

# Waiting times summary and guidance for CASSRs to sample data for the waiting times indicators

For the collection period 1<sup>st</sup> April 2008 – 31<sup>st</sup> March 2009

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**Version:** 1.0

**Date of Publication:** February 2009

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# 1. Introduction and Background Information

This document summarises all the guidance relating to measuring waiting times on assessment and receipt of services in RAP for 2008/09.

On 23<sup>rd</sup> July 2002, Secretary of State for Health announced that:

All assessments will begin within 48 hours of the first contact with social services and be completed within 4 weeks, and 70% within two weeks.

All social services for older people, following assessment, should be provided within 4 weeks, and 70% within two weeks.

These targets will be monitored via two National Indicator Set (NIS) indicators that are based on data from the Referrals, Assessments and Packages of Care (RAP) return (*see annex A for the definitions of these indicators*);

NI 132 (VSC12) timeliness of social care assessments

NI 133 (VSC13) timeliness of social care packages

Information for 2008/09 will be collected on the RAP proformas A7 and A8.

The document that follows highlights some of the key areas where there has been some confusion amongst CASSRs regarding these proforma. Items include guidance on double counting, and details of how to record assessments for clients in hospital that start and/or are completed before a section 5 notice is received. Also included are some examples on measuring waiting time to completed assessment.

Annexes A to E bring together all the information relating to waiting times in one place for ease of reference. This includes guidance and examples relating to measuring waiting times that have been issued throughout the year plus a comprehensive list of waiting times definitions for RAP.

## 2. Summary of Key Definitions for Waiting Times

The full list of definitions relating to waiting times is in Annex B. Following the 2003-04 data collection on waiting times, a questionnaire to CASSRs was used to identify any problems and improve the quality of the data. Two of the ADSS regional benchmarking groups also carried out a detailed analysis on the data quality and collection processes for the new waiting times data. As a result of these analyses this note highlights the key areas where there has been some confusion for CASSRs.

### 2.1. Baseline Populations

The baseline populations are provided in the protocols for each proforma in Annex E. We realise previously that there was some confusion for A8 as the description referred to other RAP proformas within the same period, but clients who contacted social services before the start of the period and meet the criteria below should also be included.

A7 – The baseline population for A7 is the total of new clients for whom the assessment process was completed in the period

A8 – The baseline population for A8 is the total of new clients with completed assessments who received all their services during the period.

For 2008/09 we expect CASSRs to use the definitions above. Some examples are given in appendix A.

#### **Double counting**

On both of the proformas A7 and A8 new clients should only be counted once. If a client has had more than one assessment event during the reporting period, then provide details relating to the most recent assessment event. There should be no double counting across categories.

### 2.2. Proforma A7 – Measuring time from first contact to completed assessment

- **Terminated assessments**

These should be excluded from RAP proforma A7.

- **Recording of assessments in relation to FACS**

For assessments that stop because the users needs do not meet the Fairer Access to Care (FACS) eligibility criteria, treat these as completed assessments.

- **Completing the assessment before receiving the section 5 notice**

Where CASSRs have completed the assessment for a client in hospital before receiving the section 5 notice, the time between first contact and completed assessment should be recorded in the lowest time band on RAP form A7, i.e. less than or equal to 2 days.

- **OT Assessments**

- **Inclusions:**

Assessments completed by Occupational Therapists (OT) and Occupational Therapy Assistants (OTA) and paid for by social services should be included in RAP.

If the OT/OTA contributes to a multi-disciplinary team assessment, then the OT assessment would be one assessment event within the whole assessment of the client's needs. In the Single Assessment Process OT assessments are captured under 'Specialist' assessment. If the OT assessment is the only assessment then it should still be recorded on RAP. Where social services refer the OT assessment to an outside agency, if social services have funded the assessment then it should be included in RAP.

- **Exclusions:**

Any items of equipment that are issued at or near the point of contact as a basic service and are recorded in form R2 should be excluded from the waiting times forms.

If social services have not paid for the assessment then it is excluded from RAP.

- **Measuring completed assessments**

The waiting time to completed assessment should be measured as the time social services complete their last assessment event within the whole assessment process. Three examples are given below;

A multi-disciplinary assessment is carried out within social services. This includes two assessment events, an overview assessment carried out by a social worker that was completed on 3 June and an OT assessment that was completed on 10<sup>th</sup> June. The date in which the assessment is counted on RAP as complete is 10<sup>th</sup> June.

A SAP assessment is carried out to look at both the health and social care needs of the client. The social services element of the assessment is completed on 3<sup>rd</sup> June and the assessment of the health needs is completed on 10<sup>th</sup> June. The date the SAP assessment is counted on RAP as complete is 3<sup>rd</sup> June, when the social services part is complete. This example is also applicable to joint teams under section 75 arrangements of the NHS Act 2006 (formerly section 31 of the Health Act 1999). [From the service user perspective this is not ideal but reflects the possible problem of not knowing when the health part of the assessment is complete.]

A joint assessment is **coordinated by social services**. Social services have completed their part of the assessment by 3<sup>rd</sup> June but the assessment of health needs is not completed until 10<sup>th</sup> June. The date in which the assessment is counted on RAP as complete is 10<sup>th</sup> June.

## 2.3. Proforma A8 – Measuring time from completed assessment to receipt of all services

- **Date of receiving service** – this should be the date when the client **actually** first receives the service as opposed to the planned or desired date of receipt. The exceptions to this are set out below.
- **Equipment and adaptations** – for measuring the receipt of all services on proforma A8, this should include **all** equipment and minor adaptations provided or commissioned by and funded by the CASSR.

- **Major adaptations** - the waiting time is measured as the time from completed assessment to the date that the request for a major adaptation is referred to a housing department or a housing association or an application is submitted for a Disabled Facilities Grant (DFG). In some cases there may need to be a social services “top up” but reaching final agreement on the amount involved is excluded from the waiting time.
- **Professional support** - For a client to be considered as having professional support, the service must be included as part of their care plan. This does **not** include the process of care management (i.e. assessing or reviewing their care needs, even if the case is “open” or “active” on 31<sup>st</sup> March), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, e.g. counselling. For professional support to be regarded as received the requisite input must be provided by or on the date recorded.

Although we have issued guidance on how to record the date of receipt for some specific services, we are aware that some CASSRs are still confused about this. The guidance on key areas causing confusion is set out below for ease of reference.

The guidance issued already states that services that are not actually required by the client within 4 weeks of completed assessment are counted as being received as long as arrangements for those services have been put in place within 4 weeks. However there is an issue whereby the client is in need of a service, but because a date for the service has not been specified it is not possible to put arrangements in place.

If the arrangements for this service are not in place then all services have not been received, i.e. if no dates are specified in the care plan then arrangements for the service can not be put in place and therefore it is likely that the majority of these cases would miss the target of 4 weeks from completed assessment to receipt of all services.

In this situation the client would be considered to have received all their services once a date for the service had been given **and** the arrangements had been put in place, even if this is several months after receiving all other services.

**Example:** The client completes their assessment on 1<sup>st</sup> May. Their care plan includes meals, equipment and day care with no date specified. The meals are first received on 7<sup>th</sup> May and equipment is first received on 10<sup>th</sup> May. The client then asks for day care on 20<sup>th</sup> June to start at the end of July. The arrangements for day care are put in place by 25<sup>th</sup> June. The waiting time between the completed assessment and receipt of all services is measured as the length of time between 1<sup>st</sup> May and 25<sup>th</sup> June.

We understand this means it will be impossible for CASSRs to meet the target of 100% of services in place within 4 weeks for practical reasons. This will be taken into account when the bands for the indicator are set.

- **Short-term residential care – not respite** – This refers to the provision of short term residential care for the client for any purpose other than respite care of a carer. It includes the provision of rehabilitation services (see glossary definition for ‘Components of service’ for clarification).

- **Services that may be modified in light of experience** – for this situation the waiting time is measured from completed assessment to receipt of all services in the **initial** care plan (see *examples in protocol A8*). Any future services included in the care plan, for example at the 5 week review, should still be put in place as soon as possible but will be excluded from the indicator as these services are following a review.
- **Needs assessed during a residential placement -**
  - (a) If the **initial** service in the care plan is to go into residential care for further assessment, then count the date that the client moved into residential care as the date when all services were received.
  - (b) If the initial needs are still being assessed, the assessment has not been completed and the client does not have an agreed care plan for CASSRs to put in place. Hence these clients would be excluded from form A8 in the current reporting period.
- **Sampling guidance** – previously a document providing guidance on sampling for proforma A8 has been issued. This guidance is set out in annex D. If you intend to provide data based on a sample for 2008/09, some key areas to note are;

A “random” sample must be taken of clients from across the whole period 1<sup>st</sup> April 2008 to 31<sup>st</sup> March 2009. The Audit Commission does **not** allow samples based on some months of the year and uprated to the whole year, for example the last 3 months multiplied by 4.

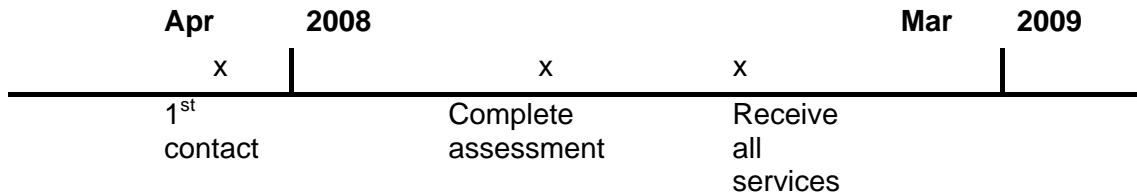
As a minimum the sample sizes for 2008/09 should meet the requirements set out in table A of appendix A of the sampling guidance. **Any data based on a smaller sample size will not be accepted for RAP or the performance indicators.**

Sample data should be uprated to the whole population before it is submitted on the RAP return. A grossing up tool for CASSRs who have applied weights to their data is available at: <http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/collections-2009>.

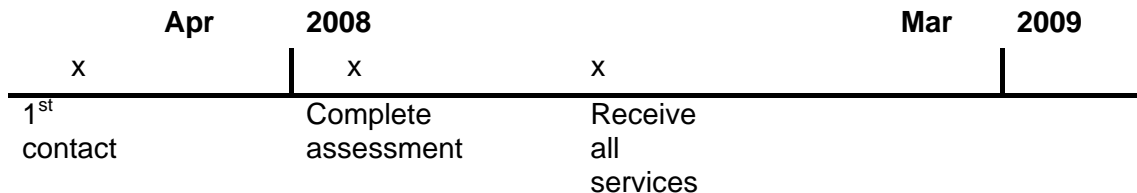
- **Validation checks**  
Annex C provides a list of validation checks for the waiting times proformas A7 and A8. This list includes the validation checks that are on the Internet Data Collection (IDC) system and some data quality checks that will be carried out by the Adult Social Care Statistics team in The NHS Information Centre for health and social care (IC).

### 3. Appendix A – Examples to illustrate the baselines for the proformas on waiting times for 2008/2009

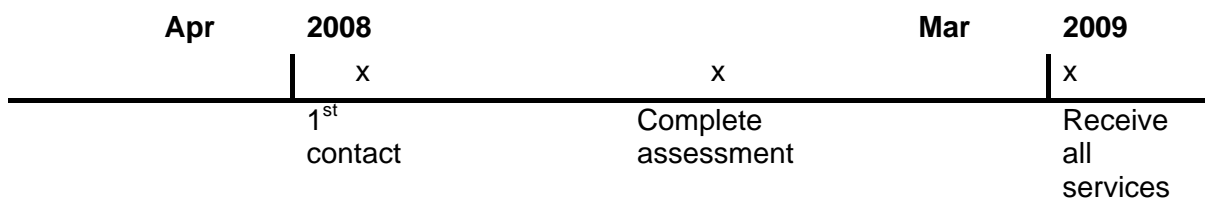
(i) Client A will be recorded in A7 and A8



(ii) Client B will be recorded in A7 and A8



(iii) Client C will be recorded in A7



(iv) Client D will be recorded in A8 only



## 4. Annex A – Waiting times National Indicators for 2008/2009

### 4.1. NI 132/VSC 12: Timeliness of social care assessment

Definition	For new clients (aged 18+), the percentage from where the time from first contact to completion of assessment is less than or equal to four weeks.
The numerator	Of new clients aged 18 and over in the denominator, the number for whom length of time from first contact to completion of assessment was less than or equal to four weeks.
The denominator	The total number of new clients aged 18 and over whose assessments were completed in the year regardless of which year the first contact was made.
Source	<i>Numerator:</i> RAP Table A7 Page 1 (1) All new clients aged 18-64 lines 1 to 3 (2) All new clients aged 65 and over lines 1 to 3. <i>Denominator:</i> RAP Table A7 Page 1 (1) All new clients aged 18-64 lines 1 to 5 (2) All new clients aged 65 and over lines 1 to 5.

### 4.2. NI 133/VSC 13: Timeliness of social care packages

Definition	For new clients (aged 65+), the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to four weeks.
The numerator	Of the number of new clients (aged 65+) in the denominator, the number for whom length of time from completion of assessment to provision of all services in a care package is less than or equal to four weeks (28 calendar days).
The denominator	The total number of new clients (aged 65+) whose assessment was completed and who went on to receive all services in the reporting year.
Source	<i>Numerator:</i> RAP Table A8 Page 1 (65 and over table) lines 1 to 2. <i>Denominator:</i> RAP Table A8 Page 1 (65 and over table) lines 1 to 4.

## 5. Annex B – Full list of definitions for measuring waiting times on RAP

All waiting times in RAP are based on calendar days, not working days.

### **First Contact:**

*All individuals excluding those who are inpatients in hospitals:* This is the date when first contact is received from or on behalf of the client in relation to the needs that require assessment. The contact may be by way of personal call, phone call, letter or other form. It may be direct or through an intermediary (such as a neighbour, relative or GP). The date of first contact is not necessarily the same as the date of screening, though in many CASSRs screening will take place on the same day as contact.

*Individuals who are inpatients in hospital:* This is the date when it is confirmed by an NHS hospital to a social services department by means of a 'section 5 notice' that the patient is medically fit and ready for discharge. The contact may be by way of phone call, letter or other form.

If a CASSR is informed that a patient's intended release is delayed for medical reasons, the time of the first contact should be reset to when the CASSR is re-notified by the hospital via a section 5 notice. If an assessment has already been carried out before the release date changed and no further assessment is required, the start of assessment must be the new date of discharge.

### **Completed assessment:**

For RAP purposes include all assessments which were completed in 2008/09 whether or not they started in 2008/09. Exclude any assessments that were not actually completed by 31<sup>st</sup> March 2009. This clarifies the current guidance as set out in the glossary.

### **Measuring completed assessments:**

The waiting time to completed assessment should be measured as the time social services complete their last assessment event within the whole assessment process. Three examples are given below;

A multi-disciplinary assessment is carried out within social services. This includes two assessment events, an overview assessment carried out by a social worker that was completed on 3<sup>rd</sup> June and an OT assessment that was completed on 10<sup>th</sup> June. The date the assessment is counted on RAP as complete is 10<sup>th</sup> June.

A SAP assessment is carried out to look at both the health and social care needs of the client. The social services element of the assessment is completed on 3<sup>rd</sup> June and the assessment of the health needs is completed on 10<sup>th</sup> June. The date the SAP assessment is counted on RAP as complete is 3<sup>rd</sup> June when the social services part is complete. This example is also applicable to joint teams under section 75 arrangements of the NHS Act 2006 (formerly section 31 of the Health Act 1999) [From the service user perspective this is not ideal but reflects the possible problem of not knowing when the health part of the assessment is complete.]

A joint assessment is **coordinated by social services**. Social services have completed their part of the assessment by 3<sup>rd</sup> June but the assessment of health needs is not completed until 10<sup>th</sup> June. The date the assessment is counted on RAP as complete is 10<sup>th</sup> June.

### **Completing the assessment before receiving the section 5 notice:**

Where CASSRs have completed the assessment for a client in hospital before receiving the section 5 notice, the time between first contact and completed assessment should be recorded in the lowest time band on RAP form A7, i.e. less than or equal to 2 days.

### **Recording of assessments in relation to FACS:**

For assessments that stop because the users' needs do not meet the Fairer Access to Care (FACS) eligibility criteria, treat these as completed assessments.

### **OT assessments:**

Assessments completed by Occupational Therapists (OT) and Occupational Therapy Assistants (OTA) and paid for by social services should be included in RAP.

If the OT/OTA contributes to a multi-disciplinary team assessment, then the OT assessment would be one assessment event within the whole assessment of the client's needs. In the Single Assessment Process OT assessments are captured under 'Specialist' assessment. If the OT assessment is the only assessment then it should still be recorded on RAP.

Any items of equipment which are issued at or near the point of contact as a basic service and are recorded in form R2 should be excluded from the waiting times forms.

Where social services refer the OT assessment to an outside agency, if social services have funded the assessment then it should be included in RAP; however, if social services have not paid for the assessment then it is excluded from RAP.

### **Receipt of all services:**

For RAP purposes, only include those clients actually in receipt of **ALL** services by the end of the financial year 2008/09.

For measuring the target for new clients these are all the directly provided, commissioned or purchased social services that are in the care plan. In this context social services will include any service that is paid for or recharged to social services budgets within CASSRs. It will also include social services provided as a result of an assessment made by a joint team operating under section 75 arrangements of the NHS Act 2006 (formerly section 31 of the Health Act 1999) whether or not this team is funded directly by Social Services (e.g. via a pooled budget).

To meet the target of services starting within 4 weeks, **all** services must be provided within 4 weeks.

There are some rare circumstances where some of the services defined in a care plan are contingent on the delivery of other services. Therefore, it is not sensible, and indeed would be detrimental to the client, for them to be delivered within 4 weeks of the assessment. On these rare occasions, the arrangements for these services to be delivered should be put in place within the 4 week period (i.e. patient need is the only reason why services are provided outside the four week period).

An example of a rare circumstance is where a care plan specifies that a client needs rehabilitation services for 5 weeks but then requires home care after coming out of rehabilitation. In this case the client's needs mean that the home care services should not be delivered within 4 weeks of the assessment. Instead we are saying that both the rehabilitation must start and the arrangements for home care are put in place within the 4 weeks of the completed assessment.

There may be other exceptional circumstances beyond the control of CASSRs, which mean that all services cannot be provided within 4 weeks of the assessment. These circumstances will be taken into consideration when setting the performance bandings for the waiting times to care packages indicator.

**Date of receiving service:**

This should be the date when the client **actually** first receives the service as opposed to the planned or desired date of receipt.

**Receiving services before the assessment is completed:**

Where the client has received all their services (or the arrangements were in place for specific services) before the assessment has been completed, the time between completed assessment and receipt of all services should be recorded in the lowest time band on RAP form A8, i.e. less than or equal to 2 weeks.

**Equipment and adaptations:**

For measuring the receipt of all services on proforma A8, this should include **all** equipment and minor adaptations provided or commissioned and funded by the CASSR.

In the case of equipment and adaptations, services are **not** complete until the equipment is received (and where necessary, satisfactorily installed).

**Major adaptations:**

The waiting time is measured as the time from completed assessment to the date that the request for a major adaptation is referred to a housing department or a housing association, or an application is submitted for a Disabled Facilities Grant (DFG). In some cases there may need to be a social services “top up” but reaching final agreement on the actual amount involved is excluded from the waiting time.

**Professional Support:**

For a client to be considered as having professional support, the service must be included as part of their care plan. This does **not** include the process of care management (i.e. assessing or reviewing their care needs, even if the case is “open” or “active” on 31<sup>st</sup> March), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, e.g. counselling. For professional support to be regarded as received the requisite input must be provided by or on the date recorded.

**Q and A**

Q: How do I record the time from assessment to the provision of all services where:

a new client who was assessed at time A and had a care plan that specified the need for 3 different services; but then later when only 2 of the 3 services in the original care plan had been provided the client's circumstances changed and a new assessment at time B revealed that the third service was no longer needed?

A: In this situation the time at which it becomes clear that all the services required in the original care plan have been delivered is at time B, when the second assessment concludes that the third service

is no longer required. Therefore, the time from assessment to the provision of all services is the time from time A to time B.

### **Guidance on specific services:**

Several types of services are listed below with guidance on how to measure when these services are received.

The guidance issued already states that services that are not actually required by the client within 4 weeks of completed assessment, are counted as being received as long as arrangements for those services have been put in place within 4 weeks. However there is an issue whereby the client is in need of a service, but because a date for the service has not been specified it is not possible to put arrangements in place.

If the arrangements for this service are not in place then all services have not been received, i.e. if no dates are specified in the care plan then arrangements for the service can not be put in place and therefore it is likely that the majority of these cases would miss the target of 4 weeks from completed assessment to receipt of all services.

In this situation the client would be considered to have received all their services once a date for the service had been given **and** the arrangements had been put in place, even if this is several months after receiving all other services.

**Example:** The client completes their assessment on 1st May. Their care plan includes day care, meals and short term residential care (not respite care) with no date specified. The day care is first received on 7th May and meals are first received on 10th May. The client then asks for short term residential care on 20th June for a week at the end of July. The arrangements for the short term residential care are put in place by 25th June. The waiting time between the completed assessment and receipt of all services is measured as the length of time between 1st May and 25th June

### **Direct payments**

We understand that the process for arranging direct payments can be quite lengthy in terms of the legal and contractual issues. Hence for direct payments the waiting time is measured as the time from completed assessment to the date the amount of the direct payment has been agreed with the client **and** the relevant processes for setting up the direct payment have been completed.

### **Other services that are booked in advance**

For example, pre-hospital admission arrangements for home care. To cover other services that are booked in advance use the date when arrangements were put in place for the home care to be provided.

### **Services that may be modified in light of experience**

In this situation, the waiting time is measured from time of completed assessment to receipt of all services in the **initial** care plan.

**Example:** It is decided initially that a client should receive 4 hours of home care a week and attend a day centre 3 times a week. It is agreed to review this arrangement in 5 weeks time. The initial home care and day care is started one week after the assessment. The waiting time is measured as the time between the completed assessment to when both the home care and day care are first received, namely one week.

Any future services included in the care plan, for example at the 5 week review, should still be put in place as soon as possible but will be excluded from the indicator as these services are following a review.

### **Needs assessed during a residential placement**

If the **initial** service in the care plan is to go into residential care for further assessment, then count the date that the client moved into residential care as the date when all services were received.

If the initial needs are still being assessed, the assessment has not been completed and the client does not have an agreed care plan for CASSRs to put in place. Hence these clients would be excluded from form A8 in the current reporting period.

## 6. Annex C – Validation checks for the waiting times proformas

### 6.1. Validation checks on the Internet Data Collection (IDC) facility

- A7 – Length of time from first contact to completed assessment for new clients
  - The sum of the values entered in all of the cells in the 'All new clients 18-64' column should be equal to the sum of the values entered in all of the cells on A6f (Page 1) plus the sum of the values entered in all of the cells on A6m (Page 1).
  - The sum of the values entered in all of the cells in the 'All new clients 65 and over' column should be equal to the sum of the values entered in all of the cells on A6f (Page 2) plus the sum of the values entered in all of the cells on A6m (Page 2).
  - The sum of each time-band row should equal the figure given in the column for 'All new clients' on page 1 for that time-band category and age group.
  - For each 'Time band' row on pages 2 & 3 and for both age groups: the sum of the values entered in all of the cells in that row should be equal to the value entered in the 'All new clients' column on A7 (Page 1) for that 'Time band' row for the corresponding age group.
  - On page 1, for both age groups ('All new clients 18-64' and 'All new clients 65 and over') the sum of the values entered in the cells in the 'Time band' rows should be within 20% of the corresponding value from the previous year.
  
- A8 – Length of time from first completed assessment to receipt of all services for new clients aged 65 and over
  - For each 'Time band' row on page 2 and for both age groups: the sum of the values entered in all of the cells in that row should be equal to the value entered in the 'All new clients' column on A8 (Page 1) for that 'Time band' row and the corresponding age group.
  - On page 1, for both age groups ('All new clients 18-64' and 'All new clients 65 and over') the sum of the values entered in the cells in the 'Time band' rows should be within 20% of the corresponding value from the previous year's data.

### 6.2. Data quality checks carried out by the Adult Social Care Statistics section

- For each proforma A7-A8, the distribution of the percentage of clients in each time band will be analysed, concentrating on the CASSRs with a very high or very low percentage of clients in the time band.
  
- For each proforma A7-A8, the percentage of all new clients in each time band in 2008/09 will be compared against the percentage distribution from 2007/2008.

## 7. Annex D – Guidance for CASSRs to sample data for the waiting times indicator from completed assessment to the receipt of all services NI 133/VSC 13

This document provides guidance to enable CASSRs to sample data to provide the data required for NI 133/VSC 13 and RAP from A8. The guidance has been agreed with the Audit Commission and therefore the methodological approach set out will be accepted by auditors. This guidance should be looked at alongside the Audit Commission guidance, see: <http://www.audit-commission.gov.uk>.

The tables of sample sizes shown in the Audit Commission guidance are purely for illustration of what is required for a particular level of accuracy. They are not a requirement. Therefore the IC guidance on sample sizes below should be followed.

### 7.1. Definitions of NI 133/VSC 13

The definition of RAP A8 is “length of time from completed assessment to receipt of all services for new clients aged 65 and over for whom all services were put in place during the period, in time bands, referral category and primary client type”

The numerator for NI 133/VSC 13 is “of new clients in the denominator, the number for whom the length of time from completion of assessment to provision of all services in a care package is less than or equal to four weeks (that is 28 calendar days).

The denominator for NI 133/VSC 13 is “the total number of new clients aged 65 or over whose assessment was completed and went on to receive all services during the reporting year”.

### 7.2. Sample sizes

Providing your sample is unbiased and you have an idea of the size of the population, you can determine the efficient number of items you need in your sample. Unfortunately, the required sample size is not a fixed proportion of the population. In fact as the population goes up, the **proportion** (but not the number) of items you need to sample goes down.

A sample will not be as accurate as looking at every record. Nevertheless the size of an unbiased sample determines how accurate it will be. Therefore there are two things to take into consideration when deciding on the number of items to sample:

a) The **margin of error** - how close you will be to the real answer (+/-4 % see appendix A)

b) The **confidence level** - how certain you want to be that your answer is within the margin of error you are prepared to accept. There is an informal but recognised norm which is 95% confidence in the estimated result.

The table in appendix B (see page 21) of this guidance sets out the sample sizes needed to produce estimates that are within 4% of the right answer with a confidence level of 95%.

**Summary: as a minimum for 2008/09 sample sizes should meet the requirements set out in Appendix B.**

It is important that the minimum requirement for sample sizes are met otherwise the margin of error surrounding the estimates of the performance indicators will be too large to allow users to draw any conclusions from the data provided.

**Identifying the population**

The population is new clients aged 65 and over for whom all services were put into place during 2008/2009 following a Community Care Assessment, regardless of whether their assessment was completed in 2008/2009 or 2007/2008. Anecdotal evidence suggests that it is difficult for some CASSRs to identify this population. The way in which CASSRs identify the target population may vary depending on their recording systems.

Set out below are different ways in which you could identify clients who should be included in this indicator. These are provided as a guide to help CASSRs and **do not** set out a methodology that must be used.

If systems allow, identify all those for whom the final service in their care plan was put in place during the year.

If this is not possible you will need to use an alternative method to identify the relevant cases. Set out below are starting points for identifying the relevant cases. Once they have been identified the cases selected will have to be studied to find out whether all services were put in place during the reporting year and they are therefore eligible to be included in the indicator.

Identify all people who either had an assessment that was agreed to provide a service or people who received a first service during the period. This approach is likely to mean that many users appear twice as they will have had an assessment but also received a first service during the period, Duplicate records should be removed. It would also include a number of people who won't receive all their services until the next reporting period.

If systems are sufficiently reliable, only identify those who received a first service during the period.

Identify all assessments during the year that led to the provision of a service. This means that some of the target population is not covered, as those that were assessed in the previous year but received all services in the current year are excluded. This means CASSRs would need to sample clients for whom assessments were completed in the last two months, say, of the previous reporting year. It also means that there are likely to be a number of clients assessed at the end of the year for which sufficient time hasn't elapsed by the end of the year for all services to be put in place.

**Selecting a sample**

The cases included in the sample should mirror reasonably closely the general characteristics of the total population from which you are drawing your sample. Thus the sample must not be biased by over or under representing the groups that make up the population. For example, the mix of clients

from different client groups in the sample should be broadly the same as the mix in the population from which you are sampling.

The usual and most simple method of insuring that you select representative cases, is to take a "random" sample. By choosing the items to be sampled at random you are ensuring that your method of selection is not influenced by factors that would give too much or too little prominence to a particular group within the population.

The Audit Commission's guidance is helpful in setting out how to avoid bias within your sample and should be referred to (see <http://www.audit-commission.gov.uk>). In addition to the issues set out it is important that your sample should reflect activity throughout the year i.e. it should include an even spread of clients for whom services were put in place covering the whole year.

The Audit Commission's guidance is clear in setting out that a sample should be random and reflect the general characteristics of the total population from which you are drawing a sample. However, you may decide locally that you want to over sample a particular group of clients, for example, those with learning disabilities or those from ethnic minorities, because the numbers in that group are small and therefore the only way to obtain a reliable estimate is to over sample that group. If you choose to do this you will need to weight your data to take this into account and make sure that the results you provide for your total population are unbiased.

### **Tool for weighting data**

The Audit Commission's guidance sets out how you should calculate weights and apply them to your results. There is a grossing up tool to help CASSRs apply weights to their data (if required) for RAP form A8. This tool is available for download (in Excel format) from the following website under the RAP section (<http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/collections-2009>)

### **Providing data to the IC**

If CASSRs use a sample to provide estimates then the data they provide to the IC should be grossed up to the size of the relevant local population before the data is submitted to the IC in RAP. CASSRs should also provide details of the size of the sample taken to provide the estimates when they return their data.

### **Sampling for other indicators and RAP forms**

At the moment this guidance is only a requirement for CASSRs using sampling for the waiting times. However, the general principles can be applied to some other indicators and RAP forms. Before using sampling for a particular indicator or form you should check with the relevant contact at the IC that sampling is appropriate and the methodology you propose is appropriate. If the data is also required for a Best Value indicator we will also need to check the proposed approach with the Audit Commission if it differs from the guidance they issue.

### 7.3. Required sample sizes for 95% confidence that the estimated error is no more than $\pm 4\%$

Estimated population	Sample size
200	150
300	200
400	240
500	275
600	300
700	325
800	345
900	360
1000	380
1200	400
1400	420
1600	440
1800	450
2000	460
2500	490
3000	500
3500	510
4000	520

Use the required sample size for the population which is the next after your own

## 8. Annex E – Proposed scenarios

The following proposals are provided to aid CASSRs in understanding when first contact occurs.

### ***Referral from hospital or GP***

A&E refer an 80 year old man who lives on his own. A&E say he wants to go home but needs an assessment to identify services to provide support. The contact worker says they will arrange for someone to come over in 1 hour to carry out a SAP assessment.

*First contact with CASSR = when A&E contact social services*

A 68 year old man suffered a serious injury through riding. He has been paralysed from the waist down and is shortly ready to leave hospital. The hospital then refers the client to the social services department under the Single Assessment Process via a section 5 notice. The social service social worker visits the man in hospital to discuss any needs for rehabilitation and support he requires at home.

*First contact with CASSR = when the social services department receive the section 5 notice issued by the hospital*

A 40 year old lady with learning disabilities lives with her mother who cares for her and had not previously been receiving social services. However, when her mother falls ill the family GP sends a referral letter to social services for the daughter as he realises that the mother can no longer cope with caring for the daughter. The social worker then visits the daughter at home to start assessing her needs to help her stay at home.

*First contact with CASSR = when social services receive the referral letter from the GP*

During a routine appointment an elderly patient mentions to her GP that she has recently noticed deterioration in her level of hearing. Her situation is not urgent, but she is concerned as she lives alone and often finds it difficult to hear the telephone and callers to the door. The GP writes a referral letter that is picked up by a member of CASSR staff as part of a once weekly collection at the surgery. A member of social services then visits the client at home to discuss her needs and any equipment/ adaptations she may require.

*First contact with CASSR = when social services pick up the referral from the GP surgery*

### ***Referral from family***

A daughter refers her 75 year old mother to social services as she is becoming confused with the onset of Alzheimer's. From the daughter's letter the social worker gathers information about the client including establishing whether the client has been medically diagnosed with Alzheimer's and checking with the daughter to see if her mother knows that a referral has been made. The social worker then speaks to the mother over the telephone later that day to start assessing her needs and whether she can continue to live at home with some support.

*First contact with CASSR = the date social services receive the daughter's letter*

The son of a 65 year old gentleman is worried as, since retiring, his father has become limited physically and appears to be finding it increasingly difficult to cope with everyday tasks at home. He refers his father to social services who then write to the man asking him to get in touch so that a date for an assessment can be arranged. The father feels that he does not need any help as his wife is able to provide all necessary care. He therefore refuses an assessment.

*First contact with CASSR = when the son refers his father to social services*

*Since the father refuses help there is no contact and an assessment is not carried out so this case would not appear in any of the RAP assessment forms.*

If the man had responded to the letter that social services had written to him by ringing the social services department and arranging an appointment to see a social worker then

*First contact with CASSR = when the son refers his father to social services*

The husband of a 33 year old lady who recently lost her sight in an industrial accident calls a CASSR corporate customer service centre for advice on registration and possible eligibility for services. The wife's details are taken by the service centre staff and then passed on to social services. An appropriate member of staff then telephones the client to arrange a suitable time to discuss her needs.

*First contact with CASSR = when details taken by the CASSR call centre*

### **Self referral**

A frail 72 year old man has recently started living on his own following the death of his wife. He feels unable to cope with getting to the shops to buy food and cook for himself. He decides to call social services who start to carry out a contact assessment over the telephone to identify the urgency of the client's needs.

*First contact with CASSR = when social services receive the telephone call from the client*

A 45 year old man with moderate needs feels he requires support services to maintain his independence at home. To establish whether he qualifies for support he completes and submits an on line self-assessment form via his CASSR website. The form is sent to the local services team who decide on the basis of the information provided that he qualifies for community based services but would also benefit from a full assessment. A member of the local social services team then contacts the man to arrange a visit and discuss his needs in depth.

*First contact with CASSR = when social services receive the form from the client*

## **Appropriate member of staff**

“An appropriate member of staff is defined as a member of staff who has been suitably trained to carry out a Community Care Assessment. This could include a support worker in a ‘contact team’ or a health staff working as part of a joint team who are suitably trained and speak to the client. It does not mean they have to be a qualified member of staff.

**Published by The NHS Information Centre for health and social care  
Part of the Government Statistical Service**

This publication may be requested in large print or other formats.

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