Measures from the Adult Social Care Outcomes Framework

England 2017-18

Appendices

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Appendix A: Data Sources

Information about each of the data sources used in ASCOF is shown below.

Short and Long Term Return (SALT)

The SALT data tracks the client journey through the adult social care system in England. It comprises two main sections, short term support (described as ‘STS’ measures) and long term support (described as ‘LTS’ measures). It also derives some of its structure from the Equalities and Classifications (EQ-CL) Framework.


Adult Social Care Survey (ASCS)

The ASCS is an annual survey for England. Service users were sent questionnaires, issued by Councils with Adult Social Services Responsibilities (CASSRs), in the period January to March 2018 to seek their opinion on a range of outcome areas.

The eligible population for this survey covers all service users aged 18 and over in receipt, at the point that data are extracted, of long-term support services provided or commissioned by the local authority or an NHS health partner under Section 75 Arrangements and part of a care/support plan following an assessment of need.

The survey seeks the opinions of service users and is designed to help the adult social care sector understand more about how services are affecting lives to enable choice and for informing service development.

There are three main variants of the questionnaire which can be sent to a service user depending on their support setting or primary support reason. However, these variants are designed to cover the same questions and the answers are combined to produce the results. The variants are:

- Users receiving services in the community;
- Users in residential and nursing care; and
- Easy read versions for service users with a learning disability.

Details of the survey questions used to produce the ASCOF measures can be found in the Department of Health and Social Care’s Handbook of Definitions.


Mental Health Services Data Set (MHSDS)

The Mental Health and Learning Disabilities Data Set (MHLDDS) was renamed the Mental Health Services Data Set (MHSDS) following an expansion in scope from January 2016 to

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include, for the first time, people in contact with mental health, learning disability and autism services for children and young people.

The MHSDS is an approved NHS Information Standard\(^3\) that delivers record-level data about the care of adults and older people using secondary mental health, learning disabilities or autism spectrum disorder services.

The MHSDS is a mandatory return for all providers of NHS funded care, including independent sector providers. Data for clients who are wholly funded by any means that is not NHS, can also be submitted on an optional basis. The data are submitted and reported on a monthly basis.


**Monthly Delayed Transfers of Care (DToC)**

Data regarding delayed transfers of care are used in ASCOF measure 2C. They are collected for non-acute (including community and mental health) as well as acute patients on the Monthly DToC return.

A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- a. A clinical decision has been made that patient is ready for transfer AND
- b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
- c. The patient is safe to discharge/transfer.

For 2017-18 the DToC measures have been calculated using revised definitions. Data on the number of delayed transfers of care (measure 2C(1)) is now the average number of delays per day over the month, averaged for that month, as opposed to a snapshot figure.

In addition, reports are now based on the number of beds occupied due to a delayed transfer of care (‘DToC beds’) rather than the number of patients whose transfer has been delayed. 2017-18 DToC figures should therefore not be compared with those from previous years.

The definition of measure 2C(2) has been amended to include only those delays that are solely attributable to social care. Delays that are jointly attributable to the NHS and Social Care are now included as new measure 2C(3).

DToC figures for January to March 2018 are still subject to revision due to the move to a new data collection system in spring 2018. Any future changes are expected to be minor.


**Hospital Episode Statistics (HES)**

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England or performed in the independent sector and commissioned by the English NHS. The data are collected during a patient’s time at hospital

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and are submitted to allow hospitals to be paid for the care they deliver. HES data are designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.

It is a records-based system that covers all NHS trusts in England, including acute hospitals, primary care trusts and mental health trusts. HES information is stored as a large collection of separate records - one for each period of care - in a secure data warehouse.

A small subset of this information on the number of people aged 65 or over who are discharged from hospitals is used as the denominator in ASCOF measure 2B2.


**Mid-year population estimates**

Population estimates are produced by the Office for National Statistics (ONS) and relate to the number of people resident in England on the 30 June in each year. They are used as denominators in ASCOF measures 2A and 2C in order to provide a rate per standard volume of population in each geographical area. The latest available estimates at the time this report was prepared were 2017 estimates.

More information on mid-year population estimates can be found at www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates

**Geography**

The council level annex tables contain disaggregation by council and region, in alignment with the Department for Communities and Local Government (DCLG) definitions. The council and region names and codes are also in alignment with those set out in the ONS Guidance for Administrative Geographies4. It should be noted however, that the classification of council type differs; the DCLG groupings used in this publication classify Greenwich as Inner London, and Haringey and Newham as Outer London. The ONS Administrative Geographies however, classify Greenwich as Outer London, and Haringey and Newham as Inner London. Details of which region each council belongs to are provided in the ONS area codes annex that is available alongside the publication.

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4 For full guidance on ONS Administrative Geographies, visit the ONS Open Geography Portal at http://geoportal.statistics.gov.uk
Appendix B: Data quality

This section outlines the data quality of each of the data sources used in the ASCOF publication. Where known issues have been identified, the councils with Adult Social Services Responsibilities (CASSRs) affected have been included as caution should be taken when reviewing their data in case their ASCOF score has been impacted and may not be comparable.

Relevance

The degree to which the statistical product meets user needs in both coverage and content

This report contains the final figures for the 2017-18 ASCOF measures for England.

The Isles of Scilly and City of London are exempt from carrying out the Adult Social Care Survey and the Survey of Adult Carers in England as the number of service users and carers within their area who met the survey eligibility criteria was too small to guarantee statistically robust results. The Isles of Scilly and the City of London do not have ASCOF outcome scores for Measures 1A, 1B, 1I(1), 1J, 3A, 3D(1), 4A and 4B.

Accuracy

The proximity between an estimate and the unknown true value

The data collected by NHS Digital undergoes validation at source via routines built into data collection tools. Further validation is carried out once the data are received by NHS Digital and any queries are passed back to CASSRs to give them the opportunity to resubmit their data. Each of the data sources which feed ASCOF measures is summarized below in terms of the accuracy of the data and any general data quality issues that have been identified to or by NHS Digital:

1. Short and Long Term (SALT) Return

The SALT data is an aggregated collection taken from council administrative systems. As NHS Digital does not have access to the individual records behind the aggregate counts, we are reliant on CASSRs to assess their own data quality.

In many instances, assessing reliability depends on local knowledge, as each CASSR determines the approach taken in their area; what may be an anomaly in one area could be considered standard practice elsewhere. However, a range of activities are undertaken to check and improve quality. Validations within the 2017-18 data return alerted CASSSRs to potential data quality issues, and each CASSR also received validation reports and follow-up support where potential data quality issues were identified. Further details on the validation and submission process are available in the Adult Social Care Activity and Finance data quality report.

The Adult Social Care Activity and Finance data quality annex contains details of data quality issues by CASSR and theme.

The CASSR issues below were all identified post-collection and are known to impact on the CASSRs SALT ASCOF scores:

- Islington council advised that in STS002a Table 1, the data in Column E (Long-term support (in any setting)) had been transposed with the data in Column D (Early Cessation of service (leading to long term support)), which is used in the calculation of measure 2D.

- Barnet council informed us of issues with Long Term tables and STS002bA (number of supported living services). During migration to a new case management system, data were mapped to a supported housing category rather than to the ‘community’ category. As a result, the LTS001 tables and any tables which cross reference them (e.g. STS002b) are undercounting clients in long term services by several hundred people. This error led to a discrepancy of 155 working age adults with a primary support reason of learning disability between tables LTS001a and LTS004, which are used to calculate ASCOF measures 1E and 1G.

- Hampshire council advised post-submission that there is an error with LTS002. The totals in table 1a and 1b are correct rather than the individual cells, which are used in the calculation of ASCOF measure 2A.

The figures included in the CASSR issues above are rounded to the nearest five.

2. Adult Social Care Survey (ASCS)

The following information provides a summary of the data quality for the Adult Social Care Survey (ASCS). Full details of this report, along with further information on data quality and the underlying methodology and validations are available from: https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/2017-18.

**Missing data and response rates**

The data quality annex\(^6\) provides an overview of the level of missing administrative data submitted and the response rate for each CASSR.

**Bias**

**Random sources of bias – Confidence Intervals and Margin of Error**

Surveys produce statistics that are estimates of the real figure for the whole population which would only be known if data was collected from the entire population. Therefore, estimates from the sample surveys are always surrounded by a confidence interval which assesses the level of uncertainty caused by only surveying a sample of service users.

A 95 per cent confidence interval gives the range within which it would be expected that the true indicator value would fall 95 times if 100 samples were selected.

The survey is designed so that the 95 per cent confidence interval around an estimate of 50 per cent can be no more than ±5 percentage points. For example, this means that if the survey gives an answer of 50 per cent we can be confident that the true figure is between 45 and 55 per cent.

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When comparing two estimates, where confidence intervals do not overlap the difference between the two is considered to be statistically significant.

In a confidence interval, the range of values above and below the sample statistic is called the margin of error. In the example given above, the margin of error is 5 percentage points.

The data quality annex provides the margin of error achieved for each council. It should be noted that for councils with very small numbers of service users who are eligible for the survey, it is particularly difficult to achieve the margin of error requirement. 24 councils have a margin of error greater than five percentage points and of those four recorded a margin of error greater than six percentage points.

The largest margin of error (6.4 percentage points) is for Rutland; Rutland also have the smallest Eligible Population amongst all the English CASSRs that participated. Rutland would have required a response rate of 61.8 per cent to a survey of all eligible service users to achieve a margin of error of less than five percentage points.

**Non-response and Sampling bias**

Non-response and sampling bias can occur if response rates are low and if particular subgroups of the population are more likely to respond than others. The response rates for each question for each CASSR are provided in the data quality annex7.

**Survey design sources of bias**

**Help completing the survey**

Respondents were permitted to have assistance when completing the questionnaire and although this approach is not preferred, allowing this as part of the survey design is essential in order to help to make the survey representative of as many service users as possible. The service users who completed the survey unaided are a small subset of state funded social care users and therefore, restricting the survey to this group would provide a biased impression of the view of social care users.

For 2017-18, 78.4 per cent of respondents to question 21 for England reported having help to complete the questionnaire, in comparison to 79.1 in 2016-17. The help the service user received in completing the questionnaire is reported as help from a care worker, help from someone living in the same household or help from someone living outside their household. For 2017-18 the highest proportion of service users (32.7 per cent) indicated they had help to complete the questionnaire from someone living outside their household. This response option also had the highest proportion in 2016-17 at 33.6 per cent.

In addition to asking respondents if they received help, the type of help received is then captured. Whilst there were instructions on the covering sheet to say that the service user should be involved in completing the questionnaire, 10.3 per cent of responses indicated the service user had not been involved at all in completing the questionnaire, this compares to 10.4 per cent for the previous year.

Further information on how services users responded to the survey questions against the type of help they received can be found in the Annex tables file (T3 - Answers by response)8.

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For the first time in 2017-18, additional testing was carried out on the responses to five questions given by those who had help completing their survey compared with those who did not. For all five questions tested, the responses given by people who had help were significantly different from those given by people who completed the survey without help. Details of the statistical tests used are included in the Methodology and Further Information Report and the ASCS data quality statement.

**Collection method**

Of those who responded, where the method of collection is known, 99.9 per cent of the returned questionnaires were completed by the same method (post), with the lowest percentage at a council level 92.5 per cent for Hartlepool who offered 35 (7.5 per cent) face-to-face surveys. After Hartlepool, the next lowest was 99.0 per cent. Therefore, at a national, regional and council basis, there is minimal bias caused by the different methods of data collection.

**Additional questions**

70 CASSRs (based on those who provided information to NHS Digital) added or modified questions to gain specific information from service users. The survey guidance makes it clear that if CASSRs wish to add questions to the questionnaire then they must seek approval from NHS Digital, and local research governance processes should be followed. Also, modifications must not be made to any section of the survey materials that are not highlighted as requiring input from the council unless consent has been given by NHS Digital. This aims to limit variation between councils conducting the survey and to help guard against order effects; for example, how the inclusion of additional questions may impact on responses to subsequent questions.

**Use of reminders**

11 CASSRs informed NHS Digital that their use of reminders was inconsistent with the guidance materials; this included not sending reminders out. Four CASSRs reported that they did not include a copy of the questionnaire with the reminder letter, contrary to the guidance. The guidance outlines that CASSRs are required to send out reminders and a further copy of the questionnaire to all service users who hadn’t responded to the initial survey to ensure consistency between CASSRs.

Statistical tests were carried out to see if survey responses were different for respondents that filled in a reminder version of the survey compared with those that completed the original version. Details of the statistical tests used are included in the Methodology and Further Information Report. Of the five questions tested, statistical differences in responses were found in all five. Service users that responded to the reminder version of the questionnaire reported lower levels of positive satisfaction (63.0 per cent said they were extremely or very satisfied with the care and support services they receive) than service users that completed the original survey (66.1 per cent said they were extremely or very satisfied with the care and support services they receive). Further results of the statistical tests are included in the ASCS data quality statement.

**Use of translated materials**

NHS Digital provides translated versions of the survey materials for CASSRs to use where the service user’s known main language is not English. 0.2 per cent of service users completed a translated version of the questionnaire, this was an increase from 0.1 per cent in 2016-17.

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Statistical tests were carried out to see if survey responses were different for respondents that filled in a translated version of the survey and those that completed an English version. Details of the statistical tests used are included in the Methodology and Further Information Report.

Of the five questions tested, statistical differences in responses were found in all five. When making comparisons between the responses of service users that used a translated version of the questionnaire and those that used an English version, the margin of error needs to be considered. Due to the small number of translated questionnaires received, the margins of error are much larger.

Service users who completed a translated version of the questionnaire reported lower levels (47.1 per cent, 480 service users) of feeling extremely or very satisfied with the care and support services they received compared with service users that completed English versions (65.0 per cent, 419,030 service users).

The respondents that completed the translated versions also had a higher proportion (6.7 per cent, 70 service users) who were extremely or very dissatisfied with the care and support they received, compared with 2.0 per cent (13,010 service users) for respondents who completed the English version. Further results of the statistical tests are included in the ASCS data quality statement.

**Timescales of Fieldwork**

CASSRs were required to select an extract date for their eligible population during the period 30 September to 31 December 2017. Seven CASSRs informed NHS Digital that they were unable to extract their eligible population during this period.

CASSRs should distribute the questionnaires to a random sample of service users who are eligible for the survey between January and March 2018. A fixed period is recommended to minimise the impact of any wider contextual issues, such as national news stories, that may influence the views expressed by respondents. 25 councils made NHS Digital aware that it was necessary for them to conduct at least part of their fieldwork beyond this period. One CASSR gave an invalid date. Details of the extract dates are included in the data quality annex.

11 councils informed NHS Digital that their use of reminders was inconsistent with the guidance materials; this includes not sending reminders out.

Four councils informed NHS Digital that they did not include a copy of the questionnaire with the reminder letter, contrary to the guidance.

The data quality annex shows which CASSRs reported inconsistencies with the timescales for population extraction, fieldwork, reminders and questionnaires. If a CASSR is not listed in the table then they did not report inconsistencies in these areas to NHS Digital.

**CASSRs not submitting a valid data return by the mandated deadline**

The mandated deadline for submitting data returns was 16 May 2018 and 149 CASSRs submitted a data return. Blackburn and Darwen were the only CASSR not to submit by the mandated deadline. NHS Digital worked with the CASSR to ensure they were able to submit for the final deadline. However, due to missing the mandated deadline, Blackburn with Darwen did not receive a data quality summary report and so their data has not been through the same validation process as the other CASSRs. Users of the data may wish to consider this when making comparisons between CASSRs.

Wirral council did submit by the mandated deadline but as the structure of their data return had been significantly changed due to the deletion of columns, their initial data return was
not able to be processed and so they were not able to receive a data quality report. Like Blackburn with Darwen, Wirral’s data has not been through the same validation process as the other CASSRs. Users of the data may wish to consider this when making comparisons between CASSRs.

Other Questionnaire Inconsistencies
Across the different stages of the collection, several CASSRs have reported other issues or inconsistencies which have affected their survey process, further details of which are provided below. Users of the data may wish to consider these inconsistencies when reviewing the data.

Essex council removed the pictures from their Easy Read questionnaires, this is contrary to section 4.11 of the guidance. The CASSR has informed NHS Digital that they will ensure the pictures are not removed from their Easy Read questionnaire in future years.

Southwark council added two additional questions which were approved by NHS Digital. However, when adding the questions, they used question routing to advice service users to skip one of the questions. As explained in the guidance, respondents to postal surveys often find routing difficult to deal with. As a result, the survey should not contain any routing.

Warwickshire council sent standard questionnaires to all their service users. Service users could request a copy of the easy read version. All the returned questionnaires were standard versions. As explained in the guidance, easy read questionnaires should be used for all service users with learning disabilities.

Derby council reported using incorrect questionnaires. 35 community Standard and 55 community easy read questionnaires were used instead of the Nursing and Residential questionnaires. In addition, they also issued two thirds of community clients with Easy Read community questionnaires instead of Standard community questionnaires.

Tower Hamlets council only used two questionnaire types, namely one standard version directed at non-Learning Disability clients in a residential, nursing or community setting and the other an easy read version directed at learning disability clients in a residential, nursing or community setting. There are slight differences between the community and residential and nursing versions of the questionnaires. Tower Hamlets stated they were also not able to exclude those users lacking mental capacity.

Blackpool council informed NHS Digital that they used a different process this year for undertaking the survey and the guidance around marking blank, returned questionnaires was not followed. They are therefore likely to be under-reporting the number of questionnaires which were returned blank.

Survey fatigue
Durham council removed 270 service users who had received a council-run survey within the last few months. This was in line with the guidance to avoid survey fatigue.

Liverpool, Worcestershire and Leicestershire councils removed all service users that had completed the 2016-17 Adult Social Care Survey, this is contrary to section 5.37 of the guidance where it explains appearing in the sample in consecutive years would not be

10 https://digital.nhs.uk/binaries/content/assets/legacy/pdf/e/6/personal_social_services_adult_social_care_survey__england_information_and_guidance_for_the_2017-18_.pdf
Measures from the Adult Social Care Outcomes Framework

2016-17 Survey errors
Post publication of the 2016-17 Adult Social Care Survey, Barnet council informed NHS Digital that due to a coding error, the proportion of people who answered extremely satisfied and very satisfied to their overall satisfaction and who answered so good and very good for their quality of life, was understated. Users of the data may want to consider this when making comparisons to 2016-17 data. This error impacted on their 2016-17 Adult Social Care Outcomes Framework (ASCOF) scores 1A and 3A.

Accuracy of Eligible Population
During the validation process, NHS Digital queried the eligible population data reported by some CASSRs. Where a CASSR’s eligible population differed by 20 per cent or more from the figure the CASSR provided in their 2016-17 SALT return, the council were contacted to ask them to review their eligible population and explain why the figures differed. A number of CASSRs resubmitted their data returns and amended their eligible population data, whilst others provided an explanation as to why the figures were different.

The data quality annex provides the eligible population submitted in the Adult Social Care Survey data return and the figures presented in table LTS001b of the Short and Long Term Support (SALT) 2016-17. The extract period for SALT and Adult Social Care Survey are different, however it is expected that they should closely align in most cases.

The ASCS data reported an eligible population of 645,940 service users in England, compared to 654,830 for the same group reported in the 2016-17 SALT collection, a difference of 1.4 per cent. Where CASSRs have provided a comment to explain the difference in population this has been included in the annex file.

The eligible population for the survey is defined as service users aged 18 and over in receipt, at the point that data are extracted, of long-term support services funded or managed by social services following a full assessment of need. This is the same definition as service users that would be included in table LTS001b of the Short and Long-Term Support (SALT) return\(^\text{11}\). The extract period for SALT and the Adult Social Care Survey are different but it is expected that the figures should closely align in most cases. The 2017-18 ASCS data return was adapted to include the CASSRs previous year’s SALT data so CASSRs could see the difference in their eligible population for the survey and their SALT figure. The figure was highlighted where it differed by more than 20 per cent. The data quality report sent to CASSRs who submitted data by the mandated deadline also included a section on the eligible population and highlighted where there were differences of more than 20 per cent to SALT.

The eligible population and SALT 2016-17 figures are included in the data quality annex\(^\text{7}\). Leeds council informed NHS Digital that they were unable to include all service users that would be included in the SALT table because some service user data is only available annually. NHS Digital advised that the numbers were estimated and included in the eligible population, but Leeds were unable to do this before the deadline.

Northamptonshire council were unable to include mental health clients in their sample. They were included in their eligible population.


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The 2017-18 ASCS data reported an eligible population of 645,940 service users in England, compared to 654,830 for the same group reported in the 2016-17 SALT collection, a difference of 1.4 per cent.

**Validations**

Validations are carried out at various stages of the process. Conditional formatting within the data return flags up invalid or contradictory entries and blank cells for mandatory questions. All CASSRs that submitted their data return by the initial mandated deadline received a validation report and a restricted data summary report. Further details on the validations carried out are available in the ASCS data quality statement.8

3. Mental Health Services Data Set (MHSDS)

In January 2016 the source for statistics about people in contact with secondary mental health and learning disabilities services changed from Mental Health and Learning Disabilities Dataset (MHLDDS) to Mental Health Services Data Set (MHSDS). The change in dataset impacted on the completeness of data submitted by some providers.

Due to the completeness and quality of the data, the 1F and 1H scores were suspended in 2016-17 but have been reinstated for 2017-18. Although scores for these indicators were made available as a separate annex in 2016-17, these were for information only and therefore should not be compared with figures from 2017-18. For this reason, the 1F and 1H scores for 2016-17 have not been included in the time series annex or the ASCOF Power BI interactive report.

To aid the improvement of the quality and completeness of this data, an interactive report has been made available to enable CASSRs to view their monthly data at CASSR and provider level. It is recommended that this report is reviewed alongside the annex file to understand the completeness of the data for a particular council.

Monthly Data Quality reports are also available as part of the MHSDS monthly publication series. The March 2018 publication provides a time series dating back to April 2017 of the coverage of data in MHSDs. This table not only provides details of the number of records submitted overall but also the number of records submitted to particular tables each month.

4. Hospital Episode Statistics (HES)

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England or performed in the independent sector and commissioned by the English NHS. Data submissions that populate HES are subject to data quality checks on a number of key fields. Data quality dashboards are produced to provide feedback on quality to data suppliers, and the data quality team within NHS Digital works with suppliers to identify and resolve issues.

For this year’s report we have used final HES data.

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5. Monthly Delayed Transfers of Care (DToC)

NHS England compiles monthly delayed transfers of care data through a central return that is split into two parts: Patient Snapshot and Total Delayed Days. A delayed transfer of care is categorised by: the type of care the patient receives (acute or non-acute); the organisation responsible for the delay (NHS, Social Care or Both); and the reason for delay.

Healthcare providers submit DToC data to NHS England via an online tool. Data are associated with the council in which each delayed patient resides. Once data are submitted and signed off, NHS England performs central validation checks to ensure good data quality.

The data contained in this publication and associated files have been based on DToC data published in May 2018. Figures for January to March 2018 are still subject to revision due to the move to a new data collection system in spring 2018. Any future changes are expected to be minor. Further information on Delayed Transfers of Care, including revisions to 2017-18 data, are available from: www.england.nhs.uk/statistics/delayed-transfers-of-care/.

The changes to the methodology for calculating the DToC measures 2C(1) and 2C(2) in 2017-18 mean that the figures are not comparable with 2016-17. Measure 2C(3) is new for 2017-18.

Timeliness and punctuality

Timeliness refers to the time gap between publication and the reference period
Punctuality refers to the gap between planned and actual publication dates

The data relate to the financial year 2017-18 and therefore the lag from the end of the financial year is seven months. This publication has been released in line with the pre-announced publication date and is therefore deemed to be punctual.

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information
Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice

There are no access restrictions that apply to the published data. Various approaches to suppression have been applied to different aspects of the data. Full details of these rules are available in the spreadsheet annex on the publication page at http://digital.nhs.uk/pubs/aduscoccareof1718.

Coherence and comparability

Coherence is the degree to which data that are derived from different sources or methods, but refer to the same topic, are similar
Comparability is the degree to which data can be compared over time and domain

Coherence

The ASCOF measures are derived from seven difference data sources. Changes to the data sources are outlined in Appendix C: Comparability over time.
**Comparability**


For ASCOF measures 1B, 1I, 2A, 3A, 3D and 4A the underlying numerator and denominator have been collected for 2010-11 and in previous years, even though they have not been used to form a measure or indicator. Exceptions to this are Measure 4B, as the survey question used for this measure was not included in the 2010-11 ASCS, and Measure 2D, as 2014-15 was the first year in which the SALT collection which captures sequel-to-service data was implemented.

ASCOF measure 2C(3) is new for 2017-18 and so has not been reported in previous years.

**Assessment of user needs and perceptions**

The processes for finding out about users and uses, and their views on the statistical products

User feedback on the format and content of this report, as well as regarding the associated data outputs, is invited. Suggestions or comments can be emailed to enquiries@nhsdigital.nhs.uk.

The ASCOF is co-produced by the Department of Health and Social Care-chaired ASCOF Reference Group which has membership from Department of Health and Social Care, local government and NHS Digital. It is updated annually in order to ensure that the framework best supports and reflects central and local government priorities for adult social care.

In developing new measures, the Department are mindful of the reporting burden on councils, and the need to retain a focus on measuring the success of the adult social care system in delivering high quality care and support.

Data collections contributing to this publication were developed by the SALT Group and the Social Services User Survey Group (SSUSG) which has representation from NHS Digital, Department of Health and Social Care (DHSC), council performance and information managers as well as researchers from PSSRU.

The 2017-18 collections were approved by the Data and Outcomes Board (DOB). This group is co-chaired by DHSC and the Association of Directors of Adult Social Services (ADASS) in England.

**Performance, cost and respondent burden**

The effectiveness, efficiency and economy of the statistical output

The data collection process used for the NHS Digital data sources in this publication are subject to the Challenging Burden Service (CBS) procedure (previously known as Burden Advice and Assessment (BAAS)) and licensed by BAAS. This is to ensure that data collections do not duplicate other collections, minimise the cost to all parties and have a specific use for the data collected. Information on BAAS can be found at: [https://digital.nhs.uk/services/the-challenging-burden-service](https://digital.nhs.uk/services/the-challenging-burden-service).
Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices

The data contained in this publication are collected and prepared in line with the Code of Practice for Official Statistics.


The NHS Digital publications calendar web page provides links to relevant NHS Digital policies and other related documents at: https://digital.nhs.uk/search/document-type/publication/publicationStatus/true?area=data&sort=date.

Please see the links below to relevant policies and guidance material.

Statistical Governance Policy

Disclosure Control Procedure

Freedom of Information Process

NHS Anonymisation Standard

Data Access and Information Sharing
https://digital.nhs.uk/services/data-access-request-service-dars

Privacy and Data Protection
Appendix C: Comparability over time

As a result of changes to the sources and definitions of measures, care should be taken when comparing outcome values over time. Comparability comments have been added where there are changes to the measure which can affect comparability over time. These changes include changes to how the data is collected. Comparability comments are arranged in date order followed by collection type. The table below shows in which year there have been comparability comments for each measure.

Table 1: Summary of the year’s changes have been made to the ASCOF Data Sources and which measures are affected

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult Social Care Survey based measures</th>
<th>Activity based measures</th>
<th>Carers survey based measures</th>
<th>Mental Health Dataset based measures</th>
<th>Delayed Transfers of Care based measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>1A, 1B, 1I(1), 3A, 3D, 4A and 4B</td>
<td>1E, 1G, 2A and 2B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012-13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3D</td>
</tr>
<tr>
<td>2013-14</td>
<td>3D(1)</td>
<td></td>
<td></td>
<td>3D(2)</td>
<td>1F and 1H</td>
</tr>
<tr>
<td>2014-15</td>
<td>1A, 1B, 1I(1), 3A, 3D(1) 4A and 4B</td>
<td>1C, 1E, 1G, 2A and 2B</td>
<td></td>
<td>1D, 1I(2), 3B, 3C, 3D(2)</td>
<td></td>
</tr>
<tr>
<td>2015-16</td>
<td></td>
<td>1C, 1E, 1G, 2A, 2B and 2D</td>
<td></td>
<td></td>
<td>1F and 1H</td>
</tr>
<tr>
<td>2016-17</td>
<td>1J</td>
<td>1E and 1G</td>
<td></td>
<td>1D, 1I(2), 3B, 3C, 3D(2)</td>
<td>1F and 1H</td>
</tr>
<tr>
<td>2017-18</td>
<td>1J</td>
<td>2A(1), 2A(2)</td>
<td></td>
<td></td>
<td>1F and 1H, 2C(1), 2C(2), 2C(3)</td>
</tr>
</tbody>
</table>
Delayed transfers of care

2C(1) and 2C(2) – The methodology for reporting delayed transfers of care was changed in 2017-18 from a monthly snapshot to an average daily figure for each month. The reporting was also changed from the number of patients whose transfer was delayed to the number of beds occupied due to delayed transfers. Figures from 2017-18 are therefore not comparable with those from 2016-17. Full details of the methodology can be found in the ACSOF Handbook of Definitions.

2C(2) and 2C(3) – The definition of measure 2C(2) was changed, from delayed transfers of care that were attributable to social care or jointly attributable to the NHS and social care, to only include delays that were solely attributable to social care. Delays that were jointly attributable to the NHS and social care are now recorded under measure 2C(3). 2017-18 figures for 2C(2) are therefore not comparable with those from previous years.

Mental Health Data Set measures:

1F and 1H – Following the suspension of these indicators last year (see 2016-17 notes) these indicators have been reinstated in the main report. The Mental Health Services Dataset (MHSDS) methodology has also been updated so that only whole numbers are published. 2017-18 figures are not comparable with previous years.

Activity based measures:

2A(1) and 2A(2) – In 2017-18 the tables that are used in the calculation of measures 2A(1) and 2A(2) were amended. A new mandatory Route of Access ‘Self-funder with depleted funds’ was added to tables STS001 and STS002a, and fields relating to prison were made mandatory (although please note that service users in prison are excluded for ASCOF). The impact of these changes is not expected to be large but should be considered when comparing data from 2017-18 with previous years. Full details of the changes to the tables can be found in the SALT 2017-18 guidance.

Hospital Episode Statistics

Please note that the HES data used for this year’s publication were subject to different suppression rules from those used in 2016-17. Details of the new suppression rules can be found in the HES Disclosure Control Methodology document. These differences should be considered when comparing this year’s scores with previous years.

Adult Social Care Survey based measures:

1J – measure 1J for 2017-18 is calculated using a refined methodology and is therefore not directly comparable to figures published in the 2016-17 report. Figures for 2016-17 using the updated methodology will be available within the 2017-18 report by 13 November 2018.

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2016-17

Carers’ based measures:

1D, 1I(2), 3B, 3C and 3D(2) – In 2016-17 the eligible population changed so that in addition to carers being included that have had a carer’s assessment or review from the local authority in the 12 months prior to the survey taking place, carers are also now included who have not been assessed or reviewed during the year. For completeness and to review the impact of the change in eligible population, ASCOF scores have also been calculated using the original eligible population (i.e. excluding those that did not have a review). These scores are available in brackets in Table 1 of the report and the time series annex.

Mental Health Data Set measures:

1F and 1H – As mentioned below (see notes for 2015-16), in January 2016 the source for statistics about people in contact with secondary mental health and learning disabilities services changed from Mental Health and Learning Disabilities Dataset (MHL DDS) to Mental Health Services Dataset (MHSDS). The change in dataset impacted on the completeness of data submitted by some providers.

To aid the improvement of the quality and completeness of this data, an interactive report has been made available to enable CASSRs to view their monthly data at CASSR and provider level.

Due to the completeness and quality of the data, the 1F and 1H scores were temporarily suspended in 2016-17 and so are not included in the report. The CASSR scores have also not been included in the disaggregated annex and time series annex file. The CASSR scores were made available in a separate annex file to enable CASSRs to see what their 2016-17 scores would have been. It is recommended that the interactive report is reviewed alongside the annex file to understand the completeness of the data for a particular council.

Activity based measures:

1E and 1G – SALT (Short and Long Term) data return was changed in 2015-16 to enable councils to separate the number of people accessing long term support who are in Prison. The Prison column was added as a voluntary data item to SALT table LTS001a. This table is used to calculate ASCOF measures 1E and 1G. As the Prison column remained voluntary in 2016-17, councils do not need to complete it. If a council does separate clients that are in prison, the clients in prison will not contribute to their ASCOF denominator. After reviewing the 2015-16 and 2016-17 data, very few CASSRs reported clients with learning disabilities in prison so it is not felt that this change will impact on comparability over time for 2015-16 or 2016-17.

Adult Social Care Survey based measures:

1J – measure 1J was included for the first time as a new ASCOF measure in 2016-17.

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2015-16

Mental Health Data Set measures:

1F and 1H – In January 2016, the mental health data set changed from Mental Health and Learning Disabilities Dataset (MHLDDS) to Mental Health Services Data Set (MHSDS). Due to the potential for change, and the proximity of the change to the point at which the data were needed, the ASCOF reference group agreed that data from the new data set (MHSDS) would be reviewed before being used as part of the ASCOF indicators. For the 2015-16 ASCOF measures, calculations are therefore based solely on the data from MHLDDS.

The change in dataset also resulted in providers only being able to submit a primary version of their December data. A second, final submission is usually made and this was not possible for December: This data therefore does not have the same definition as the final data used from April to November. As a result, the ASCOF measures have therefore been calculated using the average of eight monthly scores from April to November.

The overall definitions of the ASCOF measures 1F and 1H remain unchanged, so it was expected that the monthly scores should remain consistent. Analysis has shown a reduction in the scores in October and November but this appears to follow the longer-term monthly trend; further details on this are provided in sections 1F and 1G of the report.

As the definitions have remained unchanged and the monthly data shows consistent patterns to earlier months, scores from 2015-16 can be compared to those from previous years. However, caution should still be taken when making these comparisons.

Activity based measures:

1C, 1E, 1G, 2A, 2B and 2D – this is the second year of the SALT (Short and Long Term) collection and councils were provided with the opportunity to revise their 2014-15 data; as such, some data has been updated from last year and the 2014-15 ASCOF scores contained within this report have been recalculated. These revised scores are included within table 1 and are used as the basis for comparisons over time. Further information about the resubmissions is included within the Community Care Statistics publication report which explains that only some of the councils who would have liked to have reviewed their data had the technology and resources to do so. Given this, caution should be exercised when reviewing the year-on-year trends provided and additionally, the SALT-based ASCOF scores (1C, 1E, 1G, 2A, 2B and 2D) originally published in the 2014-15 publication should no longer be used.

1E and 1G – SALT (Short and Long Term) data return was changed in 2015-16 to enable councils to separate the number of people accessing long term support who are in Prison. The Prison column was added as a voluntary data item to SALT table LTS001a. This table is used to calculate ASCOF measures 1E and 1G. As the Prison column is voluntary, councils do not need to complete it. If a council does separate clients that are in prison, the clients in prison will not contribute to their ASCOF denominator. After reviewing the 2015-16 data, very few councils reported clients with learning disabilities in prison so it is not felt that this change will impact on comparability over time for 2015-16.
2014-15

Adult Social Care Survey based measures:

1A, 1B, 1I(1), 3A, 3D(1), 4A and 4B – the changes to these measures create a break in the time-series. Previously, the eligible population of adult social care users for the ASCS has been those in receipt of council-funded services following a full assessment of need (i.e. a snapshot of those eligible for inclusion in Referrals, Assessments and Packages of Care (RAP) table P1). However, with the introduction of SALT, the eligible population has changed to a snapshot of the most closely comparable SALT table, LTS001b, as at the chosen extract date. To be included in LTS001b a service user must, at the point that data are extracted from council systems, be in receipt of long-term support services funded or managed by the LA following a full assessment of need.

The key changes to the population covered by the survey are:

• Service users whose only services are the provision of equipment, professional support or short-term residential care were included in P1 but are not included in LTS001b. The exception to this is that service users receiving professional support for their mental health needs are included in LTS001b even where this support is the only service they receive.

• ‘Full-cost clients’ (those who pay for the full costs of their services, but whose care needs are assessed and supported through the LA) were not eligible for inclusion in RAP but are included in SALT.

1A, 1B, 1I(1), 3A, 3D(1), 4A and 4B – for the 2014-15 Adult Social Care Survey, a new weighting methodology was introduced. To enhance accuracy, the new methodology considers each council for each stratum, and uses a different set of weights for each question depending on the number of useable responses there were for each question. These weights were calculated by dividing the count of the eligible population for each council / stratum combination by the count of useable responses to that question. This change improves the accuracy of the aggregate level results because variability in sampling and response rates between councils and questions are accounted for. Due to the change in the eligible population, mentioned above, creating a break in time-series, 2013-14 scores have not been recalculated using this new weighting methodology.

Carers’ based measures:

1D, 1I(2), 3B, 3C and 3D(2) – for the 2014-15 Carers’ Survey, a new weighting methodology was introduced for the calculation of regional, council type and national results. The new methodology considers each council as a stratum, and a set of weights is calculated for each question based on the number of useable responses to each question. This change improves the accuracy of the aggregate level results because variability in sampling and response rates between councils are accounted for. There is no change to the calculation of council level results. The 2012-13 Carers Survey (SACE) data has also been recalculated using this new weighting methodology and the new figures are provided within the report and supporting annexes to allow comparability. For completeness, the original outcomes where no weighting has been applied have also been included in brackets within Table 2.1 and Table 2.3.
Activity based measures:

Previously, measures 1C, 1E, 1G, 2A and 2B were based on data from the Referrals, Assessments and Packages of Care (RAP) and Adult Social Care – Combined Activity Return (ASC-CAR) returns. However, these have been replaced with the SALT return, and the data captured for these measures differs as below (for full details of the transition to SALT and the associated changes to data please see the SALT guidance document available at http://digital.nhs.uk/socialcarecollections2016).

1C – parts 1 and 2 have now been split (into 1a, 1b, 2a and 2b) to account for users and carers separately. The data pertaining to Users is now a snapshot as at 31st March, whereas previously the data was a flow from the reporting year. The data pertaining to Carers, however, remains a flow.

Full cost clients are now included in SALT, this will impact on the denominator for 1C(1A) and 1C(2A).

The numerator (the number of service users receiving self-directed support / direct payments) and denominator (the number of clients accessing long-term support) for 1C(1A) and 1C(2A) will also be affected by the exclusion of groups who were previously included in RAP P tables, as only those “in receipt of long-term support” as recorded in SALT LTS001b are included. Therefore, the denominator now excludes those clients solely in receipt of equipment and adaptations, those receiving short term support to maximise independence, and those in receipt of professional support and short-term residential care (not respite); these clients would have been included in the RAP P tables on which the measure was previously based.

1E and 1G – the changes to these measures create a break in the time-series. Previously, this measure included “all adults with a learning disability who are known to the council.” However, SALT LTS001a only captures those clients who have received a long-term service in the reporting year. Furthermore, the measure now only draws on the subset of these clients who have a primary support reason of Learning Disability Support; those clients who may previously have been included in the client group Learning Disability in ASC-CAR might not have a primary support reason of Learning Disability Support and are now excluded from the measure.

2A(1) and 2A(2) – the transition from ASC-CAR to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of younger adults to residential and nursing care homes, per 100,000 population".

With the introduction of SALT, the measure was re-defined as "Long-term support needs of younger adults met by admission to residential and nursing care homes, per 100,000 population."

12-week disregards and full cost clients are now included, whereas previously they were excluded from the measure. Furthermore, whilst ASC-CAR recorded the number of people who were admitted to residential or nursing care during the year, the relevant SALT tables record the number of people for whom residential/nursing care was planned as a sequel to a request for support, a review, or short-term support to maximise independence.

1D – measure 1D was included for the first time as a new ASCOF measure in 2014-15.
2013-14

Mental Health Data Set measures:

1F and 1H – previously, these measures were calculated annually from the Mental Health Minimum Dataset. However, from 2013-14, the outcome is calculated each month from a snapshot, and the ASCOF measure for the year is derived as an average of these monthly scores.

Adult Social Care Survey and Carers Survey based measures:

3D, 3D(1) and 3D(2) – measure 3D was split into two parts to reflect the views of users and carers separately. 3D(1) relates to service users, and 3D(2) relates to carers. In years where the Carers Survey (SACE) does not take place, 3D(2) is not calculated.

1I – measure 1I was included for the first time in 2013-14. Time series data have been based on historical releases of the Personal Social Services Adult Social Care Survey and Personal Social Services Survey of Adult Carers.

2012-13

Adult Social Care Survey and Carers Survey based measures:

3D – previously, this measure was based on ASCS data only. However, for 2012-13, the measure was based on a combination of ASCS and Carers’ Survey data; an outcome was calculated for the users, and an outcome was calculated for the carers. These outcomes were then averaged to yield the ASCOF measure for the year.

2011-12

Adult Social Care Survey based measures:

1A, 1B, 1I(1), 3A, 3D, 4A and 4B – stratified sampling was introduced for 2011-12, resulting in council-level data being weighted to reflect the size of the eligible population in each stratum. Additionally, there was a change to the way in which councils checked whether a service user had the capacity to consent to take part in the survey. The impact of these changes is not thought to be significant (based on the size of the confidence intervals of the survey estimates).

Activity based measures:

1E and 1G – a data definition change allowed councils to include service users in the numerator as long as their employment status had been 'captured or confirmed' during the year, whereas previously the employment status had to have been recorded at assessment or review.

2A(1) and 2A(2) – the responsibility for some learning disability services was transferred from the NHS to councils in 2010-11; these service users were treated as new admissions, even though they had been receiving a service previously. Had no such transfer taken place, it is estimated that the outcome values for 2A(1) and 2A(2) would have been those shown in brackets in the relevant rows of Table 2.2.
2B(1) and 2B(2) – a data definition change in 2011-12 allowed clients who were discharged from hospital who had an assessment from social care services only to be included in the measure. Previously, these clients were excluded; only those who were discharged from hospital who had an assessment from health and social care services were included.
Appendix D: How are the statistics used? Users and uses of the report

Uses of statistics by known users
This section contains comments based on responses from the users listed. All these users have found the information in the report useful for the purposes set out.

Department of Health
- Inform policy monitoring.
- Speeches and briefings for Ministers and senior officials.
- PQs and Prime Minister's Questions.
- Media Enquiries and other correspondence.
- ASCOF measure 2B (Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services) is part of the NHS Outcomes Framework.
- ASCOF measures 1G (Proportion of adults with a learning disability who live in their own home or with their family), 1H (Proportion of adults in contact with secondary mental health services who live independently, with or without support) and 1I (Proportion of people who use services and their carers who reported that they had as much social contact as they would like) are part of the Public Health Outcomes Framework.

NHS Digital
These data are also used on the NHS Choices My NHS website available at: https://www.nhs.uk/service-search/performance/search

Councils with Adult Social Services Responsibilities (CASSRs)
Different CASSRs will use the data in different ways but there will be some commonality between them. Uses of the report made by CASSRs include:
- Benchmarking against other CASSRs.
- Measuring/monitoring local performance.
- Policy development.
- Service development, planning and improvement.
- Management information, local reporting, accountability.
- Informing business cases.
- Identifying any immediate priorities/areas for concern.
Towards Excellence in Adult Social Care (TEASC)

TEASC is a programme to help councils improve their performance in adult social care. The sector-led initiative builds on the self-assessment and improvement work already carried out by councils. The key emphasis of this approach is on promoting innovation and Excellence and collective ownership of improvement. Its core elements involve regional work; robust performance data; self-evaluation; and peer support and challenge. TEASC includes representatives from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA), the Care Quality Commission (CQC), the Department of Health (DH), the Social Care Institute for Excellence (SCIE), the Society of Local Authority Chief Executives (SOLACE) and Think Local, Act Personal (TLAP). TEASC have published a narrative of progress in Adult Social Care which draws heavily on the data within this report.

Unknown users

This report is free to access via the NHS Digital website and therefore the majority of users will access it without being known to NHS Digital. It is important to understand how these users are using the statistics and also to gain feedback on how we can make the data more useful to them. We welcome feedback from report users, ideally covering the following points:

- How useful did you find the content in this publication?
- How did you find out about this publication?
- What type of organisation do you work for?
- What did you use the report for?
- What information was the most useful?
- Were you happy with the data quality?
- To help us improve our publications, what changes would you like to see (for instance content or timing)?
- Would you like to take part in future consultations on our publications?

Contract NHS Digital to have your say about this publication. Contact us detail are available at https://www.digital.nhs.uk/Contact-us.

Feedback, comments and requests for further information may be sent to:
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NHS Digital
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE
Telephone: 0300 303 5678
Email: enquiries@nhsdigital.nhs.uk
Appendix E: Related Publications

This report forms part of a suite of statistical reports. Other reports cover information on the wider scope of activity and social services provided for adults by councils. All reports will become available on the NHS Digital website.

Comments on this report would be welcomed. Any questions concerning any data in this publication, or requests for further information, should be addressed to:

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This publication can be downloaded from the NHS Digital website at:
http://digital.nhs.uk/pubs/aduscoccareof1718


Previous ASCOF publications can be downloaded from the NHS Digital:


Publications relating to social care activity, finance, staffing, and user experience surveys for adults can be downloaded from the NHS Digital website at https://digital.nhs.uk/data-and-information/areas-of-interest/social-care
Data for child services
Information on social care for children is available at www.gov.uk/childrens-services/childrens-social-care

Data for the UK
Information within this report relates to England data. Similar publications for Wales, Scotland and Northern Ireland can be found via the following links:
The Welsh Assembly Government
http://www.wales.gov.uk/topics/health/publications/socialcare/reports/?lang=en
The Scottish Government
http://www.scotland.gov.uk/Topics/Health/Support-Social-Care
The Northern Ireland Government
https://www.health-ni.gov.uk/topics/social-services