Identifying the Impact of Adult Social Care (IIASC)

2014-15 Summary Information and Worked Example

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Contents

Executive Summary

The existing ASCOF Indicator 1A (Social Care related Quality of Life) tells us about the current (care-related) quality of life of people using social care, but this might not be the best indicator of the impact that care and support services have on care-related quality of life. We know people's rating of their current quality of life will depend on a whole range of other factors in their lives, as well as the care and support they use.

Following discussion of the issue at the Outcomes and Information Development Board (OIDB), it was agreed that the Department of Health would commission a research project from the Quality and Outcomes of Person Centred Care Policy Research Unit (QORU) to develop a 'value added' measure of social care-related quality of life. This work was initially considered as a potential ASCOF indicator by the ASCOF reference group and, following discussion was included in the 2015-16 Handbook of Definitions as placeholder ASCOF indicator 1J (Adjusted Social care-related quality of life – impact of Adult Social Care services). It will form part of the 2016-17 indicator set.

QORU's paper detailing the conclusions of the research and development phase of their work can be found at the following link http://www.qoru.ac.uk/publication/iiasc/report/.

This summary paper seeks to describe:

- the background, methods and results of the QORU study which produced the calculation needed in constructing this new indicator,
- the application of this calculation to existing data flows to derive aggregate local authority-level data, and
- the interpretation of these individual and aggregate measures, again drawing on the QORU study.

Local authority-level data (based on the 2014-15 Adult Social Care Survey submissions) are provided in the accompanying dataset and a similar dataset will be made available in due course to cover 2015-16. Outputs relating to 2013-14 are available here: http://content.digital.nhs.uk/catalogue/PUB16161.

Any queries or comments should be directed to ascof@dh.gsi.gov.uk in the first instance.

Background

ASCOF was introduced in 2011 to increase transparency around the effectiveness of local authority social care for people with long-term conditions or disabilities and older adults. The principle behind the ASCOF is that this information should empower local communities to hold local authorities (LAs) to account for public care services, and should in turn drive local innovation in social care policy, and the commissioning and delivery of services.

ASCOF includes two overarching measures of social care-related quality of life (SCRQoL); one for users of social care services and another for informal (unpaid) carers. Quality of life however can be affected by a number of factors, some of which may be outside of the direct control of social care services and may fluctuate by geographic region or over time. As such, the underlying aim is to develop, as far as possible, an indicator where (just) the effect of care services on quality of life is measured.

As a result of these issues, the Outcomes and Information Development Board (OIDB) commissioned QORU to provide independent advice and analysis on measuring the impact of adult social care services which could potentially, in time, form the basis of an additional Social Care related Quality of Life indicator within ASCOF.

Over the period of QORU's research, both OIDB and the ASCOF reference group received regular updates on the progress of the work and emerging findings. Once QORU had completed their analysis, this work was presented to the ASCOF reference group for consideration. After discussion of the implications of QORU's work and construction of the indicator, the ASCOF reference group agreed that this work should form ASCOF Indicator 1J and recommended its inclusion to the Data and Outcomes Board (DOB - the successor to OIDB). DOB agreed that ASCOF Indicator 1J should be included in the 2015-16 ASCOF as a placeholder and become a live indicator for 2016-17 onwards.

Approach

The primary purpose of QORU's study into identifying the impact of adult social care (IIASC) was to develop outcome indicators that better reflect the contributions made by adult social care services. The overall approach was to use a method to attribute the effect (on care-related quality of life) to the different factors, including the effect of care services and support. In the study this problem of attribution was tackled using a statistical adjustment of self-reported quality of life to remove the effect of non-service-related factors. Specifically, the IIASC study sought to identify an approach by which data already collected via the Adult Social Care Survey (ASCS) and the Survey of Adult Carers in England (SACE) can be used to generate a measure of 'added value', reflecting the impact of support provided by LAs on social care-related outcomes.

Adjustment methodologies generally involve developing a formula that uses external data to manipulate the baseline indicator (in this case SCRQoL) to give an adjusted indicator. That is, the adjusted indicator will be calculated using a baseline indicator plus or minus a set of parameter-weighted factors. The IIASC study therefore collected additional information from service users and carers across 22 LAs in England. By including a wide range of measures of social care service use and non-service-related factors, QORU sought to identify the best adjustment methodology to ensure a fair comparison between local authorities, and over time.

By understanding, as a result of this additional information, how people's current SCRQoL is determined, there should be a basis for isolating those factors that are beyond the control of the care systems and that can therefore serve as a basis for adjustment. Factors to be taken into account in determining overall level of SCRQoL include:

- effectiveness of support
- the amount/intensity of support
- underlying conditions
- personal characteristics
- environmental characteristics
- other impacts

Of these factors, the adult social care system will be unable to (directly) affect: underlying conditions, personal characteristics, environmental characteristics (such as proximity to

services), other impacts. These factors are therefore potential adjustors. In particular, if all these factors are removed from the above equation, what is left is more likely to measure the impact on SCRQoL due to the effectiveness of support and the amount/intensity of support – this enables the added-value that LAs are providing to be compared.

Utility Weighted Indicator

Social care-related quality of life (SCRQoL) is measured using the Adult Social Care Outcomes Toolkit (ASCOT) indicator. The indicator combines service users' ratings in eight aspects of their life, ranging from their experience of basic functioning such as feeding and dressing to higher order domains such as social contact and occupation. Because people place different degrees of importance on these domains and between levels within the domains, the ASCOT tool uses a set of 'utility weights' which are multiplier numbers that apply to each possible rating[1]. These weights are outlined as part of Figure 1.1 below.

The ASCOT measure currently used within the ASCOF (Indicator 1A) is equally weighted i.e. it does not give greater weight to some domains than others. This option is more straightforward, but since the research to derive the utility weights clearly showed that people place more weight on some outcomes than others, the utility weighted version appears to be more relevant as the basis for further adjustment and the determination of service value added. For this reason, QORU's main analysis used the weighted SCRQoL score.

Study design and data collection

Although the final adjustment equation for measure 1J was developed to solely use data contained within the ASCS, its derivation needed more detailed information than was available in that survey. As outlined briefly above, and described in greater detail within QORU's main paper (http://www.qoru.ac.uk/publication/iiasc/report/), the IIASC research therefore undertook the collection of additional bespoke data via a survey of social care service users (and their carers where relevant and possible) across 22 local authorities in England.

Each LA was asked to identify a sample of service users in receipt of community-based support from their social care records. Those service users who consented to take part in the research were then interviewed using a structured questionnaire. A total of 770 users (546 with physical disabilities or sensory impairment and a further 224 with mental health conditions) as well as 387 of their associated carers were interviewed. A further sample was drawn of service users with learning disabilities, however due to the smaller size of this sample results are currently exploratory and are therefore not proposed for inclusion as part of measure 1J at this stage.

QORU's study investigated the development of value added measures as counterparts to both the service user and carer quality of life indicators in ASCOF. However, given the more complex nature of the impact of care and support for cared-for people on carers' quality of

[1] Netten, A.P., P. Burge, J. Malley, D. Potoglou, AM. Towers, B. Brazier, T. Flynn, J. Forder, and B. Wall. 2012. Outcomes of social care for adults: developing a preference-weighted measure. Health Technology Assessment 16 (16).

life, and the relatively small sample size, the research recommended only using the service user adjustment mechanism at this stage.

Prior to data collection, a favourable ethical opinion was sought and obtained from the Social Care Research Ethics Committee (SCREC). The research was authorised by the research governance process for each local authority that had agreed to participate in the study.

For further details of QORU's research, please visit http://www.qoru.ac.uk/publication/iiasc/report/.

Derivation of adjusted scores

In order to be able to calculate adjusted indicators routinely at the current time, the IIASC study produced formulas that only need variables that are available in the ASCS (or SACE). To allow councils to calculate adjusted indicators for their service users and an average score for their council, an Excel calculator has been made available alongside this report[2]. Councils need to paste in their data from the ASCS data return and then follow the instructions provided. The utility weighted care-related quality of life and adjusted care-related quality of life scores can then be calculated for each eligible user.

A worked example for a fictitious service user follows to illustrate how adjusted scores can be determined based on data collected via the ASCS questionnaire.
The first step is to calculate the utility-weighted indicator for each service user. This is illustrated in figure 1.1 below:

Figure 1.1: Calculation of the utility-weighted indicator[3]

Utility weighted care-related quality of life		Original	Weighted	*Response / Weight Options*			
				Ideal State	*No Needs*	*Some Needs*	*High-level Needs*
Qn	Description	Response	Response	*1*	*2*	*3*	*4*
3a	Which of the following statements best describes how much control you have over your daily life?	3	0.541	*1.000*	*0.919*	*0.541*	*0.000*
4a	Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?	1	0.911	*0.911*	*0.789*	*0.265*	*0.195*
5a	Thinking about the food and drink you get, which of the following statements best describes your situation?	2	0.775	*0.879*	*0.775*	*0.294*	*0.184*
6a	Which of the following statements best describes how clean and comfortable your home is?	2	0.780	*0.863*	*0.780*	*0.374*	*0.288*
7a	Which of the following statements best describes how safe you feel?	2	0.452	*0.880*	*0.452*	*0.298*	*0.114*
8a	Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?	1	0.873	*0.873*	*0.748*	*0.497*	*0.241*
9a	Which of the following statements best describes how you spend your time?	2	0.927	*0.962*	*0.927*	*0.567*	*0.170*
11	Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?	3	0.295	*0.847*	*0.637*	*0.295*	*0.263*
	TotalSumOfWeights	**16**	**5.554**				
	Utility weighted care-related quality of life (=(TotalSumOfWeights*0.203)-0.466)		**0.6615**				

The original responses listed above (available options being 1-4) are the answers provided to the eight questions within the ASCS questionnaire. These scores are then translated into weighted responses using the table of response weight options[2] to reflect the importance users place on each of these domains. For example the original response to question 3a was 3, indicating that this service user has some needs. Column 3 in the response weight options tables for question 3a (indicating 'some needs') has a value of 0.541 (as determined

[2] http://content.digital.nhs.uk/catalogue/PUB18657
[3] Netten, A.P., P. Burge, J. Malley, D. Potoglou, AM. Towers, B. Brazier, T. Flynn, J. Forder, and B. Wall. 2012. Outcomes of social care for adults: developing a preference-weighted measure. Health Technology Assessment 16 (16).

by the statistical modelling process) and this value is copied across into the weighted response column. Similar transformations are applied for each question before the weighted responses are summed to produce an overall weighted response of 5.554. This value is then transformed using the formula in the final row of Figure 1.1 to yield a score on a scale that is 'anchored' so that a value of one means full quality of life and a value of zero is a quality of life that is described as being no better than being dead. Negative values are possible meaning that a person has such a poor quality of life, it is worse than being dead. Scores on this type of scale are generally easier to interpret given their similarity to percentages, but more importantly this approach also supports comparison between different measures which have been similarly anchored around full quality of life and death.

In the example above, the utility-weighted indicator is calculated as 0.6615 (highlighted in the last row of the table); a value that is certainly towards the upper end of the weighted scale and indicative of a reasonable level of life quality. Indeed perhaps as would be expected, this finding is also in line with the corresponding ASCOF 1A indicator score of 16 (out of 24) which also indicates a reasonable overall level of satisfaction with life quality.

The second step in the calculation process is to quantify the overall support needed by the service user in carrying out activities associated with daily living (ADLs – activities related to personal care and mobility about the home), and those that are instrumental to daily living (IADLs – further activities important to living independently). These may be achieved by the service user easily, with difficulty, or only with help. This calculation is outlined in Figure 1.2 below:

Figure 1.2: Quantifying the level of assistance required in carrying out activities associated with daily living and those that are instrumental to daily living

Count of I/ADLs with difficulty or unable to do by self without help		Original	Adjusted	*Easily*	*With Difficulty*	*With Help*
Qn	Description	Response	Response	*1*	*2*	*3*
15a	Do you usually manage to get around indoors (except steps) by yourself?	2	1	*0*	*1*	*2*
15b	Do you usually manage to get in and out of a bed (or chair) by yourself?	3	2	*0*	*1*	*2*
15c	Do you usually manage to feed yourself?	1	0	*0*	*1*	*2*
15d	Do you usually deal with finances and paperwork - for example, paying bills, writing letters – by yourself?	1	0	*0*	*1*	*2*
16a	Do you usually manage to wash all over by yourself, using either a bath or shower?	3	2	*0*	*1*	*2*
16b	Do you usually manage to get dressed and undressed by yourself?	3	2	*0*	*1*	*2*
16c	Do you usually manage to use the WC/toilet by yourself?	3	2	*0*	*1*	*2*
	Total / Count of I/ADLs with difficulty or unable to do by self without help (carried forward to main calculation below)		**9**			

In summary the responses to questions 15a-d and 16a-c from ASCS are each reduced by 1 (to simplify the modelling process) and then summed to provide a total I/ADL score. In the example above, the total score of 9 is highlighted in the final row.

The third step involves taking the following questions from the ASCS and translating these for each service user as outlined in Figure 1.3 below:

Figure 1.3: Other factors taken into account in final calculations

Supplementary Questions		Original	Adjusted					
Qn	Description	Response	Response	*1*	*2*	*3*	*4*	*5*
	Aged 65 years or older?	2	Yes	*No*	*Yes*			
13	How is your health in general?	3	Fair	*Very good*	*Good*	*Fair*	*Bad*	*Very bad*
17	How well do you think your home is designed to meet your needs?	3	Some	*Well*	*Mostly*	*Some*	*Inappropriate*	
18	Thinking about getting around outside of your home, which of the following statements best describes your present situation?	3	Unable	*Okay*	*Difficult*	*Unable*	*Not Leave*	

The fourth stage in the process is to bring these various elements together in order to produce the final calculations as outlined in Figure 1.4 and described below:

Figure 1.4: Calculation of adjustment factor and final adjusted indicator

Adjusted care-related quality of life indicator (ASCOF Measure 1J)		Original Response	Weighted Response
	Aspect		
	Base: 0.5798	N/A	0.5798
	Count of IADLs with difficulty or unable to complete (from above): Subtract Count × 0.0202	9	-0.1818
	If aged 65+: Add 0.0473, else 0	Yes	0.0473
	If health is fair: Subtract 0.0148, else 0	Yes	-0.0148
	If health is bad or very bad: Subtract 0.1090, else 0	No	0.0000
	If home design meets most needs: Subtract 0.0308, else 0	No	0.0000
	If home design is inappropriate: Subtract 0.1250, else 0	Yes	-0.1250
	If local environment is 'difficult to get to all places': subtract 0.0603, else 0	No	0.0000
	If local environment is 'unable to get to all places' or 'do not leave home': Subtract 0.1100, else 0	Yes	-0.1100
	Adjustment factor (=Base + Age Factor - sum(Other Factors))		**0.1955**
	ASCOF Measure 1J: Adjusted care-related quality of life indicator (=Utility weighted indicator - adjustment factor)		**0.4660**

This calculation uses values derived from the statistical modelling process and begins with an intercept value of 0.5798. Further values are then added or subtracted as determined by the responses documented in Figures 1.2 and 1.3 above to produce an overall adjustment factor. In the example shown this adjustment factor is calculated by summing these weights to produce a value of 0.1955 (highlighted in the penultimate row in Figure 1.4 above).

The values available for this adjustment factor range from a minimum of -0.0470 (describing a service user aged less than 65; who is unable to do any I/ADLs without help; whose health is generally bad or very bad; whose home is inappropriately designed; and who is unable to get to all the places they need to or to leave their home at all) through to a maximum of 0.6271 (a service user aged over 65 with no issues on any of the above criteria). With an adjustment value of 0.1955, this particular service user is therefore towards the more in-need end of the spectrum, with a number of service requirements that need to be met.

The final step in the process is to then subtract this overall adjustment factor from the utility-weighted indicator derived in Figure 1.1 above (0.6615). This produces a final adjusted care-related quality of life indicator in this example of 0.4660 (highlighted in the final row in Figure 1.4 above).

The available scale for this final measure therefore ranges from around -0.8 (given a service user with no apparent adjustment criteria requirements (i.e. a maximum score of around 0.6) being subtracted from the minimum self-reported quality of life score of around -0.2), through to a maximum of around +1.0 (for a service user with the highest possible self-reported quality of life score (1) and the maximum level of need (near 0)).

Discussion

Although a single figure is being determined for each service user, two distinct factors and scales are being combined to produce the adjusted care-related quality of life indicator. Service users may have higher or lower levels of need, as evidenced by the adjustment factor, as well as higher or lower levels of quality of life, as evidenced by the initial unadjusted utility-weighted measure.

In general, service users with a higher level of need (in the absence of services) have a smaller adjustment factor compared to low-need people. This is demonstrated by the adjustment factor calculation beginning at 0.5798 and being reduced, to account for increasing levels of need in relation to a service user's difficulties with daily activities as well as their health, home and environment, to a minimum of around zero.

Table 1.1 shows the level of need (defined by the adjustment factor) and the unadjusted quality of life for all the 32,535 service users who completed the survey in 2014-15. The table shows that most of the individuals who completed the survey had a reasonably low level of need and high quality of life. These individuals will be given a higher adjustment factor to allow for their low level of need and so their adjusted quality of life score will be lower.

Table 1.1: Level of need and quality of life of 2014-15 service users

Adjustment factor

	High need						Low need	Total
High quality of life	20	145	625	1,380	1,970	2,205	1,465	**7,810**
	35	230	745	1,575	2,065	1,790	700	**7,140**
	60	335	900	1,455	1,535	1,090	270	**5,645**
	85	425	960	1,305	1,090	560	85	**4,510**
	105	440	810	860	540	230	40	**3,025**
	105	370	535	490	280	105	10	**1,895**
	85	265	320	250	120	30	5	**1,075**
	65	210	205	130	60	20	5	**695**
	55	125	105	60	25	10	0	**380**
	25	80	60	25	5	5	0	**200**
	25	45	25	15	5	0	0	**115**
Low quality of life	20	15	10	0	0	0	0	**45**
Total	**685**	**2,685**	**5,300**	**7,545**	**7,695**	**6,045**	**2,580**	**32,535**

Source: ASCS

Bringing these two measures together:

- High-need service users have lower adjustment factors, i.e. values that are closer to 0 than 0.6. High unadjusted weighted SCRQoL scores are represented with values that are closer to 1 than 0. For high-need service users with high unadjusted weighted SCRQoL scores, this must reflect that care and support is making a significant difference for these people and this will be shown in these individuals yielding *adjusted* scores that are higher, relative to service users with less need and higher adjustment factors. Whilst almost all scores will be depressed with the subtraction of the adjustment factor, LAs which add value and make an impact on care-related quality of life will see the scores of their service users less reduced in relation to service users in other LAs.
- Conversely, adjustment factors are large (closer to 0.6 than 0) for low-need people because it is this lack of need, rather than the provision of services, that determines their unadjusted scores. Consequently, service users with low need (closer to 0.6) who begin with high levels of unadjusted current SCRQoL scores (closer to 1 than 0) will see lower adjusted scores as a result of their higher unadjusted SCRQoL scores being at least partially cancelled out by subtracting the higher adjustment factors that result from their lower levels of need.
- Similarly, high need individuals (scoring closer to 0) with a low unadjusted SCRQoL score (closer to 0) will also see a relative increase in their adjusted quality of life score (compared to service users with similar unadjusted SCRQoL scores but with lower

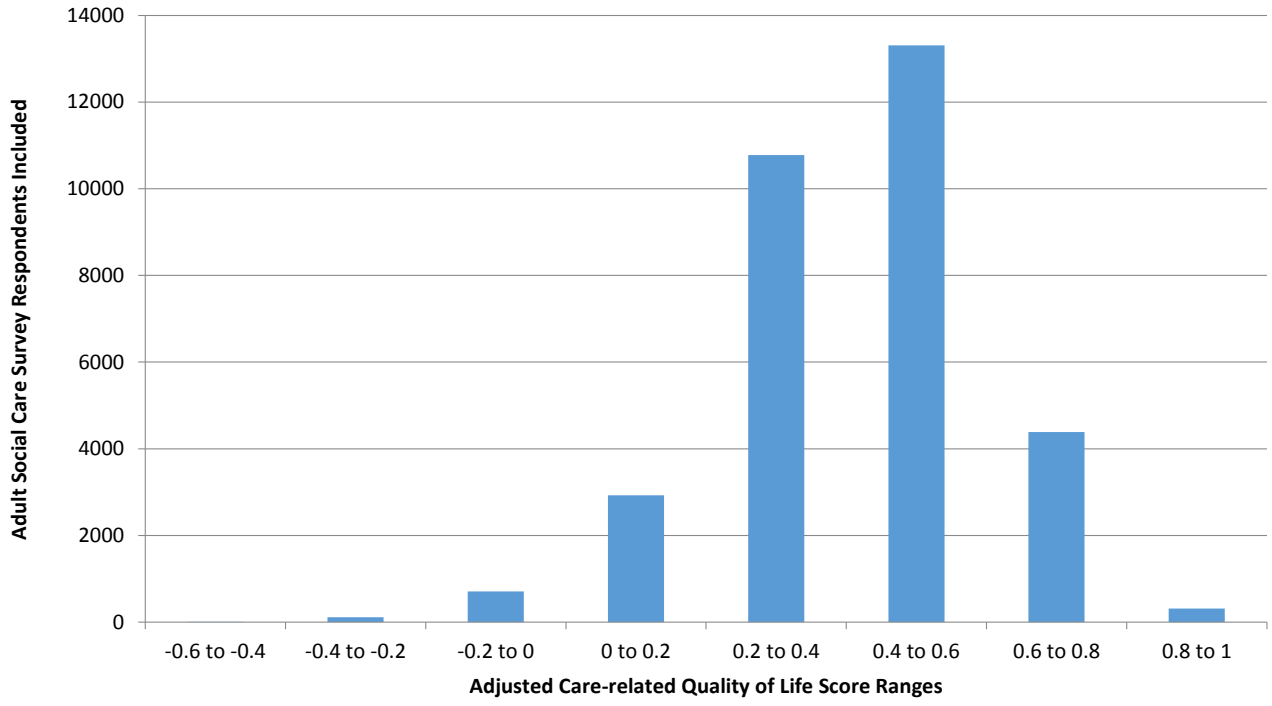
levels of need) due to the smaller adjustment factors (reflecting higher levels of need) that will be subtracted from their unadjusted SCRQoL scores.

- Finally, the lowest, potentially negative values may arise where low unadjusted quality of life scores (closer to 0 than 1), are combined with adjustment factors that are larger (closer to 0.6 than 0) indicating lower levels of need. This implies that the care and support services provided by the council are not having a large impact on the care-related quality of life of the service user.

Overall, and given similar levels of unadjusted SCRQoL scores, councils are therefore likely to have relatively higher adjusted scores as a result of having larger proportions of high-need service users. Conversely, councils with a higher proportion of low-need users will find it more difficult to score highly on this adjusted indicator. The adjusted SCRQoL score enables the added value that councils are providing to be compared.

Calculating scores for each of the 32,535 completed community-based user surveys in 2014-15 illustrates that around 74% of the adjusted scores sit between 0.2 and 0.6, with around 97% sitting between 0 and 0.8. The full distribution is shown in Figure 1.6 below:

Figure 1.6: Distribution of adjusted, care-related quality of life scores; 2014-15



Our example score of 0.4660 sits towards the upper side of both the theoretical and observed ranges outlined above.

Impact of change from RAP and ASC-CAR to SALT; and from Primary Client Group to Primary Support Reason

In 2014-15, the "Short and Long Term" (SALT) activity collection replaced two activity-related collections: "Referrals, Assessments and Packages of Care" (RAP) and "Adult Social Care Combined Activity Return" (ASC-CAR). This change resulted in an alteration to the eligible population used for the Adult Social care Survey (ASCS).

In 2013-14, the eligible population used for the ASCS was those service users in receipt of Local Authority funded services following a full assessment of need. These data were collected via the RAP template.

When SALT was introduced in 2014-15, the eligible population changed to be a snapshot of the most closely comparable SALT table. To be included in the table chosen, a service user must, at the point that data are extracted from LA systems, be in receipt of long-term support services funded or managed by the LA following a full assessment of need. 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 RAP but are not included in SALT. The exception to this is that service users receiving professional support for their mental health needs are included in SALT 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.

Furthermore, as part of the introduction of SALT, Primary Client Groups have been replaced by Primary Support Reasons. As outlined in the "Study design and data collection section above", the volumes of data available for analysis and the creation of the 1J model were only robust enough for Primary Client Groups of:

- Physical Disability, Frailty and Sensory Support and
- Mental Health

Following the introduction of SALT, this criterion has been updated to reflect the nearest equivalent set of Primary Support Reasons, namely:

- Physical Support,
- Sensory Support,
- Support with Memory and Cognition, and
- Mental Health Support

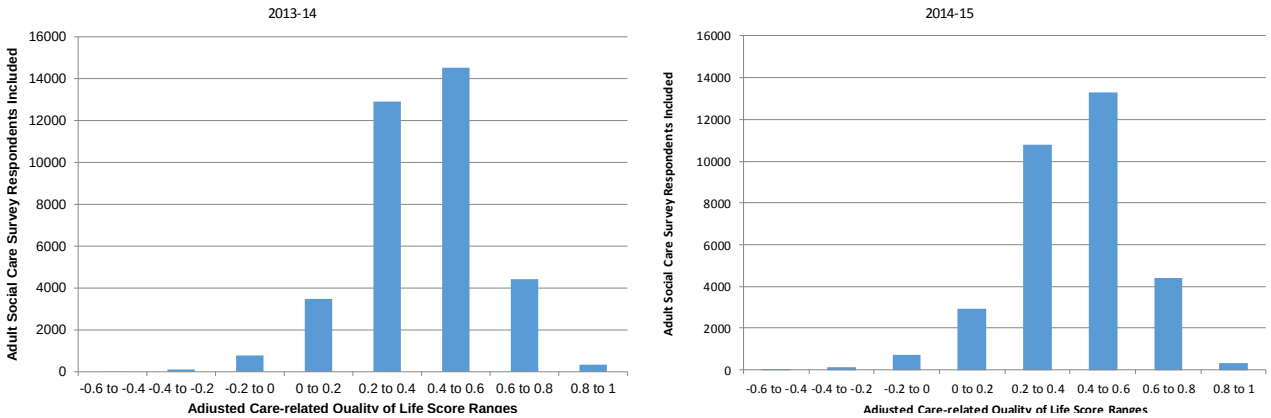
Further details on the changes to the Survey requirements can be found in the 2014-15 publication[4].

Figure 1.7 compares the average adjusted quality of life score ranges in 2013-14 and 2014-15. The bar charts illustrate that the distribution of the average care-related quality of life scores are very similar between the two years. As these distributions are similar, despite the changes to the eligible population and from PCG to PSR, this implies that neither of these

[4] http://content.digital.nhs.uk/catalogue/PUB18642/pss-ascs-eng-1415-rpt.pdf

changes has materially impacted the detail, applicability or interpretation of the 1J model developed for 2013-14 and a new formula for the creation of adjusted scores is not required. In line with the approach adopted for other activity-based ASCOF scores, the data are however not directly comparable from a time series perspective. It should become possible however, to compare scores over time once 2015-16 scores are made available in due course.

Figure 1.7: Distribution of adjusted, care-related quality of life scores; 2013-14 and 2014-15



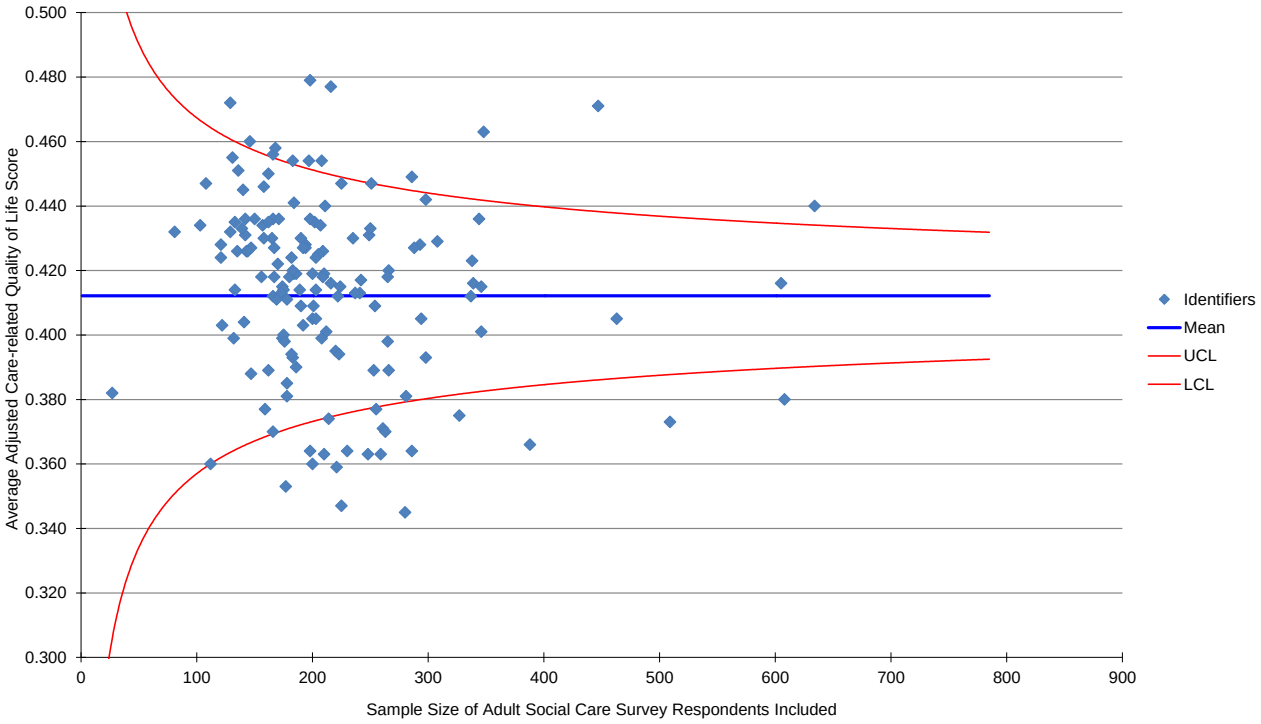
Aggregate Findings

By calculating scores as outlined above for each of the community-based respondents, excluding those with learning disabilities, who fully completed the relevant questions in the ASCS for 2014-15, NHS Digital has determined mean (average) values for each local authority.

These values should enable local authorities to be compared with each other as well as, in due course as outlined above, to review changes over time. The 2014-15 data file is provided alongside this report.

Please note however, that whilst summary scores have been provided for each LA, the numerical or ordering differences between scores do not imply that statistically significant differences exist between local authorities. To support interpretation of these scores, the data are therefore presented in the form of a funnel plot in Figure 1.8 below:

Figure 1.8: Funnel plot showing ASCOF Measure 1J by Local Authority; 2014-15



Local authorities who find themselves on or beneath the lower funnel line of figure 1.8 (calculated as three standard errors below the overall mean, varying based on the sample sizes drawn and shown as the red lower control limit (LCL)) may benefit from investigating how other services are being provided to identify whether new ideas or approaches may be available. As outlined above however, these councils may simply have higher-than-typical proportions of low-need users, and may therefore have lower average scores as a result. Calculating the adjustment factors for their users (using the template provided alongside this report) would certainly be a useful starting point for determining whether this is the case, and indeed calculating adjustment factors and adjusted scores for previous years could also help in identifying any trends over time or specific events which may have led to current scores. The determination of a suitable course of action, including the monitoring and analysis of any interventions that have been implemented, can then be undertaken as required.

Alternatively, if a local authority finds itself above the upper control limit (UCL) line (calculated as three standard errors above the overall mean), these organizations could look to share their good practices in the interests of supporting improvement across the sector as a whole. Generally however, this funnel plot appears to illustrate that the majority of local authorities have mean values that are within the funnel lines and do not therefore appear to be operating at significantly different levels at this time. Indeed, after controlling for the characteristics of the populations of the various councils, it is perhaps not surprising to find that councils are generally delivering services to a similar standard.

Next steps

Complete local authority-level data are provided in the accompanying dataset and a similar dataset will be made available in due course to cover 2015-16. This indicator will become part of the live ASCOF dataset for 2016-17.

Any queries or comments should be directed to ascof@dh.gsi.gov.uk in the first instance.