**NHS Digital**

**Indicator Supporting Documentation**

**IAP00414 Proportion of people who use services and their carers, who reported that they had as much social contact as they would like (Part 2- Carers)**

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| IAP Code | IAP00414 |
| Title | The proportion of people who use services and carers who find it easy to find information about support (people who use services) – 3D, Part 2 |
| Published by | NHS Digital |
| Reporting period | Annual |
| Geographical Coverage | National |
| Reporting level(s) | England, Local Authorities, Councils with Adult Social Services Responsibilities (CASSRs) |
| Based on data from | Survey of Adult Carers in England (SACE), NHS Digital |
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| Rating | Fit for use with caveats |
| Assurance date | 11/07/2019 |
| Review date | 11/07/2024 |
| Indicator set | ASCOF |
| Brief Description | This is the second part of Indicator 1I - Proportion of people who use services and carers who reported that they had as much social contact as they would like of the Adult Social Care Outcomes Framework. Measures for users and carers are presented separately in the Library of Quality Assured Indicators as IAP00413 and IAP00414 respectively.  The measure is defined by determining the percentage of carers choosing “I have as much social contact as I want”. This response has been chosen to focus the measure on individuals achieving the best outcomes to allow for better use in benchmarking. |
| Purpose | There is a clear link between loneliness and poor mental and physical health. A key element of the Government’s vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and carers.  The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability. Local authorities also use this data for their own benchmarking purposes.  The key roles of the ASCOF are:   * Locally, provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes which identify their priorities for making improvements. Local Authorities can also use ASCOF to inform outcome-based commissioning models. * Locally, it is also a useful resource for Health and Wellbeing boards who can use the information to inform their strategic planning and leadership role for local commissioning. * Locally, the ASCOF also strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold their council to account for the quality of the services that they provide, commission or arrange. Local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved and their priorities for developing local services. * Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement and promotes the sharing of learning and best practice. * At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system and continues to inform and support, national policy development.   The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability. |
| Definition | The percentage of carers choosing “I have as much social contact as I want”. |
| Data Source | Survey of Adult Carers in England (SACE)  https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-user-surveys/social-care-carers-survey-2018-19 |
| Numerator | The Department of Health and Social Care (DHSC) defines the construction of the indicator.  The sum of all those who in response to question 11 of the Carers Survey, selected the response “I have as much social contact as I want” after weighting has been applied |
| Denominator | The sum of all those that responded to question 11 of the Carers Survey with one of the three possible responses:   * I have as much social contact as I want * I have some social contact but not enough * I have little social contact and I feel isolated   in SACE after weighting has been applied. |
| Calculation | For both the numerator (X) and denominator (Y), weighted data should be used to calculate the measure.  The data from the survey will be weighted by NHS Digital to take account of the stratified sampling technique that has been used when conducting the survey. The weights are automatically calculated within the survey data return along with the ASCOF outcome measures.  **Weighting Methodology**  *Variables and methodology:*  The introduction of stratified sampling and allowing councils to oversample in strata of interest to them, leads to the need to weight the data to convert the achieved sample back to represent the population from which the sample was drawn.  This is commonly done by dividing the number of people in each of the stratum in the eligible population by the number of returned questionnaires in each stratum. This has the effect of weighting for both the sample design and non-response at the same time.  These weights are provided automatically within the data return based on the number of responses in each stratum and the number of people in the eligible population in each stratum. |
| Interpretation Guidelines | This is part of the ASCOF Indicators and sits within Domain 1 – Enhancing quality of life for people with care and support needs   * 1A - Social care-related quality of life (SCRQoL) (IAP00405) * 1B - Proportion of people who use services who have control over their daily life (IAP00406) * 1C - Proportion of people using social care who receive self-directed support and those receiving direct payments (IAP00407) * 1D - Carer-reported quality of life (IAP00408) * 1E - Proportion of adults with a learning disability in paid employment (IAP00409) * 1F - Proportion of adults in contact with secondary mental health services in paid employment (IAP00410) * 1G - Proportion of adults with a learning disability who live in their own home or with their family (IAP00411) * 1H - Proportion of adults in contact with secondary mental health services living independently, with or without support (IAP00412) * 1I (Part 1) - Proportion of people who use services and their carers who reported that they had as much social contact as they would like (people who use services) (IAP00413) * 1I (Part 2) - Proportion of people who use services and their carers who reported that they had as much social contact as they would like (Part 2- Carers) (IAP00414)   1I provides the data for this indicator. |
| Caveats | * The Adult Social Care Outcomes Framework (ASCOF) was developed as a whole suite of indicators however further rationale is required to justify each individual indicator in the Framework * A ‘good’ result is detailed as being a high percentage result however there needs to be an ideal range or a specific result on which to fully assess the data. * The weighting methodology is explained however an actual example of the methodology in practice is required to allow accurate recreation of the published figures. |

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| **Section 1: Introduction and Overview** |  |  |  |
| **1.1 Indicator title** | Proportion of people who use services and their carers who reported that they had as much social contact as they would like (Part 2 – Carers) | **1.8 Application type** | *New* |
| **1.2 Reference number** *(if unsure, please leave for IMAS team)* | IAP00414 | **1.9 Requesting organisation** | Department of Health and Social Care |
| **1.3 Topic area** | Enhancing quality of life for people with care and support needs | **1.10 Applicant details** | Name Robyn Wilson  Title Analytical Section Head  Phone 01132542470  Email [robyn.wilson@nhs.net](mailto:robyn.wilson@nhs.net) |
| **1.4 Domain (if applicable)** | **N/A** | **1.11 Alternate contact details** | Name:  Email: |
| **1.5 Set** | Adult Social Care Outcomes Framework (ASCOF) | **1.12 SRO/ sponsor / policy owner details** | Name Greg Ceely  Title: Statistician, Social Care Data Lead  Phone:  Email: [socialcaredata@dhsc.gov.uk](mailto:socialcaredata@dhsc.gov.uk) |
| **1.6 Please explain if ‘Set’ is ‘Other’ or ‘N/A’** |  | **1.7 Brief Summary of indicator (max 100 words)** | This is the second part of Indicator 1I - Proportion of people who use services and carers who reported that they had as much social contact as they would like of the Adult Social Care Outcomes Framework. Measures for users and carers are presented separately in the Library of Quality Assured Indicators, as IAP00413 and IAP00414 respectively.  The measure is defined by determining the percentage of carers choosing “I have as much social contact as I want”. This response has been chosen to focus the measure on individuals achieving the best outcomes, to allow for better use in benchmarking. |

This application form should cover one indicator. Each indicator in a set will require its own application. Wherever you’re unsure about answering any section please contact [indicator.assurance@nhs.net](mailto:indicator.assurance@nhs.net)

Sections 2 and 3 cover policy and presentation which will be reviewed and approved by the Indicator Governance Board (IGB).

Sections 4 and 5 cover the data, construction and testing of the indicator and will be reviewed and approved by the Methodology Review Group (MRG). MRG will also advise IGB of their thoughts on policy and presentation as appropriate.

The final section is an overall view of the application by the Indicator and Methodology Assurance Service (IMAS) and will be completed by IMAS in conjunction with the applicant to advise both MRG and IGB.

Applications should be updated to take on board comments from IGB and MRG'; once approved, the finalised application and the Appraisal Log will form the basis of for its entry into the National Library of Quality Assured Indicators

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| **Section 2: Rationale and Policy Basis (IGB to assess, MRG to advise)** |  |
| **2.1 Why is this indicator needed and why is it important that it be measured?** | There is a clear link between loneliness and poor mental and physical health. A key element of the Government’s vision for social care is to tackle loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family. This measure will draw on self-reported levels of social contact as an indicator of social isolation for both users of social care and carers. |
| **2.2 Is there any clinical evidence or professional opinion that can be cited in the development of this indicator?**  *.* | The social isolation indicator, introduced in 2013/14, has shown that the majority of social care service users and carers do not have as much social contact as they would like. In most local authorities the proportion of respondents who say they have as much social contact as they would like is below 50%. This shows that there is scope for local authorities to make progress in order to achieve social integration for the users of social care services, including carers.  The Adult Social Care Outcomes Framework for 2015/16 was published on 14 November 2014. The framework has been developed by the Department of Health and Social Care (DHSC), the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA).  The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.  The key roles of the ASCOF are:  • Locally, the ASCOF provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements. Local Authorities can also use ASCOF to inform outcome-based commissioning models2.  • Locally, it is also a useful resource for Health and Wellbeing boards who can use the information to inform their strategic planning and leadership role for local commissioning.  • Locally, the ASCOF also strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold their council to account for the quality of the services that they provide, commission or arrange. Local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services.  • Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice.  • At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development.  NICE NG32 recognises lack of social contact as a risk factor for decline in independence and mental wellbeing: <https://www.nice.org.uk/guidance/ng32>  The International Consortium for Health Outcomes Measurement (ICHOM) older person outcome set includes loneliness as an outcome that matters most: <https://www.ichom.org/portfolio/older-person/>  The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.  The framework has been developed by the Department of Health and Social Care (DHSC), the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA).    Previously the framework was overseen by the Outcomes and Information Development Board (OIDB) made up of representatives from across the social care sector including HSCIC, Local Government Association (LGA) and Care Quality Commission (CQC). In September 2014 the Adult Social Care Data and Outcomes Board (ASC-DOB) was established. ASC-DOB is responsible for overseeing national data collections and for the annual Framework publication and Handbook of Definitions.    ASCOF was developed from ASCOT which is described here: https://www.pssru.ac.uk/ascot/development-of-ascot/. A wealth of papers from the Personal Social Services Research Unit (PSSRU) supporting the development of ASCOT are listed here: https://www.pssru.ac.uk/ascot/references/ |
| **2.3 Is there any clinical evidence or professional opinion to support the ongoing need for this indicator?** | Previously the framework was overseen by the Outcomes and Information Development Board (OIDB) made up of representatives from across the social care sector including HSCIC, Local Government Association (LGA) and Care Quality Commission (CQC). In September 2014 the Adult Social Care Data and Outcomes Board (ASC-DOB) was established. ASC-DOB is responsible for overseeing national data collections and for the annual Framework publication and Handbook of Definitions.    There are various studies using ASCOF data by the PSSRU such as <https://www.pssru.ac.uk/pub/dp2542.pdf>, <https://www.pssru.ac.uk/pub/4633.pdf>  which demonstrate the importance of ASCOF. |
| **2.4 Which governmental strategies or policies is supported by the use of this indicator?** | The Care and Support White Paper, published in July 2012, set out the Government’s vision for a reformed care and support system, building on the 2010 Vision for Adult Social Care, and Transparency in Outcomes: a framework for quality in adult social care  The Care Bill became the Care Act in May 2014, signalling the most significant change in care and support policies in over sixty years. The impact of the Care Act will be far reaching with fundamental changes to the way that care is delivered and paid for taking place over the next few years. These changes will mean that users of the services and their carers are in control of their own care and support and having access to relevant information and advice is essential to this. The ASCOF for 2018-19 will support councils to rise to this challenge of delivering key priorities by providing a clear focus for local priority setting and improvement and by strengthening the accountability of councils to local people. |
| **2.5 Who would use this indicator and why?** | The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability. DHSC define the construction of the indicator and NHS Digital conform to this methodology. Local authorities also use this data for their own benchmarking purposes.  The key roles of the ASCOF are:   * Locally, the ASCOF provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements. Local Authorities can also use ASCOF to inform outcome-based commissioning models. * Locally, it is also a useful resource for Health and Wellbeing boards who can use the information to inform their strategic planning and leadership role for local commissioning. * Locally, the ASCOF also strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold their council to account for the quality of the services that they provide, commission or arrange. Local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services. * Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice. * At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development.   The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability. |
| **2.6 Is there a relationship to other existing indicators?** | This is part of the ASCOF Indicators and sits within Domain 1 – Enhancing quality of life for people with care and support needs     * 1A - Social care-related quality of life (SCRQoL) (IAP00405) * 1B - Proportion of people who use services who have control over their daily life (IAP00406) * 1C - Proportion of people using social care who receive self-directed support, and those receiving direct payments (IAP00407) * 1D - Carer-reported quality of life (IAP00408) * 1E - Proportion of adults with a learning disability in paid employment (IAP00409) * 1F - Proportion of adults in contact with secondary mental health services in paid employment (IAP00410) * 1G - Proportion of adults with a learning disability who live in their own home or with their family (IAP00411) * 1H - Proportion of adults in contact with secondary mental health services living independently, with or without support (IAP00412) * 1I (Part 1) - Proportion of people who use services and their carers, who reported that they had as much social contact as they would like (people who use services) (IAP00413) * 1I (Part 2) - Proportion of people who use services and their carers, who reported that they had as much social contact as they would like (Part 2- Carers) (IAP00414)   1I provides the data for this indicator. |
| **2.7 Comparability to other existing indicators** | It links to Public Health Outcomes Framework measure 1.18 Social Isolation, specifically 1.18ii which relates to the SACE. The PHOF measure is identical to ASCOF, and relies on ASCOF for the calculation of the indicator, however PHOF has not been through the assurance process. |
| **Section 3: Presentation and interpretation (IGB to assess, MRG to advise)** |  |
| **3.1 How will the indicator be presented?** | This indicator is disseminated by NHS Digital as part of ASCOF annual publication. There is an annual disaggregated spreadsheet released, as well as a time-series of aggregated outcomes.  The latest publication can be found at <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current> and covers 2017/18.  The data is also available in a PowerBI report which is available in the Adult Social Care Analytical Hub[[1]](#footnote-1): <http://bit.ly/SocialCare_HUB> (within the ASCOF section). This enables councils to view interactive tables and charts of their data compared to their peers and councils in their region.  The latest SACE data (2016/17) can be found at <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/personal-social-services-survey-of-adult-carers-in-england-2016-17>. The data is collected biennially (every two years).  Disaggregation’s available: National and by Council with Adult Social Services Responsibility (CASSR)  Equalities: Age, Gender, Ethnicity, Religion, Sexual orientation  Primary Support Reason (all ages): Physical Support, Sensory Support, Support with Memory and Cognition, Learning Disability Support, Mental Health Support, Social Support.  The data is also available in the NHS Digita[l Clinical Indicators](https://indicators.hscic.gov.uk/webview/) collection. |
| **3.2 What contextual information will be provided alongside the indicator?** | Measure 1I was included for the first time in 2013-14, time series data have been based on historical releases of the Personal Social Services Adult Social Care Survey and Personal Social Services Survey of Adult Carers.  There is a need to understand more about how services and support are affecting the outcomes in people’s lives. Personalisation means putting the user at the heart of care planning and provision and it is critical to have high quality information to aid our understanding of the impact and outcomes achieved, to enable choice and inform services development and improvement. A robust survey programme, collecting the views of the people who use services and support, is the best and most appropriate vehicle to achieve this.  Outputs published include a narrative-based report which provides analysis of the key themes and trends in the data as well as a series of annex files which provide:  a) details of the methodology and  b) datasets in various formats (by question, local authority and key demographics)  to support further analysis by end-users. |
| **3.3 What is considered “good” performance? What is considered “bad” performance?** | The higher the indicator value the better the performance. However, as with all indicators, particularly high values should be investigated, either for good practice which can be shared across organisations, or to find out if there are untoward reasons for the high scores. |
| **3.4 Is there a target to be achieved?** | The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the ASCOF will inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.  Regionally however, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice.    Also, as outlined above, local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services.  Furthermore, within the 2014/15 ASCOF publication, we were able to include evidence of where local authorities had been able to identify areas to improve processes: “We use ASCOF scores to produce summary sheets with quartiles, rankings and colour coding to show how our local authority is performing compared to other local authorities within the region and nationally. We identify area where performance looks low and add text boxes to document explanations. From the comments received we have identified some themes and we are now using these to produce an action plan to address the issues. We also highlight areas where we are performing well. We have used the benchmarking data to improve our 2C part 2 measure outcome by reviewing processes and implementing regular monitoring.” |
| **3.5 How will any interested parties use the information provided by the indicator?** | The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.  Also, as outlined above, local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services. |
| **3.6 Consider how the results can be used for benchmarking. If so, what methodology will be used?** | Using the PowerBI report, councils can for example benchmark their performance against Chartered Institute of Public Finance and Accountancy (CIPFA) derived nearest neighbour peer groups as well as against their regional peers or known, similar organizations. CIPFA derived nearest neighbour peer groups are groupings of comparable local authorities chosen using a model which finds similarities between authorities based on a range of social and economic indicators such as employment. More information about the Nearest Neighbour Model is on the CIPFA website (<http://www.cipfastats.net/resources/nearestneighbours/>). The standard 2018 model (i.e. using default settings) is currently being used. |

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| **Section 4: Data (MRG to assess)** |  |
| **4.1 What is the source of the data and why should it be used?** | This indicator (1I, Part 2) uses the Survey of Adult Carers in England (SACE).  The SACE was created in 2009-10 and is a biennial national survey, conducted by Councils with Adult Social Services Responsibilities (CASSRs), which covers carers aged 18 or over, caring for a person aged 18 or over.  Under the Care Act (2014) councils have a duty to ensure relevant information and advice are made available. This provides a clear rationale for including carers who were not assessed or reviewed during the year but who the local authority reports are receiving support. The survey seeks carers’ opinions on a number of topics that are considered to be indicative of a balanced life alongside their caring role.  IAP00413 (1I, Part 1) uses the Adult Social Care Survey (ASCS). Part 1 and 2 are not combined to a single figure.  In 2016-17 the eligible population changed so that in addition to carers being included that have had a carer’s assessment or review from the local authority in the 12 months prior to the survey taking place, carers are also now included who have not been assessed or reviewed during the previous 12 months.  https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-user-surveys/social-care-carers-survey-2018-19    All LAs with an eligible population of 150 or more carers are required to participate in the survey. LAs with an eligible population totalling less than 150 are not required to participate in the survey, as the resulting data may not meet the minimum requirements that are set out in terms of statistical accuracy.  The surveys were put in place to generate the data needed for the outcome’s framework.  There are no other data sources to consider as this is the only source available. |
| **4.2 Was any other data source considered?** | No, the SACE is the only available data collection that we can use for this, with the users equivalent to compare against from a separate, independent survey – Adult Social Care Survey. |
| **4.3 What is the coverage period of the data?** | The SACE is carried out biennially (every two years) – usually October and November each alternate year to cover the previous financial year, e.g. October and November 2019 to cover 2018-19. |
| **4.4 Which geographic area(s) will be covered and reported on by this indicator?** | Data is available at Councils with Adult Social Services Responsibilities (CASSRs), regional and England level. |
| **4.5 How will the data be extracted or collected?** | Councils are asked to send questionnaires to a random sample of carers aged 18 or over, caring for someone aged 18 or over, who are recorded within the last three rows of Short and Long Term Support (SALT) return on carers provided support during the year (i.e. excluding the first row; carers aged under 18). The sample frame therefore contains all carers aged 18 and over who either received “support direct to carer” or “no direct support to carer”, irrespective of whether their cared-for person received respite care.  NHS Digital provides councils with detailed survey guidance and with survey materials such as questionnaires, forms and letters. There are large-print and translated versions of the materials. The questionnaires are also provided as an interview script so that carers who request an interview can participate in the survey.  The survey uses data from a sample of carers to make inferences (or estimates) about the whole population. These estimates are subject to a degree of uncertainty that can be expressed as a ‘margin of error’. The margin of error of an estimate is related to the proportion of the population that responds to the survey; as this proportion increases, the margin of error decreases. Therefore, the margin of error can be reduced by increasing the survey sample size and/or response rate. Councils are required to select a sample such that the survey results have a margin of error of less than five percentage points.  The selected sample is checked for carers who should not be sent a survey for one or more reasons. For example, the person has stopped being a carer, the carer or the cared-for person has died, the carer has been hospitalised, or is involved in an open safeguarding alert or investigation. In addition, a survey is not sent if the carer is in active dispute with the council and it is felt that sending them a questionnaire could be perceived as being unduly provocative or insensitive. Carers removed from the sample for any of these reasons are replaced with other randomly selected eligible carers.  The recommended fieldwork period is during October and November. The survey is conducted mainly using a postal questionnaire. Councils can use a face-to-face or telephone interview if requested by the carer. One reminder letter is sent to each non-respondent .  The returned questionnaires are coded onto the data return and the resulting datasets are returned to NHS Digital for validation and analysis.  Further information about the SACE, such as the guidance document (which contains more detail about the survey process) and the survey materials, can be found at: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-user-surveys/social-care-carers-survey-2018-19> |
| **4.6 Data fields required** | Numerator – SACE Question 11; “Thinking about how much social contact you’ve had with people you like, which of the following statements best describes your social situation?”  *- I have as much social contact as I want*  *- I have some social contact but not enough*  *- I have little social contact and I feel isolated*  Geographic CASSR Code  Denominator - Number of people who responded to the survey |
| **4.7 Are any data filters required?** | None |
| **4.8 Are there any linkages to other datasets?** | N/A |
| **4.9 Are there any limitations or potential bias?** | 57,860 people out of a sample of 126,755 carers responded to the survey, which is a response rate of 46 per cent.  Due to a change in recording practices, the time series from 2014-15 onwards would not be directly comparable with previous years.  The higher the level of non-response to a survey the greater the number of questionnaires that need to be sent out in order to achieve an acceptable sample size. Unfortunately, the higher the level of non-response, the higher the risk of serious non-response bias. Non-response bias comes about because the people who do not take part in a survey are different from those that do. If for example the people who respond to user satisfaction surveys are more likely to be dissatisfied than those that do not, any user satisfaction survey is likely to overestimate the true level of dissatisfaction among all users. The higher the level of non-response the greater this overestimation will be. In other words, any advantage gained by boosting the sample size in order to reduce the margins of error around results will be compromised if the issue of non-response is ignored.  To ensure results are meaningful and that comparisons can be made with a degree of certainty, it is a requirement that the margin of error around the estimates produced by the survey is no more than +/- 5%. Early in the process, councils need to work out how large a sample they will need to survey in order to achieve this margin of error. If the response rate achieved falls below that outlined as required by the sample size calculator available on the NHS Digital website at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/social-care-user-surveys/social-care-carers-survey-2018-19, the margins of error (produced as part of the annex outputs that are made available alongside the final report) could be too wide for the results to be useful.  Random variation – Not all carers are sent a questionnaire so the measures are only an estimate of the true value, which would be obtained only if the entire population was surveyed. Councils are required to select a sample size such that any estimates from the survey have a 95 per cent confidence interval of less than +/- 5 per cent. This also means that ASCOF measure 1A, which is calculated from scores based on eight questions, has a confidence interval of less than +/- 2 per cent.  Collection mode bias – 99.9 per cent of the returned questionnaires were completed by post (councils were able to use a face to face or telephone interview if requested by the carer) and therefore there is minimal bias caused by the different methods of data collection. |
| **4.10 Further notes on data** | The data return for the Carers’ Survey includes some in-built validations such as flagging missing data and ensuring that only valid responses to questions are given (e.g. not allowing a response of 5 to a question which only has 4 response levels). There are also some cross-field validations (such as ensuring that information is provided for at least one question, if the service user has been flagged as having responded to the survey). It also includes one-way analysis tables of all variables provided both from the questionnaire and from council records; councils were encouraged to use these tables to sense-check the quality of their return prior to submission.  A full list of validations can be seen on the survey guidance webpage at:  [www.hscic.gov.uk/article/2214/User-survey-guidance-Carers-2012-13](http://www.hscic.gov.uk/article/2214/User-survey-guidance-Carers-2012-13)  Adult carers of someone below the age of 18 should not be included in the sample as some of the participating councils do not have responsibility for providing or commissioning services for ill or disabled children. Carers below the age of 18 should also not be included in the sample because gathering this would require a different methodological approach and a range of age-appropriate questionnaires.  All eligible carers should be included in the sample frame, including those who care for self-funders or where the cared-for person is not known. If two people in any one household are carers then they should both be included in the sampling frame. Carers should answer the questions in relation to the person they spend the most time helping. If they spend an equal amount of time caring for two or more people, they should answer in relation to the person who lives with them. If they live with two or more people that they spend an equal amount of time caring for, they should then choose one person to answer about. |
| **Section 5: Construction and Testing (MRG to assess)** |  |
| **5.1 How will the indicator measure be calculated / constructed?**  *Please provide explanation of coding where applicable and rationale behind demographic breakdowns* | The indicator is calculated as the percentage. For both the numerator (X) and denominator (Y), weighted data should be used to calculate the measure.  The data from the survey will be weighted by the NHS Digital to take account of the Stratified sampling technique that has been used when conducting the survey. The weights are automatically calculated within the survey data return along with the ASCOF outcome measures.  Weights are used to ensure the survey results are representative of the eligible population. The following standard formula for variance of estimates in a stratified design has been used.  Taking H to be the total number of strata within the survey; the sampling weight for each stratum *h*, where *h=1,…,H,* is denoted by:  where is the number of eligible population elements in each stratum and  is the overall eligible population for the survey. |
| **5.2 Numerator explanation** | The sum of all those who in response to question 11 of the Carers Survey, selected the response “I have as much social contact as I want” after weighting has been applied (see section 5.6 for weighting methodology). |
| **5.3 Denominator explanation**  *.* | The sum of all those that responded to question 11 of the Carers Survey with one of the three possible responses:  - I have as much social contact as I want  - I have some social contact but not enough  - I have little social contact and I feel isolated  in SACE after weighting has been applied (see section 5.6 for weighting methodology). |
| **5.4 Provide a worked example** | Worked example:  The number of carers who said “I have as much social contact as I want” was 197.  The number of carers who responded to the question was 420.  Data is weighted to reflect the stratified sampling technique that has been used when conducting the survey.  The indicator value is [(197/420)\*100] which equals 46.9% |
| **5.5 Could any risks be associated with the use of this indicator?** | As 5.8 |
| **5.6 Risk adjustment or standardisation type and methodology** | **Weighting Methodology**  *Variables and methodology:*  Weights are used to calculate a national, regional and council type estimate which makes the calculation of confidence intervals for these aggregated results more complicated. The standard formula for variance of estimates in a stratified design has been used taking each council as a stratum.  While the survey question asks directly about services, it is potentially subject to influence of exogenous factors, for example the characteristics of carers. Further analysis will be required to explore this and establish whether risk adjustment should be applied.  For SACE, it is be possible to recreate the weighting using the Eligible Population published in the [SACE 2016-17 [Data Quality Annex](https://files.digital.nhs.uk/publication/a/g/sace_data_quality_annex_2016-17.xlsx)](https://files.digital.nhs.uk/publication/a/g/sace_data_quality_annex_2016-17.xlsx) , using the worksheet “T5 - Sample Size”, and the [SACE 2016-17 [Annex](https://files.digital.nhs.uk/excel/3/r/sace_annex_2016-17.xlsx)](https://files.digital.nhs.uk/excel/3/r/sace_annex_2016-17.xlsx) shows the number of responses for each question on worksheet “T3a – Answers by Response”.  The weighting methodology changes were developed and agreed by the Social Services User Survey Group, which includes representatives from the HSCIC, the Department of Health, the Personal Social Services Research Unit, the Care Quality Commission, and local authorities in England. See Appendix C of  <https://files.digital.nhs.uk/publicationimport/pub18xxx/pub18642/pss-ascs-eng-1415-meth-info.pdf>  Further information can also be found in the 2014-15 methodology change notice: <https://digital.nhs.uk/binaries/content/assets/website-assets/publications/publications-admin-pages/methodological-changes/personal-social-services-adult-social-care-survey-england-2014-15.pdf> |
| **5.7 What are the confidence intervals and control limits and why have they been used?** | Confidence Intervals provide an indication on the reliability of a figure by calculating a range in which the value could sit. For example – if a figure is quoted as 46% but has CI of 42% - 48%, then we estimate that the true value lies within this range. This is done to take into account we are projecting sample figures onto a population.  Confidence Intervals  *Methodology[[2]](#footnote-2):*  The confidence coefficient is determined by the value of the ALPHA= option, which by default equals 0.05 and produces 95% confidence limits. The confidence limits are computed as:  formula used to compute confidence limits  Where:  symbol for estimate of meanis the estimate of the mean,  symbol for standard error of the meanis the standard error of the mean  is the percentile used for the t distributionth percentile of the ***t*** distribution with ***df*** calculated as:  formula for calculation of df  Weights are used to ensure the survey results are representative of the eligible population. The following standard formula for variance of estimates in a stratified design has been used.  Taking H to be the total number of councils within the survey; the sampling weight for each council *h*, where *h=1,…,H,* is denoted by:  where is the number of eligible population elements in each stratum and  is the overall eligible population for the survey.  The variance is:  This provides the information needed to calculate the 95 per cent confidence interval, calculated by:  𝑒𝑠𝑡𝑖𝑚𝑎𝑡𝑒 ±1.96√𝑉(𝑝)  where:  *p* is the sample proportion (statistic of interest) for the aggregated result  *ph* is the sample proportion in council h  *nh* is the achieved sample size (number of useable responses) in council h  *Nh* is the size of the eligible population in council h  *H* is the number of councils.  In the normal distribution, 95 per cent of the area under a normal curve lies within roughly 1.96 standard deviations of the mean. NHS Digital uses PROC SURVEYMEANS, within the SAS software package, to calculate margins of error. Rather than using 1.96, this uses a calculation[[3]](#footnote-3) which gives slightly greater accuracy and makes fewer assumptions about the sample size. |
| **5.8 Could the indicator be manipulated to influence the outcome?** | Guidance documentation is provided to CASSRs to support them in carrying out the survey in a robust way. This seeks to mitigate the risks of these undesired behaviours occurring by for example providing a summary of the strengths and weaknesses of postal questionnaires compared to face-to-face and telephone interviews. This is designed to help councils in reaching informed decisions about how they administer the survey locally.    Where it is not possible to find appropriate support to enable carers to complete a postal questionnaire, the survey may be administered as an interview, either by telephone or face-to-face. Interviews should be used by exception: the number of interviews completed should be small in relation to the size of the sample (generally this would be expected to be less than five per cent).    Ultimately, councils are able to use SACE guidance documentation to ensure data are collected robustly and consistently, and to support transparent and fair comparisons between service providers. |

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| Logo of indicator governance board |
| Indicator Assurance Report |
|  |
| **IAP00414** |



**Final Assurance Rating from the Indicator Governance Board - 11/07/2019**

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| --- | --- |
| **Reason for assessment** | Initial assurance |
| **Iteration** | 1st IGB meeting |

|  |  |
| --- | --- |
| **Ratings Against Assessment Criteria** |  |
| Clarity | **Fit for use with caveats** |
| Rationale | **Fit for use with caveats** |
| Data | **Fit for use** |
| Construction | **Fit for use with caveats** |
| Presentation and Interpretation | **Fit for use with caveats** |
| Risks and Usefulness | **Fit for use** |
| **Overall Rating** | **Fit for use with caveats** |

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| --- | --- |
| **Outcome** | **This indicator has been approved for inclusion in the National Library of Quality Assured Indicators** |

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| --- |
| **Key findings from Assurance** |
| **Caveats**   * The Adult Social Care Outcomes Framework was developed as a whole suite of indicators however further rationale is needed to justify each individual indicator in the Framework * A ‘good’ result is detailed as being a high percentage; however there needs to be an ideal range or a specific result specified on which to fully assess the data * The weighting methodology is explained, however an actual example of the methodology in practice is required to allow accurate recreation of the published figures. |

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| **Approval date** | 11/07/2019 |
| **Review date** | 11/07/2024 |

**Details of Methodology Appraisal – 23/05/2019**

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| --- | --- |
| **Methodology appraisal body** | IMAS Methodology Review Group (MRG) |
| **Reason for assessment** | Initial assurance |
| **Iteration** | Update from MRG Chair |

***Suggested Assurance Rating by Methodology Appraisal Body***

|  |  |
| --- | --- |
| **Ratings Against Assessment Criteria** |  |
| Introduction and Overview | **Fit for use** |
| Rationale and Policy Basis | **Fit for use with caveats** |
| Presentation and Interpretation | **Fit for use with caveats** |
| Data | **Fit for use** |
| Construction and Testing | **Fit for use with caveats** |
| IMAS provided Information | **Fit for use** |
| **Overall Appraisal Rating** | **Fit for use with caveats** |

**Summary Recommendation to Applicant:**

MRG thanks the applicant for resolving the outstanding queries and as such approve this application to proceed to IGB.

**Summary Recommendation to IGB:**

MRG recommends that IGB approve this indicator with the following caveats:

* The Adult Social Care Outcomes Framework was developed as a whole suite of indicators, however further rationale is needed to justify each individual indicator in the Framework
* A ‘good’ result is detailed as being a high percentage result, however, there needs to be an ideal range or a specific result specified on which to fully assess the data.
* The weighting methodology is explained, however an actual example of the methodology in practice is required to allow accurate recreation of the published figures.

**Please see the appraisal log below for detailed description of recommendations, issues and actions that explain the above rating(s).**

**Details of Methodology Appraisal – 23/05/2019**

|  |  |
| --- | --- |
| **Methodology appraisal body** | IMAS Methodology Review Group (MRG) |
| **Reason for assessment** | Initial assurance |
| **Iteration** | 1st MRG meeting |

***Suggested Assurance Rating by Methodology Appraisal Body***

|  |  |
| --- | --- |
| **Ratings Against Assessment Criteria** |  |
| Introduction and Overview | **Not enough information provided** |
| Rationale and Policy Basis | **Not enough information provided** |
| Presentation and Interpretation | **Not enough information provided** |
| Data | **Not enough information provided** |
| Construction and Testing | **Not enough information provided** |
| IMAS provided Information | **Not enough information provided** |
| **Overall Appraisal Rating** | **Not enough information provided** |

**Summary Recommendation to Applicant:**

MRG thanks the applicant for the work done on this application and believes the queries below are minor and should be easily resolved. Once they have been addressed, there should be no issue with this indicator progressing to IGB.

**Summary Recommendation to IGB:**

N/A

**Please see the appraisal log below for detailed description of recommendations, issues and actions that explain the above rating(s).**

**What do the Assurance Ratings mean?**

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| --- | --- |
| **Rating** | **Description** |
| **Fit for use** | This indicator can be used with confidence that it is constructed in a sound manner that is fit for purpose. |
| **Fit for use with caveats** | The indicator is fit for use, however users should be aware of caveats and/or recommendations for improvement that have been identified during the assurance process. |
| **Use with caution – data quality issue** | The indicator is based on a sound methodology for which the assurance process endorse the use, however issues have been identified with the national data source which have implications for its use as an indicator. |
| **Not fit for use** | Issues have been identified with the indicator which have resulted in the assurance process currently not endorsing its use as a quality indicator. |
| **Not enough information provided** | There has not been enough information supplied to the assurance process to be able to accurately give the indicator a level of assurance. |

**Appraisal Log**

**1. Introduction and overview**

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| --- | --- | --- | --- | --- | --- | --- |
| ***Section*** | ***Issue or recommendation*** | ***Raised***  ***by / Date*** | ***Response or Action taken by applicant*** | ***Response by / Date*** | ***Resolved*** | ***Sign off by / Date*** |
| 1.1 | The construction suggests this indicator is carers reporting of social contact. If that is the case this could be simplified | MRG 23/05/19 | We are unable to change the title; however, this will be fed back to the sponsors for review. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 1.7 | This is ok if the audience is MRG. My understanding is this will populate the national library. If this is the case it might need editing with that audience in mind? | MRG 23/05/19 | The summary has now been revised. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/0/19 |

**2. Rationale and policy basis**

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| ***Section*** | ***Issue or recommendation*** | ***Raised***  ***by / Date*** | ***Response or Action taken by applicant*** | ***Response by / Date*** | ***Resolved*** | ***Sign off by / Date*** |
| 2.1 | Focus of the application seems to be split between the user survey and the carers survey. It could be confusing as to which this application refers. Please clarify that this is a two part indicator and makes clear the distinction. | MRG 23/05/19 | It is important that both are noted in this section, as they are two parts of the whole, however the text has been amended to clarify this and to state the focus of the application. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.2 | Do carers also count as users of social care services? or does it need to state that social integration needs to be achieved for carers also | MRG 23/05/19 | Clarified | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.2 | A common response to such figures is: "what proportion of the general population say they have as much social contact as they would like?" ONS - a different but related question: In 2016 to 2017, there were 5% of adults in England who reported feeling lonely “often” or “always”. | MRG 23/05/19 | This is a reasonable comment, however this indicator focuses only on carers, so is not relevant in context of this application. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.2, 2.3, 2.4, 2.5 | A lot of detail about the Framework, but not much regarding the Indicator | MRG 23/05/19 | This has been noted on previous applications for the ASCOF set and has been agreed that this would be a caveat that should be addressed before reappraisal.  *CAVEAT: The Adult Social Care Outcomes Framework was developed as a whole suite of indicators; however further rationale is needed to justify each individual indicator in the Framework* | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.2 | NICE NG32 recognises lack of social contact as a risk factor for decline in independence and mental wellbeing.  The ICHOM older person outcome set includes loneliness as an outcome that matters most.  Can the application form be updated to reflect this ? | MRG 23/05/19 | Added, including weblinks to the relevant information | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.5 | Is there any information on how it is used at a local level? | MRG 23/05/19 | NHS Digital don’t have specific examples but it could be used locally to put on targeted community activities etc | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.6 | Can IAP numbers be added to the indicators? | MRG 23/05/19 | Added. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 2.7 | Is there a duplication of effort between ASCOF and the Public Health Outcomes Framework | MRG 23/05/19 | *Yes, but only in the sense that PHOF republish the data. This is common and the recommended approach but IGB to avoid burden of re-construction of indicators.* | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |

**3. Presentation and interpretation**

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| ***Section*** | ***Issue or recommendation*** | ***Raised***  ***by / Date*** | ***Response or Action taken by applicant*** | ***Response by / Date*** | ***Resolved*** | ***Sign off by / Date*** |
| 3.1 | Link to Social Care Analytical Hub not working | MRG 23/05/19 | Complemented short link with full link as a footnote due to length of the link to ensure full access. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 3.1 | It's not at all clear where to find the indicator and most of these breakdowns. Please clarify what is available and where to find it. | MRG 23/05/19 | Added link to the latest publication | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 3.2 | For this indicator, there are some methodological disadvantages associated with mixing the way the questionnaires are administered. As this is the first time this issue has been introduced it would be useful to have an introductory sentence about what is meant by this. | MRG 23/05/19 | Amended | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 3.3 | Is there any professional opinion on what good might look like? | MRG 23/05/19 | The higher the better. There is no national target.  This has been noted on previous ASCOF applications and has been agreed that this would be caveated:  *CAVEAT: A ‘good’ result is detailed as being a high percentage result, however, there needs to be an ideal range or a specific result specified on which to fully assess the data.* | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 3.5 | Final paragraph of section 3.4 would be better in 3.5 | MRG 23/05/19 | Moved. | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 3.5 | 2.5 is who uses the data, this section is about how the data is used |  | Updated | Robyn Wilson  5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |

**4. Data**

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| ***Section*** | ***Issue or recommendation*** | ***Raised***  ***by / Date*** | ***Response or Action taken by applicant*** | ***Response by / Date*** | ***Resolved*** | ***Sign off by / Date*** |
| 4.1 | Are references to the Adult Social Care Survey relevant in this section? | MRG 23/05/19 | Removed | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.1 | This needs better references on the source data, rather than how to collect the data? | MRG 23/05/19 | Done | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.3 | Not sure Return Format or Decimal Places belong in this section | MRG 23/05/19 | Removed | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.3 | Could you add collection dates and the period that they cover? | MRG 23/05/19 | Done | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.5 | Are references to the Adult Social Care Survey relevant in this section? | MRG 23/05/19 | Removed | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.6 | To complete the information needed to understand the question, it would be useful to provide the response options here as well | MRG 23/05/19 | This has been updated to reflect this | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.6 | If someone is trying to reproduce this indicator would they need more than this? Looking ahead to later responses, is the weighted data published or would someone need to weight it themselves? | MRG 23/05/19 | These are the data fields that would be needed to extract the data. The weighting is not part of the data and is calculated once the data is extracted. | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.6, 5.6 | Where is the data to calculate the weighting available from and what does it contain? | MRG 23/05/19 | For Carers it could be possible to work out as the Eligible Population is published in [DQ Annex](https://files.digital.nhs.uk/publication/a/g/sace_data_quality_annex_2016-17.xlsx) “T5 - Sample Size”, and the [Annex file](https://files.digital.nhs.uk/excel/3/r/sace_annex_2016-17.xlsx) shows the number of responses for each question – “T3a – Answers by Response” | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.9 | *“If for example the people who respond to user satisfaction surveys are more likely to be dissatisfied than those that do not, any user satisfaction survey is likely to overestimate the true level of dissatisfaction among all users”*  I am aware only of contrary evidence: i.e. reluctant responders tend to be less satisfied. | MRG 23/05/19 | This text has appeared on previous forms. Our experience has been those that are most disgruntled are the most vocal | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.9 | Text references ‘service users’ when this application refers to carers. | MRG 23/05/19 | Amended | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.10 | Is the sampling information from another form? it feels less relevant to this question given than it is about their social context rather than the person they are caring for. | MRG 23/05/19 | Yes, has appeared on all forms relating to survey data | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 4.10 | Suggests a filter to include in 4.7? | MRG 23/05/19 | This is a filter in the sample at the collection stage and not in the final data | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |

**5. Construction and testing**

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| --- | --- | --- | --- | --- | --- | --- |
| ***Section*** | ***Issue or recommendation*** | ***Raised***  ***by / Date*** | ***Response or Action taken by applicant*** | ***Response by / Date*** | ***Resolved*** | ***Sign off by / Date*** |
| 5.1 | The survey data published on NHS Digital website (link in 3.1) includes weighted and unweighted responses by CASSR so I could access this and recreate the indicator value (X/Y \* 100). From a quick review I don't think the published data allows for recreation of the weights? If that is the case this detail might be better in 5.6. | MRG 23/05/19 | As per response for 4.6 | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.2 | if you are only using 1 of the 3 potential responses, it feels as though this is wasteful of data. Surely there is also quite a difference between people responding that they have some social contact but would like more, vs those who consider themselves isolated. The latter group are those who are most vulnerable, and efforts should be targeted to avoid this outcome rather than move those in the middle group to the top. | MRG 23/05/19 | Agree but the definitions are set by DHSC and this indicator has been defined specifically focussing on those who feel they have as much social contact as they would like | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.4 | *“Data is weighted to reflect the stratified sampling technique that has been used when conducting the survey.”*  Would welcome clarification on this | MRG 23/05/19 | *This has been debated at previous MRGs and the text subsequently approved on previous ASCOF applications* | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.6 | This does bear out the  documentation which says that weights are calculated separately for each question. But that doesn't seem to be reflected in the table below. Should the column heading 'Returned questionnaires' be changed to 'Answered this question' or have both? | MRG 23/05/19 | Information update so this has hopefully been addressed now | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.6 | Where is the data to calculate the weighting available from and what does it contain? | MRG 23/05/19 | For Carers it could be possible to work out as the Eligible Population is published, and the csv shows the number of responses for each question. | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.7 | The formula below is not a formula for degrees of freedom. Probably best just to say that df is calculated for us by SAS. | MRG 23/05/19 | *Df is calculated for us by SAS.* | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |
| 5.8 | Text references ‘service users’ when this application refers to carers. | MRG 23/05/19 | Removed | Robyn Wilson 5/06/19 |  | Gemma Ramsay  (MRG Vice Chair)  5/06/19 |

**Any feedback should be made to the Data Standards Assurance Service (DSAS) Team at NHS Digital. Likewise, if you are unclear regarding any of the recommendations in this report or have any queries about the assurance process in general, please contact the DSAS team.**

**Data Standards Assurance Service**

**NHS Digital**

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**Email:** [**Standards.assurance@nhs.net**](mailto:Standards.assurance@nhs.net)

**Website: https://digital.nhs.uk/systems-and-services/all-a-z/indicator-methodology-and-assurance-service**

1. <https://app.powerbi.com/view?r=eyJrIjoiNTZlMDRmYTYtM2JhNi00OGJlLWE3YjgtYWQ2MDQwNDUzZWUwIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9> [↑](#footnote-ref-1)
2. SAS EG Proc Means methodology - <https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm#statug_surveymeans_a0000000226.htm>. [↑](#footnote-ref-2)
3. <https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm#statug_surveymeans_a0000000226.htm> [↑](#footnote-ref-3)