

Analysis of responses to a formal consultation of the Information Centre for Health and Social Care Survey Programme Review

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Executive summary

1. **The main message is** how much respondents value the Health Survey for England (HSE) (and other survey data from the NHS Information Centre) with surveys described as 'invaluable', and 'essential'. It was 'the fifth most frequently used dataset in the UK data archive in the last 12 months, with over 890 users from over 240 organisations making 2,600 requests'.
2. **Roles for the NHS Information Centre:** Of the 5 specific roles outlined in the consultation document (1=strategic overview, 2=generic standards, 3=specific consultancy, 4=survey commissioning, 5=commissioning/funding of surveys), there was little disagreement with role 1, nor with role 5. Queries were raised about the appropriateness of roles 2, 3 and 4 and how they would be funded. For some, roles 4 and 5 were the key ones.
3. **Data Needs for HSE 2009:** 36 other respondents plus DH respondents¹ who answered this question said there was a need for HSE data in 2009. Overall a wide range of information is considered critical for the period. Most mentioned a population in conjunction with a topic.
4. **Use of current NHS Information Centre surveys.** The DH regards all surveys as essential sources of data, as do 2 other generalist policy-making data users. The DH and some other respondents made particular mention of the Adult Dental Health Survey, whose absence this year has been criticised by the Health Select Committee.
5. **Topics needed in the future HSE.** The DH responded that given its wide remit, it has need for all the suggested topics and that decisions on topics need to be policy driven, for example data on policy targets and PSA targets are 'essential'. Among other respondents every topic was needed by at least one. Ranking of 'three most important topics' produced no clear result, reflecting the divergent specialist interests of respondents.
6. **Scale of Survey:** There was a clear overall preference for a large-scale survey with less detail; though charity/service respondents were marginally more in favour of a small scale survey with more detail.
7. **Geographic Coverage:** Respondents produced no clear preference for geographic coverage, being more or less evenly divided between national, regional or local data, though there are discernible preferences between organisational types consistent with their position in the overall infrastructure of health services.
8. **Frequency:** Respondents overall were slightly more in favour of having an annual survey.
9. **All Survey Dimensions: scale/geographic coverage/frequency:** There were 110 commentaries qualifying the given response or offering an array of solutions designed to mitigate the trade-offs between scale, geographic coverage and frequency. Several gave detailed expositions of how and why enhanced demographic and social context data is required. We recommend all these comments are passed to aa42.com [in relation to the work commissioned by the NHS Information Centre to review the HSE methodology].
10. **Need for clarification & dialogue:** Some respondents found it difficult to comment on the design and/or content of future surveys because they felt confused about the context of the review. We recommend that the NHS Information Centre carefully considers how best to clarify the position of: the new HSCS and other surveys within its survey programme; the position of the survey programme as a whole within the NHS Information Centre; and the role and fit of its data within the wider context (UK and EU) of health data.
11. **Other ongoing research and potential overlaps with HSE.** Responses are listed in Annex D.
12. **Virtual User Forum:** There was great enthusiasm to further contribute to the NHS Information Centre's development work through participation in the Virtual User Forum with a total of 56 respondents volunteering. We think there would be some value in bringing the entire Forum together in a workshop event at some stage when design options emerge from the current methodological work by aa42.com and we recommend the NHS Information Centre consider this.

¹Several respondents gave answers with the same or similar wording: a group of three/four in the academic category re the nature of HSE and on mental health; a group of three across various sector on dental health; and a group of three in the charity/service sector on eyesight.

SECTION 1: Introduction

This report summarises the results of a consultation carried out during Spring 2008 on the future working of the Health Survey for England (HSE). The NHS Information Centre, and the Department of Health before it, commissioned a programme of population based health-related surveys. The principal component of the programme is the annual Health Survey for England (HSE). This survey combines questionnaire answers and a nurse examination. Each year it covers topics such as general health, smoking, drinking, fruit and vegetable consumption, plus additional occasional modules on topics of special interest. Other elements in the programme include surveys on Mental and Dental Health, Infant Feeding and Maternity, plus sponsorship of questions in the ONS General Household Survey and the ONS Omnibus.

The aims of the consultation were to:

- confirm that the HSE is required;
- understand the needs of data users so as to ensure that future surveys and the data derived from them are fit for purpose;
- enhance linkages with other data sources and surveys;
- increase mutual understanding between the NHS Information Centre and its stakeholders of its appropriate role in information gathering, governance and quality;
- recruit participants for a future users' forum;

and in particular to determine what would be best if HSE were not commissioned in 2009, obtain input to the design of surveys in 2010 onwards, and understand respondents' views on the role of the IC.

The consultation was open to anyone, but was direct emailed to user organisations with a known interest in the survey programme. These stakeholders (see Annex A) were invited to read a consultation document and respond via an online questionnaire. The consultation document and questions can be viewed online at www.ic.nhs.uk/srpconsultation.

Overall Profile of Response

In total there were 51 responses.

Table 1:1 Response Profile

Organisation (Analytical Categories)	Response Total by Analytical Categories
Department of Health	1
Academic	20
Charity or Service	10
NHS	16
Other Govt Depts/Arms Length Public Bodies (OGD/ALB)	4
Total	51

How the responses were analysed

Department of Health (DH) responses have been analysed separately from all other responses. The reasons are two-fold. Firstly, DH are the major stakeholder and funder of the NHS Information Centre and their response covers a wide range of policy interests. Secondly, the response from DH was submitted in a mixed format of completed questionnaires (10 responses) and free text. Analysis of quantitative questions excludes the DH response, since only partial counts were available for DH. Responses are grouped so as to compare the responses of stakeholder groups. The text refers to the numbered consultation questions, and these are reproduced at Annex B.

Main message from the consultation

The main message from respondents is how much they value the HSE (and other survey data from the NHS Information Centre) with surveys described as 'invaluable', and 'essential'. Usage data, provided by

respondents, bears this out. The HSE is 'very widely used by government, academics and researchers'. It provides benchmark statistics on key health measures, and is used to monitor progress towards PSA targets. It was 'the fifth most frequently used dataset in the UK data archive in the last 12 months, with over 890 users from over 240 organisations making 2,600 requests'.

SECTION 2: Responses on the role of the NHS Information Centre in future data gathering

A preliminary consultation with stakeholders had highlighted that there are a number of possible (and potentially overlapping) roles that the NHS Information Centre might undertake. Respondents were asked whether they are content with five potential outlined roles outlined in the consultation document, as follows:

Role 1: Strategic overview. The NHS Information Centre would review all existing and proposed large scale surveys in the health and care field, linking these with knowledge of user requirements and alternative sources of data.

Role 2: Generic advice on standards, methodologies and good practice to customers commissioning/conducting their own surveys.

Role 3: Specific consultancy. Extends role 2 to provide tailored advice and support

Role 4: Commissioning on behalf of others.

Role 5: Direct commission and funding of surveys.

Numbers of responses are below:

Table 2.1 Numerical responses on the role of the NHS Information Centre (base=50)

	Role 1 Strategic overview of surveys on health and social care	Role 2 Survey Advisory services on generic standards	Role 3 Survey Advisory services on consultancy	Role 4 Advisory services on survey commissioning	Role 5 commissioning and funding of surveys
Yes	43	33	28	35	38
No	2	12	15	8	7
No response	5	5	7	7	5

The Department of Health responses showed their strongest support for role 5 with role 1 second.

Thirty out of 51 respondents added a comment and these explain the variation in the table above.

Of the 5 specific roles outlined, there was little disagreement with role 1, nor with role 5. Queries were raised about the appropriateness of roles 2, 3 and 4 and how they would be funded. For some, roles 4 and 5 were the key ones.

Commentary

The comments from DH raised concerns over the danger of overlaps with the responsibilities of other organisations, in the areas of survey expertise and oversight, and the need for data linkage. This concern was shared by 6 other respondents.

Concerning role 2 seven comments argued that if the NHS Information Centre was responsible for commissioning, then it would not be appropriate for it to also set standards.

Two respondents used this space to criticise the NHS Information Centre for the absence of the Adult Dental Health Survey in 2008.

SECTION 3: Responses on data needs for 2009

Department of Health

DH respondents cited the need for data on the following topics: smoking prevalence and young people and smoking; drinking and drug use (if not collected elsewhere); adult dental health; child obesity; psychosocial health; and data from/about carers and older people. One respondent stated the need for HSE to run in 2009 as it is a primary source of data on smoking. Suspending it, they noted, would have implications for the DH commissioned evaluation of smoke-free England (ESME) as well as for tobacco control and public health research more broadly.

Other Responses

Only one respondent (an academic) from the 37² who answered this question said there was no need for HSE data in 2009 (but noted the need for data contemporaneous with the 2011 Census); another noted that there was no need to introduce *new* measures to the survey but that there was a need to continue to track/monitor those previously measured. Many respondents made points in relation to the methodology of HSE (at answers to several questions) which would bear further detailed examination.

Overall a range of information is considered critical for the period. Most mentioned a population in conjunction with a topic.

Table 3.1: Summary responses HSE 2009 data needs (Base=50)

Information required	Row	Academics	Charity /Service	NHS	OGD/ALB
Smoking related	10	7	1	2	-
Obesity	7	3	1	3	-
Dental/oral health	4 + 3*	2	1	1 + 3*	1
Physical activity	4	3	1	-	-
Alcohol related	3	1	1	1	-
General health	3	3	-	-	-
Mental health	2	2	-	-	-
Diet	2	1	1	-	-
Eyesight	1 + 3*	-	1 + 3*	-	-
Equality	2	-	-	-	2
Other	11	7	4	-	-
No new measures	1	1	-	-	-
No data for 2009	1	1	-	-	-
Total	37	16	8	10	3

* Same wording as other respondents.

The most common information needs are for:

smoking, including prevalence (among children, youth, adults), exposure to smoking in the home and cotinine measures); obesity (among adults with some mention of children); general health (adults, children, older people) and physical activity (including participation in sport); and dental/oral health (if, as respondents pointed out, the currently under review/delayed 2008 Dental Health Survey does not go ahead).

The 'other' category in Table 3.1 reflects interest in other topics:

information on alcohol consumption (and patterns of behaviour); and mental and psychological health (among children, adolescents and adults), with one respondent from the academic sector also listing prisoners, homeless people, looked after children and carers as populations of interest.

At Q12 five respondents who had not mentioned the need for dental health data at Q9 mentioned it here. Some respondents also took the opportunity at Q12 to discuss further their rationale for the data they need. Others used this question (and one or two did so at Q5/Q6) to 'champion' the HSE as a valuable and widely *and* frequently used resource (indeed a 'vital national resource'), unique in offering possibilities for detailed and in-depth analysis, both at one point in time and across time.

²Several respondents gave answers with the same or similar wording: a group of three/four in the academic category re the nature of HSE and on mental health; a group of three across various sector on dental health; and a group of three in the charity/service sector on eyesight.

SECTION 4: Responses on future survey topics

From a list of 47 topics at Question 2, respondents were asked to mark 'all those for which they have need'.

Department of Health

The Department of Health responded that since it has responsibility for all aspects of health, it has need for all the topics. It also pointed out that decisions on topics to be included in HSE needed to be policy driven, for example data on policy targets and PSAs is 'essential'. Respondents pointed to the current direction of strategic policy, citing in particular:

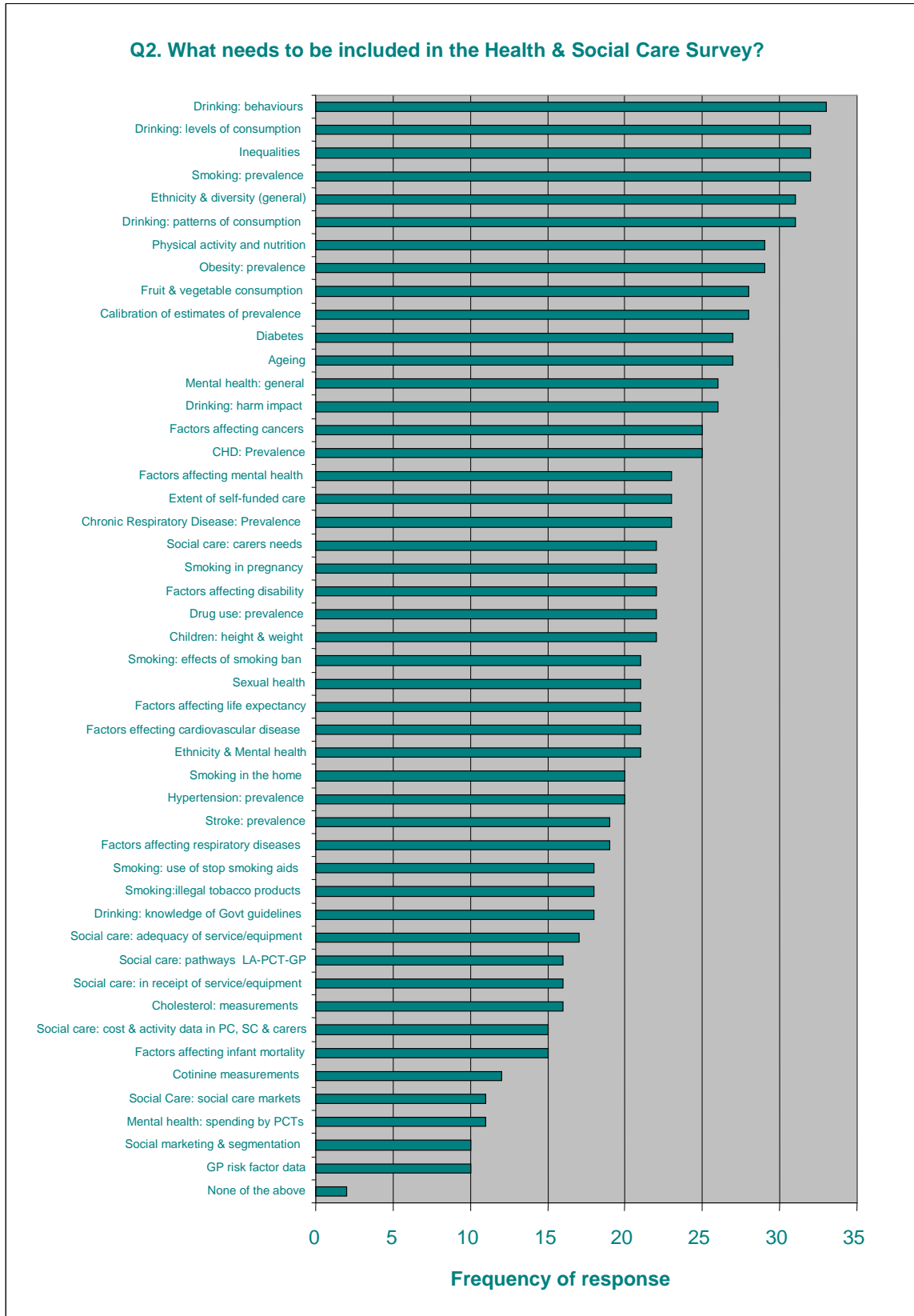
- i) the inequalities agenda
- ii) a greater focus on health and well-being
- iii) the push on prevention
- iv) the move to local accountability
- iii) the move to a focus on outcome measures.

Other respondents

Apart from two responses of 'none of these', every topic was needed. While the frequency count in Table 4.1 overleaf reflects the responses, it in no way reflects national or local health policy or priorities.

Some other respondents, who represent groups of interests, stated it was 'not appropriate' to tick individual topics.

Table 4.1: Frequency Count of Topics Needed (Base=50)



The Department of Health's response was that among all its divisions, it has need for all the topics. It also pointed out that decisions on topics to be included in HSE needed to be policy driven, for example data on policy targets and PSAs is 'essential'.

Further topics required in the HSE (all respondents)

The next question asked respondents to list any further topics they would like to see included. Respondents listed 29 different topics (see Annex C).

A good number of respondents used this comment box to make detailed methodological comments about scope and design of the future HSE. In particular, several gave detailed expositions of how and why enhanced demographic and social context data is required. We recommend that all these comments be passed to the HSE design team at aa42.com.

In a further attempt to establish data users' needs, respondents were asked to rank their three 'most important' topic headings from the earlier list.

Department of Health: Ranked three most important topic areas

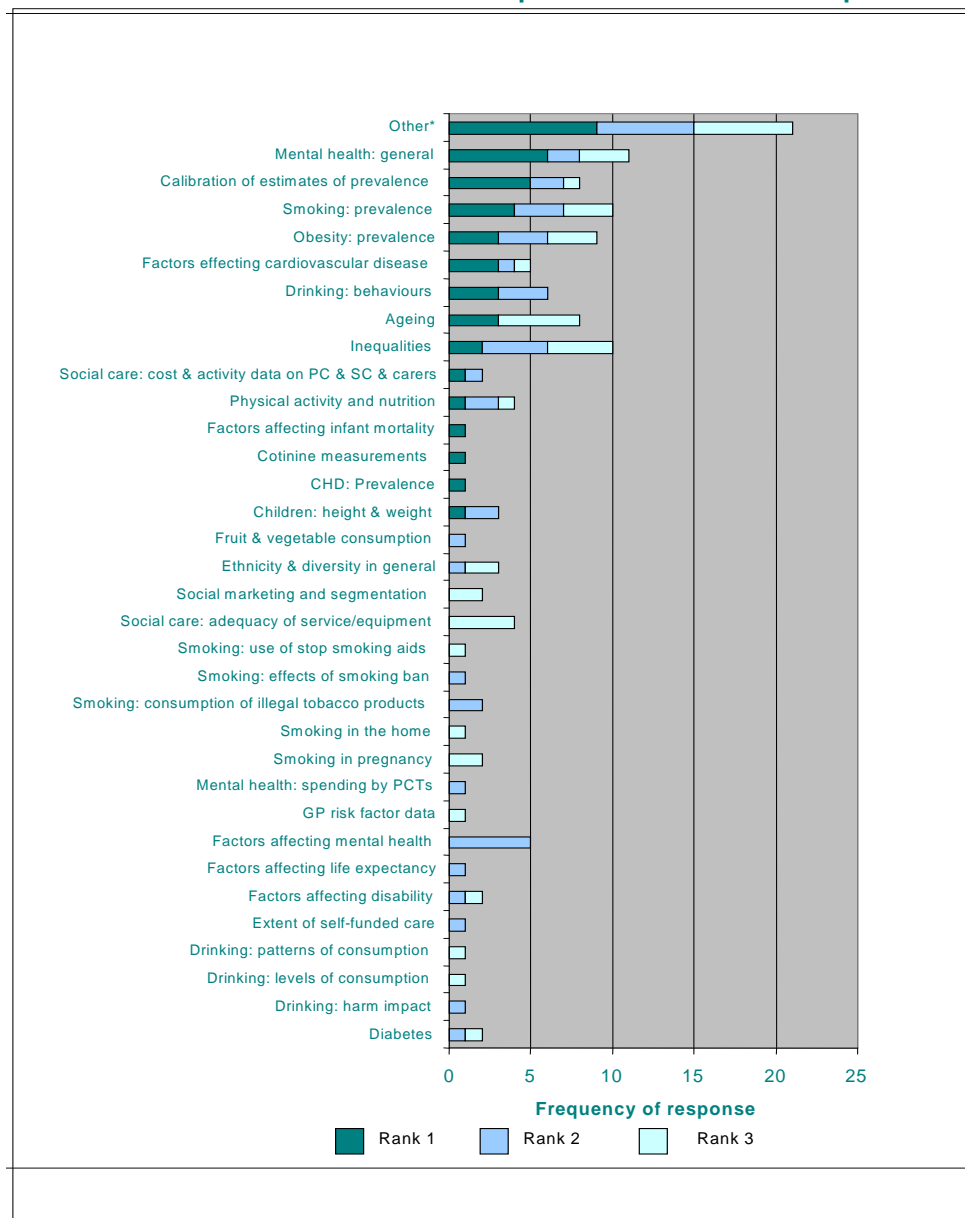
The Department's wide range of priorities made it impossible to rank the three most important topics. Its response reiterated that decisions about topics in HSE need to be driven by central policy and targets. There is an expectation that the survey programme would be able to 'fully meet' the DH's need for data.

Other respondents: Ranked three most important topic areas

A good proportion of respondents added new topics here, rather than ranking those previously listed. We may assume this reflected a wish to emphasise their priorities, however it has resulted in 'other' being the largest ranked category in the table below.

The table indicates that there is not a high degree of agreement as to importance on any topic. This reflects the divergent specialist interests of the various respondents. In line with the DH response above, two other respondents stated that it is 'uncomfortable' and 'not appropriate' to rank importance as it 'implies that other data is less of a priority'.

Table 4.2: Topics ranked as '3 most important'



* Other topics added by respondents:

Dental/Oral health
Eyecare in the community & accessibility
Oral Health Indicators (x3)
Cancer Prevalence
EQ-5D measurement
Days off work last year due to toothache

Do you have/want an NHS Dentist
Ethnicity of 'white others' from EU accession countries, e.g. Poland
Days off school due to toothache
Oral health behaviour
Use of Dental Services

Smoking prevalence
Eyecare in the community
Children's vision
Autism Spectrum Disorders including Asperger Syndrome in adults and children (x2)
When last visited the dentist
No Response (x2)

SECTION 5: Design dimensions of future surveys

This section refers to questions 5, 6 and 7 of the consultation document on the preferred scale of future surveys, the geographic coverage and frequency of data collection. The DH response reflects a need for all three dimensions. Thus, in this section we depart from the DH/Other Responses topic by topic format and instead deal the DH response for all these dimensions together initially, followed by analysis of the response for each individual dimension given by other respondents.

Department of Health response : all dimensions

DH respondents expressed confusion about the status of other surveys in the survey programme (or how the programme fits with other related surveys) and whether all historical and new data needs were expected to be shoe-horned into one Health & Social Care Survey. Equally, respondents were unclear as to what resource claims surveys had in the NHS Information Centre's overall budget. For some this made it difficult to respond to the design and/or content of future surveys.

The response is complex and difficult to unravel and merits further in-depth work. The overriding sense was that DH did not wish to lose any data sourced from the current Survey Programme and that additional new requirements had emerged. There was unease that there was no clear mechanism for them to influence decisions about design issues and selection of topics that are of paramount importance to DH. Many pointed to the HSE as a invaluable time series and its uniqueness in providing questionnaire and objective measurements pointing out it was often the only source of data (e.g smoking).

Our understanding of DH's overall position is that there is a need for an annual core survey (of unspecified scale) that is able to track PSA and other key targets such as obesity, followed up by modules rotating on a 3-year cycle on priority topics³. However, many respondents pointed to the changing policy context alluded to at the beginning of Section 4. Many of these policy-driven needs imply other survey designs and/or large-scale samples capable of providing robust local level data, which some recognised.

Others pointed to the potential for sourcing some data in other ways; from the IHS, the Place Survey or NHS administrative sources.

Other Responses :Scale

There was a clear overall preference for a large-scale survey with less detail; though charity/service respondents were marginally more in favour of a small scale survey with more detail.

Table 5.1: Response Profile Scale of Survey

Organisation	Response Total by Org Type	Large Scale	Small Scale	Other	Other Specified	Provided Comment	Did not comment
Academic	20	9	5 ⁴	6	5	13	7
Charity/Service	10	3	5	2	1	8	2
NHS	16	10	4	2	2	9	7
OGD/ALB	4	2	1	1	0	3	1
Totals	50	24	15	11	8	33	17

Base=50

Commentary

The comments for 'Other Specified' category of question 5 (8) and the Q5 general comments (33) overlapped and have been combined in the analysis. To give an overview of what is a complex set of responses, they are shown schematically in the Figure below. We cannot do them justice within the limits of this report, but these could usefully be further explored in the methodological work being conducted by aa42.com.

³ A similar model is used by the British Social Attitudes Survey

⁴ One respondent interpreted small-scale as the same size as the current HSE

Figure 5.1: Suggested other scales/design formats/methodological approaches

Annual Survey Hybrid Designs					
Design type	Year 1	Year 2	Year 3	Year 4	Year 5
Large Scale, Rolling thematic coverage, on 2-4yr cycle	Narrow range of Themes 1	Narrow range of Themes 2	Repeat of Themes 1 or Themes 3?	Repeat of Themes 2 or Themes 4?	Repeat of Themes 1
Large scale, limited detail + less frequent in-depth bolt-on, every 3-5 yrs	Large-scale Limited detail	Large-scale Limited detail	Large-scale Limited detail + In-depth here?	Large-scale Limited detail	Large-scale Limited detail OR + in-depth here?
Combination of Large Scale/Small scale.	Large-scale Limited detail	Small-scale detailed	Large-scale Limited detail	Small-scale detailed	Large-scale Limited detail
Above model of Combination of Large Scale/Small scale + additional Qs rotated on 3-yr basis ⁵	Large-scale Limited detail	Small-scale detailed	Small-scale detailed	Large-scale Limited detail	Small-scale detailed
Unclear in which years the additional questions might fall.					
Combination of Large Scale/Small scale, with proviso that comparability with HSE maintained in key areas (eg. Obesity) with increased sample to provide regional/sub-regional data on 2-3yr cycle.	Large-scale Limited detail – increased sample	Small-scale detailed Large-scale	Limited detail - increased sample	Small-scale detailed Large-scale	Limited detail – increased sample
Unclear where the regional/sub-regional data would be collected.					
Annual Hybrid Survey Designs					
Design type	Year 1	Year 2	Year 3	Year 4	Year 5
Combination of Large Scale/Small Scale: Large-scale to get full geog coverage & small-scale sub-samples to permit interpolation to small area level and in-depth data on topic area.	Large-scale Limited detail	Small-scale detailed	Small-scale detailed	Large-scale Limited detail	Small-scale detailed
Large-scale survey + follow-up of sub-samples using different data collection method	Large-scale (to get robust ethnicity/gender/inequalities/rare health issues data) + f/up sub-samples using different data collection method				
Annual Small-Scale Survey					
Small-scale with alternating topics	Small-scale Topic Set 1	Small-scale Topic Set 2	Small-scale Topic Set 1	Small-scale Topic Set 2	Small-scale Topic Set 1
Small-scale on 'regular' basis – e.g sight test data now 7 yrs out of date	Small scale	Respondent had specific requirement to inform payment negotiation between Ophthalmic Opticians and DH – called for sight test data asap & then every 3 yrs.			
Small-scale, if local level prevalence ests come from IHS/Place Survey	Small scale	Small scale	Small scale	Small scale	Small scale
Suggested Methodological Options/Issues					
Modular design, modelled on Scottish Survey – larger sample/core Qs, smaller sub-sample either asked additional Q's for core, or additional modules. No suggested variation in design over time. Crucial that HSCS retains health examination as unique resource to inform policy, health provision and research for prevalence, prevention, outcome of risk factors.					
Mental Health Surveys: Large-scale survey using SDQ + recruit to internet panel survey for detail					
Large-scale, with in-depth data from less frequent other surveys (e.g. Dental Health); frequency unclear					
Important to a) invest in methodological ways to enhance usefulness of data and b) to recognise content overlap between surveys not necessarily wasteful (with exception of prevalence) because offers ability to examine one factor in relation to others.					
Large-scale needed to get geographic variations. In-depth work is role of academic researchers, possibly better done as qualitative.					

⁵ This 3yr cycle implies that the additional questions will appear on either the large or small-scale survey alternately.

Whether large or small scale, there should be more in-depth follow-up interviews on specialised areas.
 Vary the survey type to reflect data needs. More importantly is methodological work on question wording & questionnaire design to ensure data meaningful and to ensure high response rates.

Base=45

Other Responses : Geographical coverage

Overall respondents produced no clear preference for geographic coverage, being more or less evenly divided between national (17), regional (17) or local data (16). However, there are discernible preferences between organisational types; the NHS organisations clearly opt for local data, whilst OGDs/ALBs prefer national or regional data. This is consistent with what might be expected given their structural position. Charities/Services were evenly divided, perhaps reflecting internal policy and delivery interests, whilst Academics leaned heavily toward national or regional data, with little interest in local data.⁶

Table 5.2: Response Profile: Preferred Geographic Coverage

Organisation	Response Total by Org Type	National	Regional	Local	Provided Comment	Did not comment
Academic	20	9	8	3	11	9
Charity/Service	10	4	3	3	4	6
NHS	16	2	4	10	9	1
OGD/ALB	4	2	2	0	1	3
Totals	50	17	17	16	25	25

Base = 50

Commentary

Overall 25 respondents provided commentary, mostly from academics (11) and NHS (9) respondents.

Comments relating to National Data

Four academic respondents, although at different institutions, made the identical point using the same text. They found it difficult to opt for one geographic level (though all selected a preference for 'national' data), stressing that data robustness is dependent upon the uses to which the data will be put. Two of these added a further point that it was open to LA's to conduct their own surveys using harmonised design and measurement methods. One other respondent pointed to the need to achieve a survey design of sufficient sample size to enable enhanced use of the data that would enable the generation of local model-based prevalence estimates, sub-national prevalence measures, calibration of local operational data and monitoring of headline health indicators. They also felt that greater exploitation of the data had precedence (with the exception of height and weight data needed annually) over frequency of data collection.

Comments relating to Regional Data

Ten respondents provided commentary on regional data. They fall into two broad camps:

- Those offering design options (and sometimes raising associated sampling issues)
- Those raising sample size issues

The remainder either specified the 'regional' data needed (oral health at SHA and preferably PCT level) or gave rationales for regional data (to allow for robust synthetic estimates at PCT level). One raised a methodological query as to whether estimates for LA's could be produced from survey data.

In their commentary many respondents clearly wrestled with the problematic trade-off between scale, geography and frequency, which we can only show schematically here and, once again, we strongly recommend these responses are studied in some depth.

⁶ However, there will be academics with specialisms (inequalities, equality, rare diseases, ethnicity) for whom local data will be essential.

Figure 5.2: Schematic Overview of Suggested Design/Methodological Options

Annual Core Nationally and Regionally Robust Survey (including UK prevalence data)					
Design type	Year 1	Year 2	Year 3	Year 4	Year 5
Alternating geographic levels	Robust to <i>regional</i> level	Robust to <i>local</i> level	Robust to <i>regional</i> level	Robust to <i>local</i> level	Robust to <i>regional</i> level
Rotating Local Area Sets on a 5yr cycle by design; monitoring trends using 5-yearly data or 5 yr moving average.	Local Area Set 1	Local Area Set 2	Local Area Set 3	Local Area Set 4	Local Area Set 5
	This model would mean sample size would have to take a/c of the size in a local area and the increased confidence levels at national level arising from having a more geog clustered area on HSE in any one year.				
	Though local sets would be determined by design, local areas could contribute to the cost of their set				
Purchase of local sample boost (unclear if these are ad hoc areas or to design) ⁷	Local sample boost	Local sample boost	Local sample boost	Local sample boost	Local sample boost
	Additional detail from linking local and national survey activities, OR run local surveys dedicated to specific topics to provide detail, such as a 10-yr ADHS (and one wanted to expand this to wider range of age groups than adults).				
Annual Core Survey : Balanced National Sample – Nationally & Regionally Robust					
Regular annual survey	Survey	Survey	Survey	Survey	Survey
Data aggregation at local level after 3-5yrs			Aggregation at local level here		OR Aggregation at local level here
	Point of aggregation determined by sample size ea. year and the size of the geographic area to be examined.				
Data tagged w ONS Area Classification	Local Area analysis from tagged data	Local Area analysis from tagged data	Local Area analysis from tagged data	Local Area analysis from tagged data	Local Area analysis from tagged data

Base=25

A number of respondents raised sampling issues. Most recognised that: local data implies large samples whose cost would be prohibitive; the trade-off against depth would be undesirable; and that there was a careful balancing act between survey depth and sample size.

Comments relating to Local Data

Nine respondents provided comments that specified 'local' further or gave rationales for having local data. Three of these (one academic and 2 NHS) wanted very low level data at SOA level to identify pockets of high multiple deprivation in order to target policies/interventions more accurately. In general they wanted data consistent with funding, commissioning, service provision and target monitoring geographies (PCT and LA level). Two respondents made important provisos that (a) whilst they wanted local data they required prevalence data at UK level to yield data for devolved administrations and UK benchmarking and (b) that it was crucial that HSE 2009 was conducted as normal and that there should be no continuity gaps in data collection as the HSE time series was regarded as invaluable.

Frequency : Other Responses

Respondents overall were slightly more in favour of having an annual survey; 28 opted for annual surveys, and 22 more infrequent data collections. Two groups, Academics and the NHS account for this preference with Charities/Services and OGD/ALB's being equally divided between the options. The following table shows the breakdown of response to question 7 by organisational category.⁸

⁷ Ad hoc local boosts will not yield comparable data over time.

⁸ These are re-coded analytical categories

Table 5.3: Response Profile: Preferred Frequency of Data Collection

Organis- ation	Response Total by Org Type	Annual	More Infrequent	Specified Infrequency	Did Not Specify Infrequency	Provided Comments	Did not specify or comment
Academic	20	11	9	4	4	14	1
Charity or Service	10	5	5	5	0	5	0
NHS	16	10	6	5	1	9	0
OGD/ALB	4	2	2	1	3	1	2
Totals	50	28	22	15	8	29	3

Base=50

Of the 22 who wanted more infrequent surveys, 13 either specified a 3-year interval, or a 3yr interval was at the higher or lower end of the timeframe they specified. Four gave other intervals either side of the 3-year mark: specifying 2yrs (1), 5yrs (1) and 5-10yrs (1) with the fourth simply specifying “regular”.

More interesting was the suggested hybrid combinations of design and methodology that emerged from the commentary.

Commentary

Overall, 29 respondents provided additional commentary. Almost half of these (14) came from academic organisations or individuals (see above table).

Comments Relating to an Annual Survey

Some (5) did restrict themselves to qualifying what should be included in an annual survey, (local data to inform local funding bids/commissioning; data robust at regional/sub-regional level, data for monitoring PSA/LAA targets) or providing rationales for the current HSE design (maintaining invaluable dental health trend data; maintaining valuable time series).

The majority, however, suggested hybrid bolt-on designs and/or methodologies to increase geographic or topic depth/breadth to an annual survey. Again these are merely schematically represented here, and merit follow-up.

Figure 5.3: Suggested design hybrids to annual survey

Survey comprising core questions : annually				
Bolt on elements to annual survey design				
Year 1	Year 2	Year 3	Year 4	Year 5
Topic Module (static)	Topic Module (static)	Topic Module (static)	Topic Module (static)	Topic Module (static)
Topic Module1 (rotating modules)	Topic Module2	Topic Module1	Topic Module2	Topic Module1
Regional data	Regional/Local data	Regional data	Regional/Local data	Regional data
Annual data collection but using HSCS Core/Other Surveys alternate years				
Core HSCS	Q's on other surveys in gap year	Core HSCS	Q's on other surveys in gap year	Core HSCS
Data Collection Methodology for Annual Survey				
Large scale Self- completion Small Scale Interview Qnnaire with sub-sample	Large scale Self- completion Small Scale Interview Qnnaire with sub-sample	Large scale Self- completion Small Scale Interview Qnnaire with sub-sample	Large scale Self- completion Small Scale Interview Qnnaire with sub-sample	Large scale Self- completion Small Scale Interview Qnnaire with sub-sample

Base=29

Comments relating to More Infrequent survey intervals

The majority who commented highlighted the fact that variables have their own inherent dynamic, producing measurable change at different rates and this underpinned their rational for suggesting less frequent survey intervals, or an annual core for specific variables and/or sub-national geographic data as bolt-ons. Two other suggestions are worth noting: a) that topics of concern/interest identified in the

core survey results are followed up with a dedicated survey within two years and, (b) the desirability of synchronising the pattern of data collections (if not annual) to coincide with the Census years.

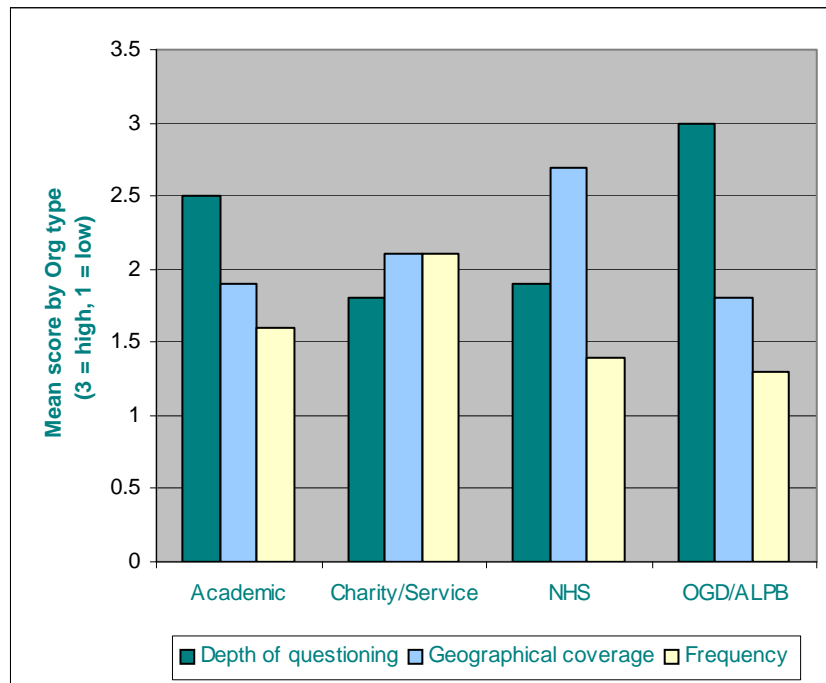
Related Development Work or Initiatives

Respondents were also asked to provide information of other relevant initiatives or work that could inform the development work for the new HSCS. These are listed in Annex D.

Most Important Dimension of Surveys

Having asked respondents about individual dimensions of survey design, they were subsequently asked to identify the most valued feature of survey design. The pattern of response is consistent with the above analysis of the individual dimensions, as Figure 5.4, below shows. The Department of Health felt that the array of policy interests, each of which would stress a particular dimension, meant they could not select just one dimension as the principle desirable survey feature.

Figure 5.4: Most Important Survey Dimension



SECTION 6: Other surveys and data needs

37 out of 51 respondents made comments in a final comment box and these are reported here.

6a Current NHS Information Centre surveys judged as essential

The question referred respondents to a list of current NHS Information Centre surveys and asked them which they regard as essential.

The DH response shows that it draws on all the surveys listed, with strong mention of the SDD.

Among other categories of respondents, the Association of Public Health Observatories pointed out that its members use all the surveys listed. Each of the specific topic area surveys was argued to be the 'only current source of appropriate data' for policy planning for that area of care.

The following surveys were mentioned as essential by one or more non-DH respondents:

Survey title
Adult Dental Health Survey
Dental health survey of children and young people
GHS
Mental health/psychiatric morbidity surveys
Omnibus
SDD [smoking drinking and drugs]
Infant feeding survey
Carers survey (new)

Of these the most strongly supported was the ADHS, which has not taken place this year. Its absence has been criticised by the Health Select Committee whose forthcoming report on dentistry will strongly support the need for this survey, along with the parallel one for children.

ADHS is 'the only source of information on dental health, dental service use and related attitudes and behaviours for a population- representative sample of the adult population. There are no alternatives.'

6b Other issues and comments

Respondents contributed a wealth of detailed information drawn from their wide-ranging expertise on relevant policy and methodology areas. We recommend that this information be forwarded in its entirety to the relevant people in the NHS Information Centre or the survey development team, as it cannot be adequately reflected in this concise summary. Responses cluster into five broad areas:

Cluster 1: pleas for more research on particular topics

Topics mentioned were:

Oral health	Mental health
Pharmacies and their use	Elderly care and accommodation
Maternity	Emotional Health
Miscarriage	Service knowledge
Disability	

Cluster 2: Requests to make access to NHS Information Centre results and reports easier

Searching by keywords and having automatic notification of when particular datasets would become accessible were two points mentioned.

Cluster 3: Methodological issues for the future HSE

Respondents emphasised the value of maintaining HSE in its present form to allow continuity of data comparison. Several current features of the HSE design were argued to contribute very importantly to its value as a data source:

- it identifies undiagnosed and untreated health conditions
- it contains a nurse examination
- It is a single source of data for a very wide range of topics
- It has self-reported health status questions.

The DH response asked for increased attention to equalities issues in the new design and other respondents argued the necessity for weightings to capture various under-represented groups or conditions.

Cluster 4: Potential links to other sources of data and other surveys

The detailed suggestions on links to other data sources and surveys need to be passed to relevant teams within the NHS Information Centre. Some respondents doubted whether data obtained from clinical reports could be as robust as that obtained from specific surveys.

Cluster 5: Arguing the need for the HSE

The Department of Health's response emphasised the importance of the core aspects of the Survey, and other respondents described it as 'invaluable' and 'a vital national resource'.

Finally, just one respondent used this space to criticise the format of the questionnaire.

SECTION 7: Virtual user forum

There was clearly enthusiasm for contributing to the ongoing development work of the NHS Information Centre. There were 14 volunteers from DH and the majority of the 50 Other respondents offered to either participate in a virtual user forum themselves (35) or referred colleagues who might be invited to participate (6), giving a potential Forum membership of 56. Annex E gives the breakdown of response.

Organisations Invited to Respond

Individuals at the following organisations with a known interest were directly invited to respond:

Age Concern
Alcohol Concern
ASH
Association of Chartered Certified Accountants
Audit Commission
British Deaf Association
British Heart Foundation
British Liver Trust
British Medical Association
Cancer Research UK
Carers UK
Centre for Independent Living (YP with disability)
Commission for Racial Equality
Council for Healthcare Regulatory Excellence
Crossroads
CSCI
DCLG
DCMS
DCSF
DEFRA
Department of Communities and Local Government
DH
DH Regions
Disability Rights Commission
DWP
East Midlands PHO
East Sussex Downs and Weald PCT
Eastern Region PHO
EMPHO (collated APHO response)
Faculty of Public Health
Foods Standards Agency
Health & Safety Executive
Health and Safety Laboratory
Healthcare Commission
Healthcare Inspectorate, Wales
Help the Aged
Hertfordshire PCTs
Home Office
Hull Teaching Primary Care Trust
INIsPHO
Institute of Alcohol Studies
Institute of Child Health
Kings College London
King's Fund
KPMG
LHO

Liverpool John Moores University
London Health Observatory
LSC
Medical Research Council
Mencap
Mental Health Act Commission
MIND
National Assembly Wales
National Audit Office
National Centre for Independent Living
National Centre for Social Research
National Patient Safety Agency
National Treatment Agency for Drug Misuse
NFER
NHS Information Centre
North East PHO
North West PHO
Northern Ireland Office
Office for Disability Issues
Office of Health Economics
ONS
Policy Studies Institute
Princess Royal Trust for Carers
PSSRU, LSE
PSSRU, University of Kent
Royal College of GP
Royal College of Physicians
Royal College of Psychiatrists
ScotPHO
Scottish Centre for Social Research
Scottish Executive
SEPHO
South Birmingham PCT
South East PHO
South West PHO
Southampton University
Southwark PCT
Thames Valley University
UCL
University of Brighton
University of Glamorgan
University of Kent
University of Leeds
University of Manchester
University of Surrey
Wales CH
Wellcome Trust
Welsh Assembly Government
West Midlands PHO
Yorkshire & Humberside PHO

Annex B

CONSULTATION QUESTIONS

There were 12 questions in all. Questions 1, 5, 6, 7, 10 and 12 additionally had a box for further commentary on the response.

- Q1 Are consultees content with the proposed roles of The NHS Information Centre as set out in paragraphs 3.2 to 3.7 of the consultation?
- Q2 In paragraphs 3.13 to 3.18 of the consultation document we set out a suggested design and content for a proposed Health and Social Care Survey. What needs to be included in the Health and Social Care Survey?
- Q3 Are there other key topics that should be included in the Health and Social Care Survey? *Please continue with the numbering sequence at Q2 and number your additional topics, starting with 48.*
- Q4 Using the topic numbers of the topics you have identified at Question 2 and Question 3, please identify the THREE MOST IMPORTANT topics to you, *with 1 being the most and 3 being the least important*
- Q5 Would your need be for a large-scale survey with limited detail, or a small survey with far more detail?
- Q6 At what geographic level (national, regional, local) would data need to be robust?
- Q7 What should be the optimum frequency for data collection for a Health and Social Care Survey?
- Q8: Of the constraints mentioned in Q5, Q6, Q7 (depth of questioning, geographical coverage and frequency), which is the most important to you? *Please prioritise with 1 being the most important and 3 being the least.*
- Q9 Using the information provided in paragraph 3.18, please outline what information is critical for you to have between late 2009 and late 2011, that you cannot obtain or estimate based on previous years' data or the other data sources listed in Annex C and Annex D to this consultation document.
- Q10 In Annex E of the consultation document we list a number of initiatives and work in progress that may have some bearing on the final design and content of our survey programme. Are there other projects or initiatives we should be aware of?
- Q11 Would you be willing to participate in the Virtual User Forum that will be invited to comment by email on the detail of our programme as it is developed? *If not, you may suggest another individual or organisation.*
- Q12 Are there any other issues you wish to raise, not covered above? As well as general points, it will be useful to us if you would identify surveys in the current programme (as listed in Annex B) other than the Health Survey for England which you see as essential, and why. This will help us to prioritise within the programme as a whole.

Annex C

Additional topics for HSE listed by respondents

[Q 3 in the consultation questionnaire]

Topic Names	No. of mentions
dental/oral health	10
use of dental services	6
child/adolescent mental health	5
Eyecare: child	4
intellectual function	4
eyecare services	3
autism	3
psychological wellbeing	2
Cigarette brands used	2
physical activity	2
eating disorders	2
adult ADHD	2
liver disorder	
payment for dentistry	
kidney measurements	
sleep	
infant feeding	
adult anthropometry	
eating habits	
Sexual health	
depression	
anxiety	
cancer prevalence	
EQ-5D measure	
musculo/skeletal functioning	
allergies	
self reporting of health status	
Smoking diseases prevalence	

Annex D

Relevant projects and initiatives

Respondents provided a wealth of interesting and relevant information, either on ongoing research and potential overlaps with HSE, or suggestions on methodology. These are listed under topic below.

Topic area	Title of project	Organisation
Ageing	English Longitudinal Study of Ageing	
Alcohol		Home Office
Birth cohort studies	Millennium Cohort Study (and previous birth cohort studies)	
Birth cohort studies	ESRC proposed new birth cohort study to start in 2012	ESRC
Body mass Index	Coverage of GP recording of Body Mass Index will reach a stage, over the next three to five years, which will render the measurement of these factors by surveying a sample of the population obsolete.	
Care	Care Quality Commission	DH launching consultation soon
Care	Pilot of questions on receipt of care	UEA/LSE
Care	proposed new study, 'Improving survey questions on receipt of, and payment for, care services among older people'	UEA/LSE and NatCen
Care	Government's major initiatives on social care and support, including the Social Care Transformation Programme, the forthcoming Green Paper on the future care and support system and the Prime Minister's New Deal for Carers	
Carers	Family Resources Survey	DWP
Child health	Forthcoming DH/DCSF Child Health Strategy (May 2008)	DH/DCSF
Customers	DH review of customer experience information	DH
Dentistry	Co-ordinates a national programme of "local" PCT child dental health surveys will be housed in North West PHO in future. It may be possible to use those surveys (with some modification) to replace the national ONS survey of children	British Association for the Study of Community Dentistry (BASCD)
Dentistry	proposed NHS Dental Epidemiology Programme for England for the next five years	
Diet		Food Standards Agency
Disability	Feasibility study for ODI survey	
Disability	Comparison of qus in different surveys	Leicester University/LSE
Drugs	British Crime Survey	Home Office
Equalities	The Equalities Review report, Fairness and Freedom (Cabinet Office, 2007)	http://archive.cabinetoffice.gov.uk/equalitiesreview/
Equalities	ONS sets out data requirement for monitoring equalities in health	http://www.statistics.gov.uk/downloads/theme_social/EDR_Final.doc.pdf
Exercise	Sport England's Active People survey: robust reporting at LA level	
Gambling	next British Gambling Prevalence Survey, to report in 2010	Gambling Commission
General		National Audit Office
General		Audit Commission
General	UKHLS. This study targets 40,000 households in the UK. Maybe, the NHS Information Centre can collaborate with ISER to do a joint project.	http://www.iser.essex.ac.uk/ukhls/
General	Integrated Household Survey route: the option to integrate the NHS Information	www.statistics.gov.uk/cpi/nugget.asp?id=936 2011 Census planning

	Centre surveys together on a similar model could be considered.	www.statistics.gov.uk/census/2011Census/default.asp see also www.neighbourhood.statistics.gov.uk and work done by the Cathie Marsh Centre at Manchester: www.ccsr.ac.uk/ssrg/research/
General	• ONS Integrated Household Survey •	
General	the health survey programme under the European Health Statistical System – most importantly, the European Health Interview Survey and the pilot work now going on testing His/HES approaches to data collection.	
Health measures	DCLG Place Survey consultation – which may include a generic health measure at “local level” – depending on outcome.	http://www.communities.gov.uk/publications/localgovernment/newplacesurvey
Health measures	Vital Signs document which is linked to the Operating Framework for the NHS 2008-9 contains a number of metrics	DH
Housing	Housing conditions	DCLG
Mental Health	National Social Inclusion Programme	CSIP
Pharmacy	Pharmacy in England white paper	
Smoking	Cancer Awareness Tool: an initiative outlined in the Cancer Reform Strategy - Smokers toolkit – surveys and analysis	
Smoking	Coverage of GP recording of smoking status will reach a stage, over the next three to five years, which will render the measurement of these factors by surveying a sample of the population obsolete.	
Targets	Requirement for data for Local Area Agreements (targets set at local authority and pct level for every top-tier local authority in the country)	

Annex E

Virtual User Forum: response

Table E1: Response Profile: Participation in Virtual User Forum

Organis-ation	Consultation Response Total by Org Type	Participate in Forum = YES	Suggested Invitee	Organisational Category of Invitee
DH	1	14	0	N/A
Academic	20	15	2	Academic (2)
Charity or Service	10	10	1	Health Surveys User Group Member
NHS	16	9	1	NHS
OGD/ALB	4	1	2	OGD/ALB (2)
Totals	50	35	6	