NHS Digital

Indicator Supporting Documentation

IAP00424 The proportion of people who use adult social care services and who feel safe

Application Form

Indicator and Methodology Assurance Service

**Title: The proportion of people who use adult social care services and who feel safe**

**Set or domain:**

**IAS Reference Code: IAP00424**

# Application Form

**Section 1 Introduction / Overview**

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| **1.1 Title** | The proportion of people who use adult social care services and who feel safe |
| **1.2 Set or domain** | Adult Social Care Outcomes Framework (ASCOF) |
| **1.3 Topic area** | Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm |
| **1.4 Definition** | The Adult Social Care Survey (ASCS) is an annual survey for England. The survey covers all service users aged 18 and over in receipt, at the point that data are extracted, of long-term support services funded or managed by the social services and have the capacity to consent to participation.  The Short and Long Term Support (SALT) guidance defines long-term support as: *Long Term support encompasses services provided with the intention of maintaining quality of life for an individual on an ongoing basis, and which have been allocated on the basis of eligibility criteria / policies (i.e. an assessment of need has taken place) and are subject to regular review.*  Service users are sent questionnaires, issued by Councils with Adult Social Services Responsibilities (CASSRs), during the period January to March in any given year.  ASCOF measure 4A is based on ASCS Question 7a: “Which of the following statements best describes how safe you feel?”  Measure 4A is then created by determining the percentage of all those responding who choose the answer “I feel as safe as I want”. |
| **1.5 Indicator owner & contact details** | Robyn Wilson  Adult Social Care Statistics - NHS Digital  robyn.wilson@nhs.net |
| **1.6 Publication status** | Currently in publication |

**Section 2. Rationale**

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| **2.1 Purpose** | Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of users’ experience and their care and support. There are legal requirements about safety in the context of service quality.  The survey seeks to learn more about how safe service users feel. Question 7a of the survey asks, “which of the following statements best describes how safe you feel”.  As well as question 7a being used for ASCOF measure 4A, it also contributes to the overarching ‘social care-related quality of life’ measure. The results are not considered in isolation are  ASCOF measure 4B follows up with: Proportion of people who use services who say that those services have made them feel safe and secure. These two measures are considered together to understand councils’ impact on perceptions of safety.  ASCOF outcome 4A gives the proportion of service users that answer “I feel as safe as I want”. The outcome score is calculated as CASSR level and disaggregated outcome scores are also calculated by age and gender. Aggregated scores are also produced at regional and England level.  The key role of the ASCOF generally is to provide 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.  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.  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 2014 model (i.e. using default settings) is currently being used. For the 2017/18 data, we will endeavour to update this to the new 2018 model (time and resources allowing).  Also, local authorities are 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. |
| **2.2 Sponsor** | Adult Social Care Informatics Policy Lead  Local Insight & Resilience Branch  Social Care, Local Government & Care Partnerships Directorate  Department of Health  [ASCOF@dh.gsi.gov.uk](mailto:ASCOF@dh.gsi.gov.uk) |
| **2.3 Endorsement** | The framework has been developed by the Department of Health (DH), 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 NHS Digital, Local Government Association (LGA) and Care Quality Commission (CQC) and co-chaired by the Department of Health and Association for the Directors of Adult Social Services (ADASS). Due to the increasing remit of the board, it has been decided to split the board to allow for a more tailored approach to the issues. In September 2014, two new boards were established: the Adult Social Care Data and Outcomes Board (ASC-DOB) and the Adult Social Care Technology and Informatics Group (ASC-TIG). Going forward ASC-DOB will be responsible for overseeing national data collections and for the annual Framework publication and Handbook of Definitions. |
| **2.4 Evidence and Policy base**  Including related national incentives, critical business question, NICE quality standard and set or domain rationale, if appropriate | The Government’s aim is to prevent and reduce the risk of adults with care and support needs from experiencing abuse or neglect. All adult social care users, including those whose circumstances make them vulnerable, should feel safe and secure  The [ASCOF Handbook of Definitions](https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions) for 2016/17 was published in July 2017, for 2017/18 in December 2017 and for 2018/19 in March 2018. The framework has been developed by the Department of Health (DH), 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.  • 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.  • 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 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. |

**Section 3. Data**

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| **3.1 Data source** | Adult Social Care Survey (ASCS)  The ASCS is a survey of users who are in receipt of council funded services. Service users are sent a self-completion questionnaire, although some service users have help completing the questionnaire.  There are two main variants of the questionnaire which can be sent to a service user depending on their particular situation. However, these variants are designed to cover the same questions and the answers are combined to produce the results. The variants are:  • Users receiving services in the community / users in residential care (with slight differences to reflect different settings).  • Users with a learning disability (easy-read version).  Respondents sent the easy-read version of the questionnaire (designed for, but not exclusively sent to, service users with a learning disability) will be treated in the same way, as this version of the questionnaire has been designed to be equivalent to the non-learning disabilities version. The easy-read version uses images from the Valuing People Clipart Collection (www.inspiredservices.org.uk) to make the questionnaire accessible to those with learning difficulties.  More information regarding the survey can be found in the Information and guidance for the Adult Social Care Survey for 2017-18 <http://content.digital.nhs.uk/media/25522/ASCS-Guidance-2017-18/pdf/ASCS_Guidance_2017-18.pdf>  Furthermore, the latest Adult Social Care Survey publication can be found at <http://digital.nhs.uk/catalogue/PUB30102>. 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. |
| **3.2 Justification of source and others considered** | The Adult Social Care User Survey was created in 2010-11, one year before becoming the basis for a number of the indicators in the ASCOF, including 4A. The survey was 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 |
| **3.3 Data availability** | Frequency of collection: Annual  Return format: Numeric  Decimal places: One  As outlined above in section 3.1, datasets are made publicly available as part of both the Adult Social Care Users Survey (ASCS) and Adult Social Care Outcomes Framework publications to support further analysis by end-users. Datasets are provided for ASCS at both aggregate level (by age, gender and local authority) as well as at respondent level with key demographics suppressed. Furthermore, datasets are provided at similar aggregate level as part of the ASCOF output set. |
| **3.4 Data quality** | **i) What data quality checks are relevant to this indicator?**  **Coverage**  - the data quality is checked during the ASCS publication process prior to receipt by the ASCOF team  **Completeness**  **Validity**  - the data quality is checked during the ASCS publication process prior to receipt by the ASCOF team  **Default**  **Integrity**  **Timeliness**  **Other**  **If you included ‘Other’ as a data quality check, please describe the check, how it will be measured, and its reason for use below:**    **ii) What are the current values for the data quality checks selected?** The period of data the current values are calculated from should be stated. Current values should be recorded as a percentage and calculated as described below.  **Period of data:**  **Coverage: Calculation:** 151 / 151 (100%) CASSRs included  **Completeness: Calculation:** 2.8% missing data for question 7a  **Validity: Calculation:** No known issues reported for question 7a  **Default:**  **Calculation:**  **Integrity:**  **Calculation:**  **Timeliness:** Usually published in October; approx. 6-month lag from year-end **Calculation:**  **Other:  Calculation:**  **iii) What are the thresholds for the data quality checks selected?**  **Coverage:** 100% CASSRs  **Completeness:**  **Validity:** Any issues would be reported in the data quality report  **Default:**  **Integrity:**  **Timeliness:**  **Other:**  **iv) What is the rationale for the selection of the data quality checks and thresholds selected above?**  All CASSRs should have a score for all ASCOF measures. To be given a score, CASSRs need to submit a data return with data completed for measure 7a. The level of missing data is monitored to understand the robustness of the CASSRs score. The ASCS data quality annex presents the amount of missing data by CASSR and the Confidence Interval for each question.  **v) Describe how you would plan to improve data quality should it not meet, or subsequently fall below, the thresholds required for this indicator.**  The ASCS publication reviews the quality of the data submitted, councils will receive a data quality report after initially submitting their data and will have the opportunity to resubmit before the final deadline. If there are still issues with the data, details will be included in the ASCS data quality report. If the issue could also affect their ASCOF score, then the CASSR will also be mentioned in the ASCOF data quality statement.  CASSRS that fail to meet the sample size requirements of the survey are named in the data quality annex of the publication in the hope that this will encourage them to achieve the requirement in the following year.  **vi) Who will own the data quality risks and issues for this indicator?**  **Name:** Robyn Wilson  **Job Title:** Analytical Section Head  **Role:** Responsible Statistician for ASCS  **Email:** robyn.wilson@nhs.net  **Telephone:** 0113 254 2470  **vii) Describe how the data quality risks and issues will be managed for this indicator, including the escalation process.**  The data quality annex for the ASCS publication will be used to review the data quality for this indicator.  **viii) Describe any assumptions you have made about data quality for this indicator.**  The data quality will be reviewed during the ASCS publication process and is used to inform the ASCOF publication.  **ix) Describe any data quality constraints you are aware of for this indicator.**    **x) Additional data quality information:**  In 2016-17, of an eligible population of 646,425, a total of 202,605 were sent questionnaires. Of these, 70,575 service users (34.8 per cent) responded to question 7a. The overall response rate for the Adult Social Care Survey for 2016-17 was 35.6 per cent. A review of response bias is included in the ASCS data quality report. Any known issues that could impact the ASCOF scores, or details of where councils have not followed the guidance will also be included in the ASCOF data quality report. This includes known constraints due to lack of resources.  Thirteen councils (8.7%) failed to meet the sample size requirements necessary to achieve a confidence interval of less than 5. These councils, many of which narrowly missed the required sample size, are outlined in the data quality annex’s in the ASCS and ASCOF publications.  The 2016-17 ASCS publication included a more detailed data quality report that showed the 13 councils that did not meet the required sample size. This report is available on the publication page: <http://digital.nhs.uk/catalogue/PUB30102>  For the 2017-18 publication, a webinar was held after the survey materials were made available to go through the publication process and outline to councils how to maximise response rates.  The publication process for all Adult Social Care collections have been reviewed and councils are now given more notice of when the collection deadlines are. It is hoped the process is now clearer for councils and there is a greater understanding that it is the councils’ responsibilities to submit their mandatory returns and meet the required sample size for the survey.  When councils submit their data return, they receive a validation report and a data quality report. These reports will highlight validation issues and any missing data. The data return was also updated for 2017-18 to include a check on the sample size so councils can see if they have enough returns to meet the required confidence interval.  The issue has been discussed in the Social Services User Survey Group (SSUSG) and the group are considering the impact survey fatigue may be having, especially in councils with a relatively small eligible population so the same service users receive a survey each year. |
| **3.5 Quality assurance** | When the ASCS questionnaires are returned to the council, they are entered onto a data return provided by NHS Digital and returned to NHS Digital for validation.  The data return 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).  The data return also includes one-way analysis tables of all variables, which councils can use to assess the quality of their data before returning it.  Validation is also carried out centrally by NHS Digital after the initial submission deadline. This replicates the automated checks built into the data return proforma to identify those which were overridden, but also includes looking for fields where an unexpectedly high number of responses are the same (e.g. 98% of all respondents reporting to feel as safe as they want), as well as identifying questions with a low response rate. The profile of the sample is compared against the eligible population to ensure the sample has been drawn randomly, and the profile of the eligible population is checked against information collected from the Short and Long Term Support (SALT) activity data collection which forms the basis of the sampling frame. The eligible population for the survey is defined as those that would be included in the last three rows of LTS003 table la of SALT. SALT is identified by payments made for care given and therefore is trusted data.  The results of these validations are sent to councils, when they have an opportunity to either submit revised data or provide explanations for any validation rules which have been flagged. Details of validations can be seen on the survey guidance webpage at:  <http://content.digital.nhs.uk/media/25522/ASCS-Guidance-2017-18/pdf/ASCS_Guidance_2017-18.pdf>  The 2016-17 publication included a demographic profile in the “Methodology and further information” report. This report showed the age, gender and ethnicity profile of the service users in the sample and the service users who responded to the survey. This is available here: <http://digital.nhs.uk/media/33045/Personal-Social-Services-Adult-Social-Care-Survey-England-2016-17-Methodology-and-further-information/pdf/pss-ascs-eng-1617-methodology>  Additional analysis has been carried out on the 2016-17 data to look at how representative the sample is to the eligible population. This will be included in the 2017-18 publication. |
| **3.6 Data linkage** | None |
| **3.7 Quality of data linkage** | N/A |
| **3.8 Data fields** | Question 7a: “Which of the following statements best describes how safe you feel?” |
| **3.9 Data filters** | None |
| **3.10 Justifications of inclusions and exclusions**  and how these adhere to standard definitions | Whilst no filters are applied to the received data following the survey being carried out, the population from which the survey sample is drawn is filtered to fit the purpose of the indicator.  All LAs with an eligible population of 150 or more service users 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. This usually affects only two councils: City of London and Isles of Scilly  Additionally, those in residential care who are deemed to not have the capacity to consent to take part in the survey are removed from the sample before the questionnaires are sent out. This is performed by the care home managers who have a duty of care to ensure individuals are approached appropriately. For clarity, this is not legally binding and does not contribute to legal matters such as ‘power of attorney’. We also perform checks to ensure there are not excessively high levels or assessed non-capacity. |
| **3.11 Data processing** | No further processing of ASCS data would be required. |

**Section 4. Construction**

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| **4.1 Numerator** | In response to Question 7a, those individuals who selected the response “I feel as safe as I want”.  Question7a: Which of the following statements best describes how safe you feel? By feeling safe we mean how safe you feel both inside and outside the home. This includes fear of abuse, falling or other physical harm.  Available responses: I feel as safe as I want / Generally I feel adequately safe, but not as safe as I would like / I feel less than adequately safe / I don’t feel at all safe  Within the easy-read version of the questionnaire, images are used to help the respondent understand the general context of each specific question and to then also visually comprehend the meanings of the various response options by the use smiley faces, ticks and thumbs up/down. |
| **4.2 Denominator** | All those that responded to question 7a in the adult social care users survey, including the easy-read version |
| **4.3 Computation** | X/Y×100  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.  Worked example:  In 2016-17, the number of users who said “I feel as safe as I want” was 49,175. The weighted numerator is 457,675.  The total number of users who responded to the question was 70,575, this is the base. The weighted denominator is 653,325.  Data weighted to reflect the stratified sampling technique that has been used when conducting the survey.  The measure value is [(457,675/653,325)\*100] which equals 70.1%. |
| **4.4 Risk adjustment or standardisation type and methodology** | **Weighting Methodology**  Variables and methodology:  This is commonly done by dividing the number of people in each of the four strata (described in table below) 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.  Example of calculating weights:  LD all ages with an eligible population of 1000 and 100 returned questionnaires – weight 10  Non-LD aged 18-64 with an eligible population of 2000 and 100 returned questionnaires – weight 20  Non-LD aged 65+ in residential and nursing care with an eligible population of 3000 and 200 returned questionnaires – weight 15.  Non-LD aged 65+ receiving community based services with an eligible population of 6000 and 500 returned questionnaires – weight 12. |
| **4.5 Justification of risk adjustment type and variables**  or why risk adjustment is not used | 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. |
| **4.6 Confidence interval / control limit use and methodology** | Confidence Intervals  *Methodology (taken from SAS EG proc Means methodology found at website*<https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm#statug_surveymeans_a0000000226.htm>.  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 to compute confidence limits  Where:  symbol for estimate of the meanis the estimate of the mean,  symbol for standard error of the meanis the standard error of the mean  symbol for percentile of the t distribution is the symbol for percentile used in calculation of the t distributionth percentile of the ***t*** distribution with ***df*** calculated as: formula for calculating 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 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.  The variance is:  This provides the information needed to calculate the 95 per cent confidence interval, calculated by:  where:  *p* is the sample proportion (statistic of interest) for the aggregated result  *ph* is the sample proportion in stratum *h*  *nh* is the achieved sample size (number of useable responses) in council *h*  *Nh* is the size of the eligible population in stratum *h*  *H*is the number of strata.  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 found at the website here[https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm#statug\_surveymeans\_a0000000226.htm](https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm" \l "statug_surveymeans_a0000000226.htm) which gives slightly greater accuracy and makes fewer assumptions about the sample size. |
| **4.7 Justification of confidence intervals / control limits used** | Surveys based on samples produce statistics that are estimates of the true figure for the whole population. Estimates drawn from a sample survey therefore are typically presented with confidence intervals around them. These are the ranges that are reasonably certain to contain the true statistics. They are calculated in order that, when comparing two estimates where confidence intervals do not overlap, the estimates can be considered statistically different, leading to opportunities for service improvement.  In the ASCS, councils are required to achieve a 95 per cent confidence interval for survey estimates no wider than ±5 percentage points for an estimate of 50 per cent. This means that if the survey gives an answer of 50 per cent, we can be 95 per cent confident that the true figure is between 45 per cent and 55 per cent.  As there are no extreme probabilities and no small numbers, the Wilson Score method is unnecessary. |

**Section 5. Presentation and interpretation**

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| **5.1 Presentation of indicator** | Disaggregation’s available:  **4A: The proportion of people who use services who feel safe**  Table to show the proportion of people who use services who feel safe, by year in England  Table to show the proportion of people who use services who feel safe by region and gender in England  Table showing data for proportion of people who use services who feel safe by region and age in England 2016 -17 |
| **5.2 Contextual information provided alongside indicator**  with justification | 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.  The Care Act 2014 consolidates past legislation and regulation, and continues to strive for greater transparency, accountability and personalisation in health and social care. Key to supporting the implementation of the Act is the need for outcome-focused intelligence.  The ASCS is the most significant pool of personal outcome information for those receiving LA-funded or managed adult social care. It is an important resource for reporting what has been achieved for local people, supporting development and improvement of local services and enabling people to make better choices about their care.  It is important to understand at national level how well services are meeting user and carer needs. However, data from the survey is not intended to be used solely to monitor performance through national outcome measures but also to be used locally to inform delivery of service and support and to monitor and develop standards. It is recognised that surveys are an important means for obtaining this information. It is understood that some councils may undertake regular feedback via their agreements with service providers but this survey will give a greater insight into outcomes for users and provide a consistent basis for comparing results across different areas.  The survey provides assured, benchmarked local data on outcomes to support local services to think about ways of improving outcomes in a very challenging financial climate. It is constructed so that an individual outcome can be disaggregated into constituent groups. So, as well as providing an overall quality of life index, it provides intelligence on whether specific groups experience better outcomes, whether services and support are meeting all outcome needs, and, in time, the value-added by social care services.  Indicator 4B follows up with: (4B) Proportion of people who use services who say that those services have made them feel safe and secure.  Numerators and denominators are presented in the annex files alongside the publication. Data is available at council, council type, regional and England level.  The data is also available in a PowerBI report which is available in the Social Care Analytical Hub (<http://bit.ly/SocialCare_HUB>). This enables councils to view interactive tables and charts of their data compared to their peers and councils in their region.  The data is also available in the NHS Digital [Clinical Indicators](https://indicators.hscic.gov.uk/webview/) collection. |
| **5.3 Calculation and data source of contextual information** | Same as indicator |
| **5.4 Use of bandings, benchmarks or targets**  with justification | 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.  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 2014 model (i.e. using default settings) is currently being used. For the 2017/18 data, we will endeavour to update this to the new 2018 model (time and resources allowing).  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 areas 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.” |
| **5.5 Banding, benchmark or target methodology**  if appropriate | Not applicable |
| **Interpretation** |  |
| **5.6 Interpretation guidelines** | The measure gives an overall indication of a reported outcome for individuals – it does not, at present, identify the specific contribution of councils’ adult social care towards to feeling safe.  While the measure will focus on those choosing the most positive response - "I feel as safe as I want" - it will be important locally to analyse the distribution of answers across all four possible responses. For example, if a council has a relatively high proportion of respondents selecting "I feel as safe as I want" (i.e. scores highly on the measure) but also has a relatively high proportion of respondents selecting "I don't feel at all safe", this could reflect gaps in safeguarding services.  A large number of factors are likely to impact on how safe and secure users feel; many of these are not controllable by the local authority. However, the variation still suggest analysis of the results is appropriate.  Towards Excellence in Adults Social Care (TEASC), exists to support local authorities, through sector led improvement, to take responsibility for their own performance and drive improvement, developing a system of performance management ‘by councils for councils’. Sector-led improvement is based on the principles that councils are primarily accountable to their local communities; they are responsible for their own performance and improvement; and have a collective responsibility for the performance of the sector as a whole. |
| **5.7 Limitations and potential bias** | The activity return Short and Long Term (SALT) replaced the Referrals, Assessments and Packages (RAP) return in 2014-15, this impacted on the eligible population for the survey. The eligible population for the ASCS changed from a snapshot of table P1 in RAP to the most closely comparable SALT table, LTS001b, as at the chosen extract date. To be included in LTS001b a service user must, at the point that data are extracted from LA systems, be in receipt of long-term support services funded or managed by the LA following a full assessment of need.  These changes are detailed in full in the [methodological change notice](http://content.digital.nhs.uk/media/18151/Personal-Social-Services-Adult-Social-Care-Survey-England-2014-15/pdf/MethChange20150724_PSS_ASCS_2014-15.pdf) that was published in July 2015. The most important changes to note are:  • The population covered by the survey now includes only those in receipt of long-term support services (community and residential); those in receipt of low-level support only (e.g. equipment and adaptations, professional support, short-term residential care) are not included in the survey population or sample.  • The population covered by the survey now includes those service users who receive support from CASSRs in terms of assessment and care management but who pay in full for the cost of their services (full cost clients); previously service users were included only where the CASSR made a contribution towards the costs of services received.  In addition to the impact on the time-series, these changes may have an impact on the comparability of data between LAs. The removal of those service users in receipt of low-level and/or short-term support only may result in greater comparability between councils as there was inconsistency in whether or not LAs included these individuals in RAP, particularly for those in receipt of reablement services.  All changes to the survey can be found in the Information and guidance for the Adult Social Care Survey for 2014-15 <http://content.digital.nhs.uk/media/15141/Adult-Social-Care-Survey-2014-15--guidance-for-local-authorities/pdf/ASCS_Guidance_2014-15_v1.0.pdf>.  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.  Random bias – Not all service users 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.  Survey design – Respondents are allowed to have help to complete the questionnaire. 81 per cent of respondents did so, and the type of help provided and who provided it was also captured. Although not ideal, allowing this as part of the survey design is essential in order to make the survey representative of as many service users as possible.  The development project carried out by Personal Social Services Research Unit (PSSRU), which fed into the survey design, found that care home workers were instrumental in ensuring care home residents were able to respond. This help ranged from simply chasing up a response to helping residents to interpret the questions by making them more meaningful to their life. To mitigate against care home workers trying to persuade residents to answer more positively than they would do otherwise, both the covering sheet of the questionnaire and the letter which was sent to care home managers said the results would not be used for inspection purposes. Anecdotal evidence also suggests it is very difficult to instruct a service user not to ask their care worker for help (both in residential and community settings) when they are used to turning to them for help with everyday tasks such as dealing with the post. Service users were also able to turn to friends and family members for assistance although the covering letter and instructions informed service users that it was their views which should be recorded and not those of the helper.  The service users who did complete the survey unaided are a small subset of state funded social care users and, therefore, restricting the survey to this small group would provide quite a biased impression of the view of social care users. It would also leave a much smaller number of respondents which would increase the potential of random bias.  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 service user) and therefore there is minimal bias caused by the different methods of data collection. |
| **5.8 Improvement actions** | Local authorities, having reviewed their outcomes for this measure compared to the scores achieved by their peer group / region / national, will be able to undertake a combination of:  • investigating disaggregation’s provided as part of ASCOF output files.  • investigating disaggregation’s available as part of the underlying adult social care user survey outputs.  • linking with relevant organizations to understand how their practices differ  in order to understand what they can do in terms of service improvement and/or amendments to policies and processes, to improve the outcomes experienced by service users within their geographical area. |
| **5.9 Evidence of variability** | Included below is an example chart which shows for a given region, the variation present in the scores for Measure 4A, as well as the margins of error around these scores. These data are published as part of the ASCS publication outputs and would enable interested councils to determine whether they were performing at a different level to their peers, or if natural variation may explain the observed difference at a specific point in time. It would be expected that changes over time would be analysed also to determine whether any action was required.  Graph to show percentage scores and margins of error per local authority for people who answered the question ' I feel as safe as I want' . |

**Section 6. Risks**

|  |  |
| --- | --- |
| **6.1 Similar existing indicators** | N/A |
| **6.2 Coherence and comparability** | The comparability of measure 4A over time is addressed via the ASCOF publication. In common with all ASCS-based measures (1A, 1B, 1I(1), 1J, 3A, 3D(1), 4A and 4B), changes to these measures have created a break in the time-series, as described in early sections due to the change in eligible population with the introduction of SALT. |
| **6.3 Undesired behaviours and/or gaming** | One of the key risks of undesired behaviours with any survey is inconsistencies introduced by the survey process. For example, where service users are helped to complete the questionnaire by a representative of the service provider or where the method of carrying out the survey excludes certain service users for example by being web- or telephone-based.  Guidance documentation is provided to local authorities 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.  As outlined in section 5.7 above, there are instances where it is reasonable for service users to call upon their service providers to help them in completing the questionnaire. Anecdotal evidence suggests that it is very difficult to instruct a service user not to ask their care worker for help when they are used to turning to them for help with everyday tasks such as dealing with the post. The questionnaire does ask if a user has had assistance completing the questionnaire, and we factor the responses to this into both our analyses and data quality assessment.  To mitigate these risks however, the guidance also provides a range of ways though which councils can ensure service users are able to complete the questionnaire as independently as possible through for example family members, informal carers or advocates. The guidance also explicitly states that “Anyone directly involved in the provision of services to the participant should not help them to complete the questionnaire. This is because respondents may not feel able to give their true opinion and this would bias the results.”  Where it is not possible to find appropriate support to enable service users 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 ASCS guidance documentation to ensure data are collected robustly and consistently, and to support transparent and fair comparisons between service providers. |
| **6.4 Approach to indicator review** | The ASCOF is co-produced by the Department of Health and local government and is updated annually. As part of the development of the ASCOF for 2017-18, work is on-going with local government colleagues to ensure that the framework best supports and reflects central and local government priorities for adult social care.  In developing new measures, the Department remain mindful of the reporting burden on councils, and the need to retain a focus on measuring the success of the adult social care system in delivering high quality care and support.  A range of potential ASCOF measures were included in ‘Consultation on Adult Social Care Data Developments 2012’. The outcome of that consultation can be seen at:  <http://content.digital.nhs.uk/media/9756/2-Consultation-on-Adult-Social-Care-Data-Developments-2012-Main-Consultation-Document/pdf/2_Consultation_Main_consultation_doc.pdf>.  The findings from this consultation should continue to be discussed by Department of Health’s ASCOF Reference Group.  The Social Care Collections are developed by the Adult Review Group and the Social Services User Survey Group (SSUSG) which is attended by NHS Digital, Department of Health (DH), Care Quality Commission (CQC), independent representatives with an active interest in the subject and CASSR performance and information managers as well as researchers from PSSRU and local councils.  The 2012-13 collections were approved by the Outcomes and Information Development Board (OIDB). This group is jointly co-chaired by DH and the Association of Directors of Adult Social Services (ADASS) and contains representatives from NHS Digital, CQC and LGA.  Information about social care data collections for 2017-18 and 2018-19 is available in the September 2017 letter to local councils, available at:  <http://content.digital.nhs.uk/socialcarecollections2018>. |
| **6.5 Disclosure control** | Generally  Risk is considered to be Normal as per the NHS Anonymisation Standard. Some cells in tables and data annexes are counts of individuals which may contain small numbers. The raw data include sensitive variables such as ethnicity, age, gender and disability and are at individual level.  Report and annex tables  For aggregated outputs there will be a sufficient level of aggregation that individuals cannot be identified in relation to sensitive variables such as religion, disability, ethnicity, age and gender.  Counts in the report will be rounded to the nearest five. Percentages in the report will be rounded to the nearest percentage point. Percentages in the annex tables will be rounded to one decimal place.  Individual record level data file (csv)  The data do not contain sensitive items (sexual identity, religion and disability will not be included in the file). Distribution is not skewed, special knowledge is not already available about individuals and there is no known availability of especially relevant information thus the risk is considered to be Normal, weak k-anonymity (k=3) will be used for individual records.  Age and ethnicity will each be grouped into two broad categories; the submitted values for age and ethnicity will not be included in the file.  Sensitive data items will be suppressed where one record or two records within a council have a unique combination of variables that could help identify an individual (council code, gender, age, and ethnicity). The exception to this is where data for gender, age and ethnicity are all missing, in which case the record(s) will not be removed. |
| **6.6 Copyright** | The Adult Social Care Survey publication is published as copyright © 2018 Health and Social Care Information Centre. All rights reserved.  The work remains the sole and exclusive property of the Health and Social Care Information Centre and may only be reproduced where there is explicit reference to the ownership of the Health and Social Care Information Centre.  This work may be re-used by NHS and government organisations without permission. |

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| Logo for Indicator Governance Board |
| Indicator Assurance Report |
| **The proportion of people who use adult social care services and who feel safe** |
| **IAP00424** |



**Final Assurance Rating from the Indicator Governance Board - 27/03/2018**

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

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

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

|  |  |
| --- | --- |
| **Approval date** | 27/03/2018 |
| **Review date** | 27/03/2021 |

**Details of Methodology Appraisal – 22/03/2018**

|  |  |
| --- | --- |
| **Methodology appraisal body** | NHS Digital Indicator and Methodology Assurance Service |
| **Reason for assessment** | Initial assurance |
| **Iteration** | 2nd MRG meeting |

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

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

**Please find a detailed description of recommendations and actions in the appraisal log at the end of the document.**

**Summary Recommendation to Applicant:**

MRG would like to thank the applicant for presenting this indicator. Members agreed that the application was well completed, had much merit and most of the reccommendations from previous MRG have been actioned.   
  
The remaining issues to be addressed are:  
• A few brief sentences clarifying the link between 4a and 4b  
• Specific methods of using PROC SURVEYMEANS, including equations from SAS documentation  
• Version of CIPFA used  
• Clarity that all 4 strata in the example are used in the actual caculation

**Summary Recommendation to IGB:**

Fit for use

**Details of Methodology Appraisal – 24/03/2016**

|  |  |
| --- | --- |
| **Methodology appraisal body** | HSCIC's Indicator & Methodology Assurance Service |
| **Reason for assessment** | Initial assurance |
| **Iteration** | 1st MRG meeting |

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

|  |  |
| --- | --- |
| **Ratings Against Assessment Criteria** |  |
| Clarity | **-** |
| Rationale | **-** |
| Data | **-** |
| Construction | **-** |
| Presentation and Interpretation | **-** |
| Risks and Usefulness | **-** |
| **Overall Rating** | **Not enough information provided** |

**Summary Recommendation to Applicant:**

The MRG thanks the applicants for the submission and the work put into the application. Currently the group do not feel they have the level of information needed to give the indicator a recommended assurance rating. Once further information as outlined in the appraisal log is supplied, the MRG recommend it returns to the group to be reconsidered.

**Summary Recommendation to IGB:**

MRG do not feel they have enough information to give the indicator a suggested assurance rating, therefore they do not recommend its escalation to IGB, or for the indicator to be included in the Library at present.

**Please find a detailed description of recommendations and actions in the appraisal log at the end of the document.**

**What do the Assurance Ratings mean?**

|  |  |
| --- | --- |
| **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**

**Clarity**

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| --- | --- | --- | --- | --- | --- | --- |
| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
| 1a | It is not clear from the application how “long-term support” is defined. | MRG 24/03/2016 | The SALT guidance defines long-term support as:  Long Term support encompasses services provided with the intention of maintaining quality of life for an individual on an ongoing basis, and which have been allocated on the basis of eligibility criteria / policies (i.e. an assessment of need has taken place) and are subject to regular review.  This has been added to section 1.4. | 22/02/2018 |  | MRG 22/03/2018 |
| 1b | The indicator title currently does not indicate that only patients receiving long-term care are included. | MRG 24/03/2016 | All the data comes from the Adult Social Care Survey which is based soley on service users who receive long term support. This is explained in the more detailed definition but is not in the titles.  During MRG meeting applicant agreed to discuss with the sponsor of the indicator the potential for changing the title of the indicator but MRG accept that it’s a decision that is out of their control, and as such should not stand in the way of assurance. | 22/02/2018 |  | MRG 22/03/2018 |

Rationale

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| --- | --- | --- | --- | --- | --- | --- |
| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
| 2a | The current indicator as specified in the application form is unable to meet the purpose of measuring how effectively services are helping service users to feel safe, as whether a service user feels safe is affected by many other factors. The group recommend either amending the purpose to meet what the current indicator is able to measure, or to change the indicator construction (see rec. no. 3a). | MRG  24/03/2016 | Additional text on the purpose of the measure has been added. This includes what the outcome score tells the council and text from section 5.4 on benchmarking has been added to this section. | 22/02/2018 |  |  |
| 2b | MRG request more detail in section 2.1, Purpose. In particular, how the measure is to be used at local level. | MRG  24/03/2016 | Further information has been added, including adding data on benchmarking from section 5.4. | 22/02/18 |  | MRG 22/03/2018 |
| 2c | MRG felt that a few brief sentences clarifying the link between ASCOF outcomes 4A and 4B would be sufficient to address recommendations 2a, 2b and 3a. | MRG  22/03/2018 | This has been addressed in the application form | 17/04/2018 |  | MRG  17/04/2018 |

Data

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| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
| 3a | Further information is required as to why question 7b is not utilised. This question asks: “Do care and support services help you in feeling safe?” with possible answers being “Yes” or “No”. The results from this question would be better aligned to meeting the purpose as stated in the application form. | MRG  24/03/2016 | This is used to calculate ASCOF measure 4B which is a separate measure. | 22/02/18 |  | MRG 22/03/2018 |
| 3b | Given that it was reported by the applicants in the meeting that the number of returns by councils are decreasing by approximately 1% per year, and that approximately 10% of councils are not meeting the sample size requirements, it is recommended that a data quality improvement plan is developed. | MRG  24/03/2016 | A more detailed data quality report was published with the 16-17 ASCS publication: <http://digital.nhs.uk/catalogue/PUB30102> this showed that 13 out of the 151 (8.6 per cent) councils did not meet the required sample size in 2016-17.  A webinar has been help for the 2017-18 publication process to go through the guidance and how to maximise response rates. Further details have been added to section 3.4 x. | 22/02/18 |  | MRG 22/03/2018 |
| 3c | More information is required with regards to the quality of SALT data. In particular, the group is interested in how successful SALT is at defining the population group. | MRG  24/03/2016 | The eligible population is the same definition as SALT. SALT is idenditied by payments made for care given and therefore is trusted data.  Further text added to section 3.5. | 22/02/2018 |  | MRG 22/03/2018 |
| 3d | The current overall response rate is approximately 1/3. Has the data been explored for response bias? | MRG  24/03/2016 | Bias is considered in the ASCS data quality report. Additional text added to section 3.4x. | 22/02/2018 |  | MRG 22/03/2018 |

Construction

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
| 4a | The confidence interval method as stated in the application is not in line with current best practice - although it is stated as “the standard formula”, it has not been the standard formula for many years. As it is a proportion, the Wilson Score method would be the standard method, as described in APHO Technical Briefing 3. http://www.apho.org.uk/resource/item.aspx?RID=48457. | MRG  24/03/2016 | We would need to discuss this further both within the team and with MRG.  Panel can provide some guidance on calculations to use. |  |  | MRG 22/03/2018 |
| 4b | It is useful to have a worked example in section 4.3 (Computation), however the example that is shown doesn’t include the weighting methodology. | MRG  24/03/2016 | Example with weighting methodology added. | 22/02/2018 |  | MRG 22/03/2018 |
| 4c | Clarification is required on the number of strata being weighted, as it is unclear whether the table in section 4.4 (Risk adjustment and standardisation) is a full example. | MRG  24/03/2016 | Yes, that is the full list – there are 4 strata. This has been made clearer in section 4.4. | 22/02/2018 |  | MRG 22/03/2018 |
| 4d | MRG requested that the use of confidence intervals (4.6) be clarified. It’s not clear in the current form how PROC SURVEYMEANS is used. It was suggested that SAS guidance for this procedure be reproduced, along with a description of how it’s specifically used in this situation. | 22/03/2018 | Applicant included included calculations in the paper and also provided the link in the document: <https://support.sas.com/documentation/cdl/en/statug/63347/HTML/default/viewer.htm#statug_surveymeans_a0000000223.htm> | 17/04/2018 |  | 17/04/2018 |

Presentation and interpretation

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| --- | --- | --- | --- | --- | --- | --- |
| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
| 5a | It is not clear from the documentation the availability of Nearest Neighbour Data. Please could the applicant clarify whether this is available in NASCIS. | MRG  24/03/2016 | The CIPFA weblink has been given – this is where the list of councils and their nearest neighbour is. NASCIS is no longer updated. The CIPFA list has been uploaded into NASICS so it can be used for older data sets. | 22/02/2018 |  | MRG 22/03/2018 |
| 5b | Although the CIPFA weblink has been provided, is was highlighted by MRG that it is not clear which version of CIPFA is being used and sought a little more clarity around that. | 22/03/2018 | Further details provided out of meeting and approved by MRG members | 17/04/2018 |  | 17/04/2018 |

Risks and usefulness

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Rec. no*** | ***Issue or recommendation*** | ***Raised by / Date*** | ***Response or Action taken by applicant*** | ***Response date*** | ***Resolved*** | ***Sign off by / Date*** |
|  |  |  |  |  |  |  |

**Any feedback should be made to the Indicator and Methodology Assurance Service (IMAS) 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 IMAS team.**

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