2 **must** be blank. • Code 4 should be used if contraception advice is given but no contraception main method is given at this consultation AND the patient is not using any contraception at the time of the consultation **Providing contraception advice does not need recording in all other instances as it is presumed that it forms part of every consultation wherever necessary.** **Figure 1 of the main SRHAD guidance document further illustrates how method status should be captured.**
	2	**Change** is where a patient changes from one main method of contraception to another, regardless of where the main method currently in use was obtained, e.g. GP or another SRH service. Only the new method is recorded in the [Contraception Main Method] field. This is where the actual method changes and not merely where a device is changed.	**4**	**Pre Contraception Consultation/ Contraception Advice** only is where the patient receives an initial consultation on contraception prior to receiving a method or where the patient receives advice on the range of methods of contraception available, etc. without (yet) receiving a non-emergency method of contraception..		

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<table>
<tr><th>Field Name</th><th colspan="4">Code Options</th><th>Format</th><th>Notes</th></tr>
<tr><td rowspan="9">Contraception Main Method</td><td>01</td><td>Injectable Contraception</td><td>08</td><td>POP</td><td rowspan="9">Length an2</td><td rowspan="9">This field can be left blank if there is no contraception activity
Only complete if Contraception Method Status is 1,2 or 3
If entering 03 IUD or 04 IUS then SRH Care Activity must not be 22 or 23 as these codes are for non-contraception only.
22 Insertion is not recorded when used for contraception purposes as it is implied by codes 01, 02 and 03 in Contraception Method Status.

23 Check does not need to be recorded when used for contraception purposes as it is implied by using code 02 or 03 in Contraception Method Status.
If entering codes 01 to 09 then gender must not be coded as Male (1)</td></tr>
<tr><td>02</td><td>Implant</td><td>09</td><td>Cap/Diaphragm</td></tr>
<tr><td>03</td><td>IUD</td><td>10</td><td>Spermicides</td></tr>
<tr><td>04</td><td>IUS</td><td>11</td><td>Natural Family Planning</td></tr>
<tr><td>05</td><td>Vaginal Ring</td><td>12</td><td>Condom (Male)</td></tr>
<tr><td>06</td><td>Contraception Patch</td><td>13</td><td>Condom (Female)</td></tr>
<tr><td>07</td><td>Combined Pill</td><td></td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Contraception Other Method 1 & 2</td><td colspan="4">As Contraception Main Method</td><td>Length an2</td><td>Record up to two additional methods of contraception given to patient.

The same validation rules and requirements as Contraception Main Method</td></tr>
<tr><td>Contraception Method Post Coital 1& 2</td><td>1</td><td>Emergency Oral</td><td>2</td><td>Emergency IUD</td><td>Length an1</td><td>Gender must not be Male (1)
If entering data for Post Coital 2 then data must be completed for Post Coital 1</td></tr>
</table>

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Sexual & Reproductive Health Activity Information			Length an2
Field Name	**Code Options**		**Notes**
SRH Care Activity	01– Sexual Health Advice 02 – Pregnancy Test 03 – Pregnancy Advice &/or Pregnancy Options Information 04 – Abortion Assessment 05 – Pre Abortion Counselling 06 – Abortion Medical Procedure 07 – Abortion Surgical Procedure 08 – Abortion Aftercare 09 – Abortion Referral (with advice) 10 – Post Abortion Counselling 11 – Cervical Screening 12 – Psychosexual Therapy 13 – Psychosexual Referral (with advice) 14 – Sterilisation/Vasectomy Assessment 15 - Sterilisation/Vasectomy Treatment (including Procedure) 16 – Sterilisation/Vasectomy Aftercare 17 – Sterilisation/Vasectomy Referral (with advice) 18 – PMS Treatment 19 – Implant Removal 20 – IUS Removal 21 – IUD Removal	22 – IUS Insertion (non-contraception) 23 – IUS Check (non-contraception) 24 – Menopause Management & Treatment (excluding IUS insertion/check) 25 – Colposcopy Treatment 26 – Colposcopy referral (with advice) 27 – Ultra Sound Scan 28 – Sub Fertility Treatment & Care 29 – Other Gynaecology Treatment & Care 30 – Alcohol Brief Intervention 31 – Safeguarding Children Referral 32 – CAF Referral 33 – Other Referral 34 – STI Related Care 35 – Complex LARC Procedures 36 – Complex Contraception 37 – Medical Gynaecology 38 – Care of Prostatitis 39 – Genital Dermatoses 40 – Sexual Assault (acute presentation) 41 – Sexual Assault (non-acute presentation)	Records other services received by the patient. • The following codes cannot be used for males **02, 04, 06, 07, 08, 09, 11, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 35, 36, 37** • Code **38** cannot be used for females • Codes **06 and 07** cannot be used on the same attendance. • Codes **06 and 09** cannot be on the same attendance. • Codes **07 and 09** cannot be on the same attendance. • Codes **15 and 16** cannot be on the same attendance. • Codes **15 and 17** cannot be on the same attendance. • Codes **12 and 13** cannot be on the same attendance • Codes **20 and 21** (IUS/IUD removal)should be used when IUS /IUS main method is being maintained (code 3 in Method status) and the device is being replaced with a new one • Codes **22 and 23** should not be used when IUS is being used for contraception and is indicated in Contraception Main Method fields. • Codes **25 and 26** cannot be on the same attendance • If the IUS insertion is to provide contraception then record under '**04** Contraception Main Method'. However if the IUS is for menorrhagia purposes only including to support menopause treatment and care then record as '**22** SRH Care Activity' • Record '**01** Sexual Health Advice' only if advice is NOT for 'CMS 4 Contraception Advice' or NOT for '03 Pregnancy Options' and is not an inherent part of and separate to a SRH care activity you are also recording at the patient's attendance. • Up to six codes can be entered per patient, but must be entered consecutively with no gaps.

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Appendix 4. Validation Rules for SRHAD

Coding Rules	Description	Error or Warning[1]
Rule_01	Contraception Method Status is BLANK; there should be data in the SRH Care Activity or Contraception Method Post Coital fields. If there is no activity, please exclude the record	Error
Rule_05	Gender is recorded as male - Contraception Main Method or Contraception Other Method is recorded as a female type (1, 2, 3, 4, 5, 6, 7, 8, 9)	Error
Rule_05b	Gender is recorded as indeterminate - Contraception Main Method or Contraception Other Method is recorded as a female type (1, 2, 3, 4, 5, 6, 7, 8, 9)	Warning
Rule_06	Initial Contact is recorded as Yes on second or subsequent record for patient within the quarter	Error
Rule_08	SRH Care Activity – codes 09 and 06 or codes 09 and 07 or codes 06 and 07 cannot be coded on the same attendance record	Error
Rule_09	SRH Care Activity – codes 12 and 13 are on the same record	Warning
Rule_10	SRH Care Activity – codes 15 and 16 or codes 15 and 17 cannot be coded on the same attendance record	Error
Rule_11	Gender is recorded as male - there should be NO data in Contraception Method Post Coital fields	Error
Rule_11b	Gender is recorded as indeterminate - there should be NO data in Contraception Method Post Coital fields	Warning
Rule_12	Gender is recorded as male - if SRH Care Activity codes are recorded as 02, 04, 06, 07,08, 09, 11, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 35, 36 and 37 exist then change gender to female.	Error
Rule_12b	Gender is recorded as indeterminate - if SRH Care Activity codes are recorded as female type (02, 04, 05, 06, 07, 08, 09, 11, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 35, 36 and 37)	Warning
Rule_13	Age has decreased, or increased by more than one year between attendances in the reporting period	Error
Rule_14	If Contraception Method Status is 1, 2 or 3 then Contraception Main Method cannot be BLANK. Also if Contraception Main Method is NOT BLANK, Contraception Method Status must be 1, 2 or 3	Error
Coding Rules	**Description**	**Error or Warning[2]**
Rule_14	If Contraception Method Status is 1, 2 or 3 then Contraception Main Method cannot be BLANK. Also if Contraception Main Method is NOT BLANK, Contraception Method Status must be 1, 2 or 3	Error
Rule_16	If Contraception Other Method is NOT BLANK, then Contraception Main Method should NOT be BLANK	Error
Rule_17	Patient ID – the patient has more than 8 attendances in the reporting quarter	Warning

[1] If warnings are correct, please email data.collections@nhs.net to confirm that the warnings are correct, stating SRHAD and your organisation name in the subject bar.
If warnings are incorrect, please amend your data at source along with any errors and resubmit.
[2] If warnings are correct, please email data.collections@nhs.net to confirm that the warnings are correct, stating SRHAD and your organisation name in the subject bar.
If warnings are incorrect, please amend your data at source if possible along with any errors and resubmit.

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Rule_18	Age is recorded between 1 and 10	Warning
Rule_19	Gender is recorded as male or indeterminate - Contraception Main Method or Contraception Other Method is recorded as a female type (13)	Warning
Rule_20	Age is over 80	Warning
Rule_21	Age is 0	Error
Rule_22	Contraception Main Method is coded 3 or 4 then SRH Care Activity fields cannot be 22 or 23	Error
Rule_23	SRH Care Activity fields are coded 19 then Contraception Method Status cannot be 1	Warning
Rule_24	SRH Care Activity – codes 25 and 26 are on the same record	Warning
Rule_25	Gender is recorded as male or indeterminate - SRH Care Activity is recorded as Pregnancy Advice and/or Options (03), Pre Abortion Counselling (05) or Post Abortion Counselling (10)	Warning
Rule_26	Gender is recorded as female - SRH Care Activity is recorded as Care of Prostatitis (38)	Error
Rule_26b	Gender is recorded as indeterminate - SRH Care Activity is recorded as Care of Prostatitis (38)	Warning
Rule 27	Contraception Method Post Coital 2 is not blank, then Contraception Method Post Coital 1 should not be blank	Error
Rule 28	SRH Care Activity Code fields should be populated in order (i.e. SRH Activity Code 1 should be populated before Code 2 etc.)	Error
Rule 29	The same Contraception Method code should not be used more than once on the same record.	Error
Rule 30	The same SRH Activity code should not be used more than once on the same record.	Error
Rule 31	Post Coital Method 1 should not be the same as Post Coital Method 2.	Error
Rule 32	Where the Activity Location is Health Centre (B01) then the Consultation Medium should be recorded as face to face (01)	Warning

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Field Rules	Description	Error or Warning
OrganisationID_Valid_Ref	Organisation ID cannot be blank and must have a valid code[3]	Error
ClinicID_Valid_Ref	Clinic ID cannot be blank and must have a valid code	Error
PatientID_Valid_Ref	Patient ID cannot be blank	Error
Gender_Valid_Ref	Gender cannot be blank and must have a valid code	Error
Age_Valid_Ref	Age cannot be blank (non numeric is treated as blank)	Error
Ethnicity_Valid_Ref	Ethnicity cannot be blank and must have a valid code	Error
LSOA_Valid_Ref	LSOA of Residence cannot be blank and must have a valid code	Error
DateOfAttendance_Valid_Ref	Date of Attendance cannot be blank and must be within the reporting period	Error
InitialContact_Valid_Ref	Initial Contact cannot be blank and must have a valid code	Error
Activity_Location_Type_Valid_Ref	Activity Location Type cannot be blank and must have a valid code	Error
ContMethodStatus_Valid_Ref	Contraception Method Status must have a valid code	Error
ContPrinMethod_Valid_Ref	Contraception Main Method must have a valid code	Error
ContOtherMethod1_Valid_Ref	Contraception Other Method 1 must have a valid code	Error
ContOtherMethod2_Valid_Ref	Contraception Other Method 2 must have a valid code	Error
ContMethodPostCoital1_Valid_Ref	Contraception Method Post Coital 1 must have a valid code	Error
ContMethodPostCoital2_Valid_Ref	Contraception Method Post Coital 2 must have a valid code	Error
SRHCareActivity1_Valid_Ref	SRH Care Activity 1 must have a valid code	Error
SRHCareActivity2_Valid_Ref	SRH Care Activity 2 must have a valid code	Error
SRHCareActivity3_Valid_Ref	SRH Care Activity 3 must have a valid code	Error
SRHCareActivity4_Valid_Ref	SRH Care Activity 4 must have a valid code	Error
SRHCareActivity5_Valid_Ref	SRH Care Activity 5 must have a valid code	Error
SRHCareActivity6_Valid_Ref	SRH Care Activity 6 must have a valid code	Error
LA District_of_Residence_Valid_Ref	LA District of Residence cannot be blank and must have a valid code	Error
General_Medical_Practice_Code_Valid_Ref	General Medical Practice Code cannot be blank and must have a valid code	Error
Consultation_Medium_Used_Valid_Ref	Consultation Medium Used cannot be blank and must have a valid code	Error
Duplicate_Record_Check	Patient has 2 or more records where all fields are identical	Warning
Same_ DateOfAttendance _Check	Patient has 3 or more records for the same date but activity is different	Warning

[3] Organisation Data Services (ODS) provides unique identification codes for organisation entities of interest to the NHS. Please contact ODS for your organisation code and site code if you do not know it (Exeter.helpdesk@nhs.net, http://systems.digital.nhs.uk/data/ods)

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Appendix 5. Example patient registration form

If you have any difficulties with this form please ask a member of staff.

Personal information will only be used to progress your individual care.

Your contact details															
Surname															
Forename															
Address line 1															
Address line 2															
Address line 3															
Address line 4															
Postcode															
Telephone: Home															
Telephone: Mobile															
The name and address of the **GP Practice** you are registered with															
Date of Birth	D	D	M	M	C	C	C	C							
Gender *Please tick next to appropriate box*	Male				Female										
What do you consider to be your ethnicity? *Please tick appropriate box*	White British				Bangladeshi										
	White Irish				Any other Asian background										
	White Other				Caribbean										
	White and Black Caribbean				African										
	White and Black African				Any other black background										
	White and Asian				Chinese										
	Other mixed background				Any other ethnic group										
	Indian				Not willing to say										
	Pakistani														
Have you been to this service before? ***Please tick next to appropriate box***	**Yes**				**No**										

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