Department of Health & Social Care

Adult Social Care Outcomes Framework: methodologies for measures derived from CLD

Methodology document
September 2025

Contents

Introduction

This document outlines the methodologies and detailed data processing steps for creating 6 ASCOF measures from client level data (CLD). The methods build upon the central transformation principles developed by NHS England. By working with local authorities via the CLD reference group and the regular sharing of measures via the local authority dashboard, we have adapted the methods to improve accuracy and comparability with SALT and minimise the impact of known data quality issues. Nevertheless, CLD derived metrics are not expected to perfectly match previous SALT derived equivalents given the change in the data source, particularly the change in method of collection from aggregate to event level reporting. A record of the changes to the methods can be found in appendix 1.

The methodologies outlined in this document are final for the 6 ASCOF measures derived from CLD for 2024/25. These methodologies represent our best efforts to measure outcomes from CLD to date. However, CLD remains is a relatively new data source and we continue to engage with local authorities and receive feedback on uses of the data. Further refinements to the methods may therefore be considered in the future where it is deemed necessary.

Please note these methodologies currently reflect the Release 1 CLD specification and will be updated to reflect Release 2 in due course.

Common data processing steps

Processing the data for analysis

Summary

As part of the central processing, main data tables are updated on a quarterly basis to cover both the latest 12-month reporting period (single submissions table) or an extended period going back to 1 April 2023 (joined submissions table). Joined submissions are required for the calculation of metrics where definitions/selection of cohorts rely on prior information about individuals' care and event histories e.g., identifying 'new' clients.

The main processing steps in production of these tables are:

- selecting submissions covering the required analysis period
- filtering the data to events in the period
- creating cleaned and derived fields
- deduplicating records

For 2024/25 onwards where local authorities have started using the Release 2 specification, the data is currently mapped back to Release 1 where possible. This interim approach is necessary until all methods and scripts are fully updated to support the Release 2 specification. No additional data rows are created, instead individual fields are amended as needed.

Methodology

The processing steps to produce the main data tables are:

1. Data cleaning and/or mapping of priority fields – for some priority fields, and fields impacted by the change from the Release 1 to Release 2 CLD specifications, data cleaning and/or mapping is carried out. Reference tables are manually updated which map invalid entries and Release 2 entries to valid entries from the Release 1 defined lists, where it is apparent what the entry should be.
2. At this stage derived fields are created, see the section on fields derived in SQL for more information.
3. Amending event end dates – to match the date of death where this precedes the service end date, or to match the reporting period end date where the service end date appears to have been erroneously left blank (i.e. the service has a blank end date in one submission but is not included in the next submission)
4. Selecting submissions and joining them together – data is selected by combining submissions covering the last 12 months plus prior periods going

back to 1 April 2023. The reporting period stated in the submission is not taken as given; instead, it is derived by checking the data in each submission.

5. Deduplication – The table below lists the fields used to determine unique events to create the joined submission table. For services, events may be submitted in multiple submissions with information in the fields such as costs and units changing over time. Whilst this makes it difficult to identify unique events, this time-varying information is not currently required for the metrics in ASCOF; therefore, the deduplication below is sufficient.

Deduplication in the joined submissions table:	Requests	Assessments	Services	Reviews
LA Code	✓	✓	✓	✓
Derived Person ID (NHS number unless missing then LA_ID)	✓	✓	✓	✓
Event Start Date	✓	✓	✓	✓
Event End Date	✓	✓		✓
Client Type	✓	✓	✓	✓
Request: Route of Access	✓			
Assessment Type		✓		
Service Type			✓	
Service Component			✓	

Data selection

As of September 2025, ASCOF figures for July 24 to June 25 (Q1 24/25), along with all previous reporting periods, have been updated with the latest submissions from July 2025 via the joined submissions table. This ensures improvements in data quality and the methods are reflected across all metrics and time periods, and that the data is consistent across all published metrics for 2024/25.

Going forwards, ASCOF figures will be updated quarterly using the data from the most recent submissions and figures for previous periods will not be revised.

Person identifiers

The anonymised person identifier used throughout the ASCOF measures is the pseudonymised traced NHS number in the first instance. If this is missing, the pseudonymised local authority provided NHS number is used. If both NHS numbers are missing, the local authority unique person identifier is used. This methodology is consistent with that used in the local authority CLD dashboard.

‘New’ client definition

Previously in SALT, the definition of ‘new’ was that a person was not in receipt of long-term support at the time of making a request for support. Within CLD, local

authorities have fed back that requests for support are not consistently submitted as event records, e.g., these are sometimes missing for people who are referred directly from the hospital for reablement. This is a known data quality issue. Further, since all requests are included in CLD (unlike SALT) and are not flagged as 'new' or 'existing', it is necessary to look at an individual's previous CLD event records to identify whether they received long-term support in the past.

How far back we look to see if a person received long-term support prior to an event varies depending on the specific measure. This is to ensure each metric captures the relevant cohort of people, depending on what outcome is being measured. It is also worth noting that as these measures are focused on the outcomes for individuals, these definitions may differ from the operational definitions used in local authority processes.

The definitions applied to the relevant ASCOF measures are listed below:

ASCOF 2A – This metric measures whether people who were previously not receiving services went on to receive further support after their reablement. A period of 3 months prior to the reablement start date is used to identify those who received long-term support and these are excluded from this measure. This approach ensures only those in long-term support in the few months prior to reablement are removed and allows the measure to focus on new and/or emerging need.

ASCOF 2B/C – This metric counts the number of new admissions into long-term residential or nursing care. A new admission is defined as someone who has not been in receipt of local authority organised or funded long-term residential or nursing care in the 12 months preceding the start date of their current nursing or residential placement. This approach ensures only first-time admissions, or those who have experienced a significant break in their residential or nursing care, are included.

Latest person details

A dataset is created which contains the most recent known details for each individual in CLD, for a range of demographic and service-related characteristics. The dataset supports analysis by curating a single record of a select few fields per individual for a given reporting period. This allows the latest know information to be used and ensures person details are consistent across different metrics.

The following fields are included in the latest person details table: gender, ethnicity, date of birth, date of death, employment status, accommodation status, carer status, primary support reason, age and age bands and client funding status.

The latest details for each person are selected for each field by applying the following prioritisation in order:

- known values over unknown values
- values associated with the most recent submission over prior submissions

- most recent event end date (with nulls prioritised)
- most recent event start date
- for date of birth, if multiple records tie then the earliest date is chosen
- for date of death, if multiple records tie then the latest date is chosen

If multiple records tie after applying the prioritisation, then the final value is considered ‘unknown’ as it cannot be determined which record is accurate.

For individuals whose resulting accommodation status is ‘unknown’, an attempt is made to infer the accommodation status from the latest service type and service component information. Appendix 6 contains more information on the mapping of services to accommodation statuses.

Please note, not all metrics require or use every field from the Latest Person Details table. Which fields are utilised depends on the requirements of each specific metric and whether the latest details are appropriate.

ASCOF 2A

The proportion of people who received reablement during the year, who previously were not receiving services, where no further request was made for ongoing support.

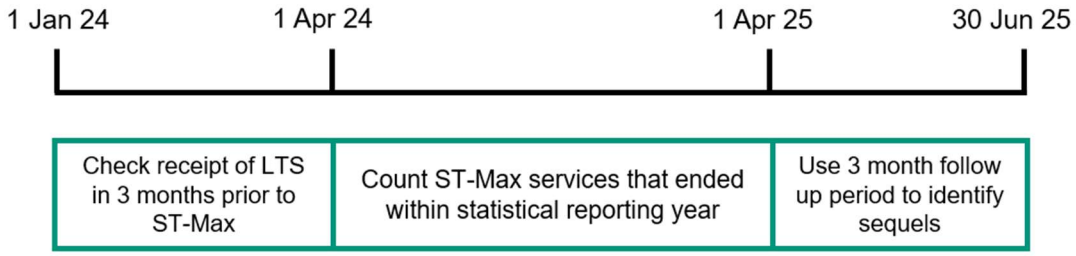
Stage 1 – Identify reablement events in scope

The first stage processes the joined submissions dataset to identify ST-Max events, clusters these events together and selects those which ended in the statistical reporting year.

1. Using the joined submissions table (see processing the data for analysis), select data covering the statistical reporting year of interest, plus an additional 3 months of data prior to the period, to establish whether an individual was previously receiving any long-term support.

   For a single year period (e.g., April 24 to March 25) there will be some ST-Max services ending towards the end of the period where the outcome (sequel) is unknown because subsequent events occur in the next quarter. This will only be cases ending in the last week of the period, as the threshold for deriving sequels for this measure is 7 days (see stage 3 below). To address this, the next quarter of data (where available) is appended to improve the likelihood of determining an outcome (sequel) for these events.

   The diagram below shows how a table comprised of joined submissions will be used to produce published figures for the 24/25 statistical reporting year:



2. Create a build table, by selecting only events where Client Type = Service User. At this stage null event end dates are replaced with '9999-01-01' for ease of processing and the event outcome field is cleaned (invalid values mapped to valid values where possible to deduce).

3. Create a sub-table of reablement events using:

   Event Type = Service
   Service Type = Short Term Support: ST-Max

4. Custer together reablement events which overlap or occur within 7 days of each other. One epsiode of reablement may be submitted as multiple event records, and this assumes that those occurring within 7 days of each other are

part of the same reablement service. Once clustered these are filtered to those ending in the period:

a. Individual records with Service Type = ST-Max which overlap or occur within 7 days of each other based on event start and end dates (i.e., the records are overlapping or maximum of 7 days apart) are clustered together.

b. Each cluster is assigned the earliest event start date and the latest event end date.

c. Each cluster is assigned the event outcome of the record with the latest event end date. If two records have different event outcomes and the same event end date, the event outcome hierarchy is applied to select the outcome with the highest rank (see appendix 2 for the hierarchy).

   The outputted dataset now consists of one line representing each cluster of reablement events, with the relevant event start and end dates and event outcome.

d. Select records where the cluster end date falls within the statistical reporting year (e.g., for 24/25 the end date must be between 1 April 2024 and 31 March 2025 inclusive).

Example ST-Max clusters for one person, where ST-Max events appear to close and reopen and potentially contain duplicates:

Service Type	Event Start Date	Event End Date	Event Outcome	ST-Max Cluster ID
Short Term Support: ST-Max	01/07/2024	03/08/2024	Progress to reablement/ST-Max	1
Short Term Support: ST-Max	05/08/2024	20/08/2024	NFA - Other	1
Short Term Support: ST-Max	06/08/2024	20/08/2024	Service ended as planned	1
Short Term Support: ST-Max	16/09/2024	29/09/2024	Progress to reablement/ST-Max	2
Short Term Support: ST-Max	04/10/2024	01/01/9999*	Provision of service	2

Service Type	Cluster Event Start Date	Cluster Event End Date	Cluster Event Outcome	ST-Max Cluster ID
Short Term Support: ST-Max	01/07/2024	20/08/2024	Service ended as planned	1
Short Term Support: ST-Max	16/09/2024	01/01/1999*	Provision of service	2

*Originally null, overwritten for the purposes of processing data chronologically

5. Link to the latest person details table to obtain each person's date of birth and date of death. Calculate age at the ST-Max cluster end date and construct age bands. Exclude ST-Max clusters where the person was under the age of 18 on the ST-Max cluster end date, or where the date of death is before the ST-Max cluster start date. Do not exclude clusters where the birth date/age is unknown.

Stage 2 – Determine those who were previously not in receipt of support

This stage selects those who received reablement in the year and were previously not in receipt of support. This is identified by looking at an individual's previous CLD event records to identify whether they received long-term support in the 3 months prior to their reablement.

1. Link the now clustered ST-Max records to all other records for the same person (present in the initial build table), regardless as to whether each event occurred before or after the ST-Max. Note, it also includes linking back to the ST-Max events themselves.
2. Flag where the ST-Max cluster has linked to the ST-Max records which formed the cluster in the first instance, these records are then replaced with null (not deleted as needed to retain any records where they have no other events, and the only instance is them joining to themselves). These records are identified by:

   Event Type = Service
   Service Type = Short Term Support: ST-Max
   Event start date is between the start and end dates of the reablement cluster
3. Identify and filter to those not previously in receipt of long-term support in the 3 months prior to the reablement start date.

Example of joining ST-Max to all events for the same person and determining if they are a new client. In this instance, the first ST-Max episode is counted as there was no prior long-term support, whereas the second episode is not as the person was in receipt of long-term support in the 3 months prior to their ST-Max.

ST-Max clusters			Joined to all other events for the same person				Create flags		
ST-Max Cluster ID	Cluster Event Start Date	Cluster Event End Date	Event Type	Service Type	Event Start Date	Event End Date	Same ST-Max Self-join)	New client (event level flag)	New client (cluster level flag)
1	01/07/2024	20/08/2024	Request	NA	06/06/2024	06/06/2024	0	1	1
1	01/07/2024	20/08/2024	Service	Short Term Support: ST-Max	01/07/2024	03/08/2024	1	1	1
1	01/07/2024	20/08/2024	Service	Short Term Support: ST-Max	04/08/2024	20/08/2024	1	1	1
1	01/07/2024	20/08/2024	Service	Short Term Support: ST-Max	06/08/2024	20/08/2024	1	1	1
1	01/07/2024	20/08/2024	Assessment	NA	22/08/2024	02/09/2024	0	1	1
1	01/01/2024	20/08/2024	Service	Long Term Support	03/09/2024	01/01/9999*	0	1	1
2	16/09/2024	01/01/9999*	Service	Long Term Support	02/01/2024	28/08/2024	0	0	0
2	16/09/2024	01/01/9999*	Service	Short Term Support: ST-Max	16/09/2024	29/09/2024	1	1	0
2	16/09/2024	01/01/9999*	Service	Short Term Support: ST-Max	30/09/2024	01/01/9999*	1	1	0

*Previously null, overwritten for the purposes of processing data chronologically

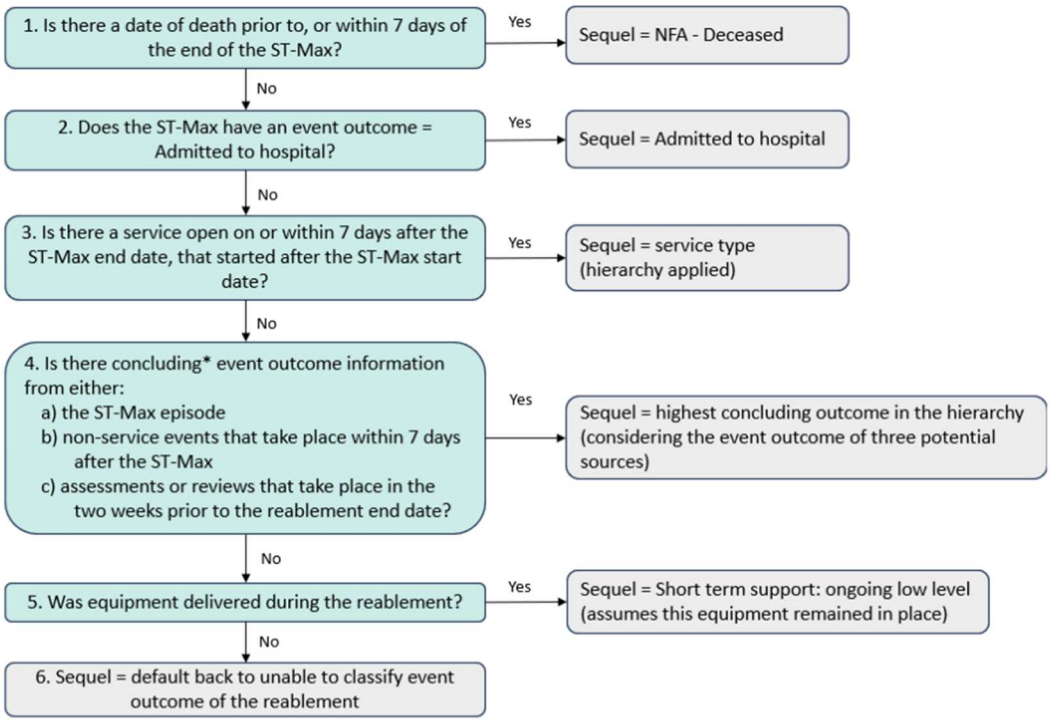
Stage 3 – Identify sequels

Summary

For the purposes of ASCOF 2A, sequels describe the immediate outcome after reablement, i.e. what happened next. They are used to identify whether a person

went on to immediately require further support or whether their reablement successfully helped them regain independence. Sequels are identified in CLD for this metric using the events which occurred during and in the 7 days after the reablement ended, and the information captured in the event outcome field.

The flow chart below sets out the steps involved in processing data for sequels:



*A 'concluding' event outcome is one where a definitive outcome can be determined (see appendix 4). The detailed data processing steps for identifying sequels are outlined in appendix 3.

Stage 4 – Determine numerator and denominator

Denominator – where outcome in:

- Long Term Support: Community
- Long Term Support: Nursing Care
- Long Term Support: Residential Care
- Long Term Support: Prison
- Short Term Support: Ongoing Low Level
- Short Term Support: Other Short Term
- Short Term Support: Residential or Nursing Care
- NFA – Information & Advice / Signposting only
- NFA – Moved to another LA
- NFA – Other
- NFA – No services offered: other reason
- NFA – Support ended: other reason
- Service ended as planned

Numerator indicating successful reablement – where outcome in:

- Short Term Support: Ongoing Low Level
- Short Term Support: Other Short Term
- NFA – Information & Advice / Signposting only
- NFA – Moved to another LA
- NFA – Other
- NFA – No services offered: other reason
- NFA – Support ended: other reason
- Service ended as planned

Both the numerator and denominator are disaggregated by age band (18 to 64 and 65 and over) based on age at the end of the reablement service.

See appendix 4 for the list of outcomes and how they are treated in the final ASCOF calculation.

Notes for interpretation

- This metric measures outcomes for people who were previously not receiving support. This is defined by anyone who did not receive local authority commissioned long-term support in the 3 months prior to the reablement service.
- The outcome of the reablement is identified based on the events in the 7 days following the reablement service and event outcomes in CLD.
- Where the event outcome of the reablement indicates that further support may be required but there is no evidence of support being provided in CLD in the short-term, these are categorised as ‘unable to classify’ and excluded from the measure.
- This measure only includes reablement that is solely or jointly provided or arranged by the local authority and reported in the local authority’s CLD submission. CLD does not include intermediate care provided by the NHS. In some areas, these health-funded services may represent a substantial proportion of post-discharge intermediate care.

ASCOF 2B/C

The number of adults aged 18 to 64 (2B) or 65 and over (2C) whose long-term support needs are met by admission to residential and nursing care homes, per 100,000 population.

1. Select data from the joined submissions table covering the statistical reporting year of interest and one year prior to this, e.g., for 24/25 statistics include data for 23/24 and 24/25 (see section on processing the data for analysis for more information). Data describing activity prior to the year of interest is required to determine 'new' admissions. Join the data to the latest person details table to obtain the date of birth and date of death, then filter to long-term residential or nursing care services by:

   Client Type = 'Service User'
   Event Type = 'Service'
   Service Type = 'Long Term Support: Residential Care' or 'Long Term Support: Nursing Care'
   Service Component = (NULL or contains 'residential' or contains 'nursing') and (doesn't contain 'short')

2. Identify people admitted within the year from the table using the event start date. For example, for 24/25 this is any event where the event start date is between 1 April 2024 and 31 March 2025 inclusive.
3. Exclude any long-term residential and nursing services with the event outcome 'NFA – Self-funded client (Inc. 12wk disregard)', as these are admissions where the individual has gone on to self-fund their care. Excluding them ensures admissions are only those where the local authority funds or organises the care in the long-term and prevents any double counting if these people were to return to the local authority due to depleted funds.
4. Of these, filter to those who are new admissions by excluding anyone with a long-term residential or nursing service within the 12 months prior to the event start date of their long-term residential or nursing service falling within the year of interest. Using this approach, a person who had a break in their long-term residential or nursing support of 12 months or more would be considered a new admission.
5. Age on admission is calculated and used to aggregate to the total number of admissions for ASCOF 2B (18 to 64) and ASCOF 2C (65 and over).

Examples: The table lists all long-term support events for each individual, which are then used to determine new admissions to residential or nursing care.

Person ID	Service Type	Event Start Date	Event End Date	New long term residential or nursing care admission
Person A	Long Term Support: Community	03/08/2024	12/12/2024	NA
Person A	Long Term Support: Nursing	15/12/2024	NULL	Yes - no long term residential or nursing care in 12 months prior to event start date
Person B	Long Term Support: Residential	18/04/2023	22/07/2023	Yes - no long term residential or nursing care in 12 months prior to event start date
Person B	Long Term Support: Residential	29/11/2024	NULL	Yes - the previous long term residential care ended over 12 months ago, this person is now a new admission
Person C	Long Term Support: Nursing	01/04/2023	31/03/2024	Yes - no long term residential or nursing care in 12 months prior to event start date
Person C	Long Term Support: Nursing	01/04/2024	15/09/2024	No - the previous long term nursing care service ended within the 12 months prior to this service start date
Person C	Long Term Support: Nursing	18/09/2024	NULL	No - the previous long term nursing care service ended within the 12 months prior to this service start date

6. Numerator – count the number of new admissions by age at the end of the reporting period to determine whether each person is counted in 2B (18-64) or 2C (65 and over).
7. Denominator – this is taken from the ONS mid-year population estimates for each local authority for the respective age groups.

Notes for interpretation

- This metric measures the number of people who have begun a local authority arranged or provided long term residential or nursing care service for the first time in a 12-month period.
- Individuals who self-funded their care and went on to receive local authority funded care when their funds depleted are counted in this metric.
- Admissions may include people who previously received a 12-week property disregard, if they presented back to the local authority after more than 12 months.
- CLD does not differentiate between temporary and permanent residential placements and therefore some temporary admissions may be included.
- This metric does not capture people who self-fund and organise their own care with no involvement from the local authority. Such individuals will be most prevalent in local authorities with higher levels of income and wealth which may affect these local authorities' results.

ASCOF 2D

The proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge.

Definitions

Cohort: People aged 65 or over who were discharged from hospital, who weren't receiving local authority commissioned long-term residential care, nursing care or prison support at the time of hospital admission. This cohort is used as the starting point for both parts of the metric.

Part 1: outcomes following reablement – the proportion of people who remained in the community within 12 weeks of hospital discharge, of those aged 65 and over who received reablement support after discharge.

Numerator: the number of people who received reablement after hospital discharge, were aged 65 and remained in the community. For the purposes of this metric, this is defined as those who did not experience one of the listed events within 12 weeks following discharge. They did not:

- receive local authority arranged or provided long-term residential or nursing care
- have an emergency (unplanned) admission into hospital
- die over this period

Denominator: the number of people aged 65 and over discharged from hospital where reablement services were provided.

Part 2: provision of reablement – this is a contextual measure describing the proportion of people who were provided with reablement services following discharge from hospital, of those aged 65 and over.

Numerator: the number of people aged 65 and over discharged from hospital where reablement services were provided.

Denominator: total number of hospital discharges of people aged 65 and over from hospitals in England. This includes all clinical specialities but excludes patients who were discharged the same day that they were admitted (a zero-length day stay in hospital). For the local authority breakdown, this is identified from the patient's usual residence.

Summary of methods

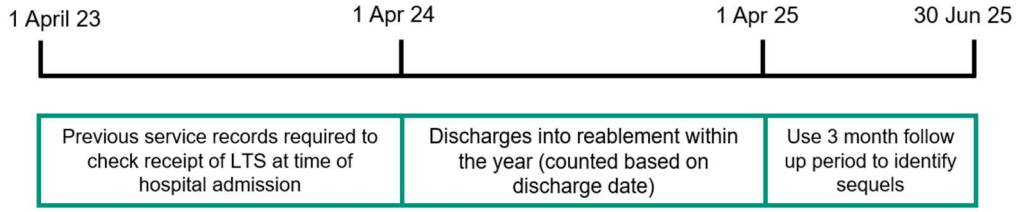
Two data sources are used for this metric, linked using the pseudonymised NHS number:

1. **Secondary Uses Service (SUS)** data which is a comprehensive national database that collects and stores hospital activity data from NHS providers. Data is selected covering the reporting period plus an additional 3-month follow-up to identify readmissions.

2. **Client Level Data (CLD)** starting from April 2023 up until the reporting period end date plus an additional 3-month follow-up to identify future admissions to residential or nursing care. Note that the dataset is created by joining data from multiple submissions.

This metric was originally designed to use ONS mortality records, which covers all registered deaths in England. However, due to delays to information governance approvals to include ONS deaths data in the current data environment, the date of death field from CLD is used in the interim.

Data from CLD and SUS will be used to generate 24/25 published figures. CLD records from the prior year (23/24) are used to identify whether someone was in long-term support when admitted to hospital. CLD and SUS data for the 3 months from 1 April 2025 to 30 June 2025 is used to track outcomes for people discharged from hospital toward the end of the reporting period.



The methodology for ASCOF 2D follows four stages:

1. Create initial CLD tables, including a table of long-term support services (to identify those in long-term support when admitted to hospital) and a table of reablement services.
2. Create a table of hospital discharges from SUS (part 2 denominator).
3. Create a linked table of discharges into reablement (part 2 numerator which is also part 1 denominator).
4. Identify outcomes for those discharged into reablement (part 1 numerator).

Stage 1 – Create initial CLD tables

1. Create an initial table of CLD using the latest joined submission table and retain the latest date of death for each person.
2. Select events where Client Type = Service User and Person ID is not null. Anyone who died prior to the reporting period is exluded at this stage and null event end dates are replaced with ‘9999-01-01’ for ease of processing.
3. To identify people receiving long-term support when they were admitted to hospital, create a table of long-term support services where Service Type contains ‘long’.

4. To identify people who received reablement, create a separate table of reablement services, clustering records together which overlap or occur within 7 days of each other. See stage 1 for ASCOF 2A for more information on the clustering. Reablement services are identified by:

    Event Type = Service
    Service Type = Short Term Support: ST-Max
    Service Component = Reablement

Stage 2 – Create table of all discharges (part 2 denominator)

1. The following filters are applied to the SUS dataset, to ensure that only relevant discharge episodes are retained:
    - this discharge date is within the reporting period (i.e. 1 April 2024 to 31 March 2025)
    - include patients aged 65 years or older on discharge
    - exclude patients with a zero-day length of stay (day cases)
    - exclude patients who died in hospital
    - include only specific acute and community treatment functions
    - exclude those discharged into other NHS hospitals, independent hospitals and hospices
2. Join the table of discharges to the CLD table of long-term support services using the pseudonymised NHS number, and identify those where a long-term residential care, nursing care or prison service was open on the hospital admission date. These discharges are then excluded from the dataset, used in both parts of the metric.
3. For the remaining discharges, create a flag to identify whether they were in long-term community support or not on the hospital admission date.
4. The lower super output area (LSOA) of the person's postcode on the discharge record (based on a patient's usual place of residence) is mapped to the local authority code using a lookup table (Open Geography Portal).
5. Count the number of distinct discharge episodes. **This is the part 2 denominator – total discharges for people aged 65 and over.**

Stage 3 – Create table of discharges linked to reablement (part 2 numerator = part 1 denominator)

1. The reablement events tables created in stage 1 are linked to the hospital discharge records present in the part 2 denominator, using the pseudonymised NHS Number as the common person identifier. The following conditions are applied to identify whether the reablement episode followed a hospital discharge:

- the hospital admission date occured before the reablement event start date
- the hospital discharge date occurred up to 7 days prior to the reablement start date or up to 3 days after the reablement start date.
- the hospital discharge closest to the reablement event is linked where multiple hospital discharges occurred

2. Count the number of distinct discharges where reablement was provided. **This is the part 2 numerator and forms the part 1 denominator – total discharges for people aged 65 and over where reablement was provided.**
3. The proportion of people who receive reablement is then calculated using:

$$\frac{\text{Discharges where reablement was provided}}{\text{Total discharges in scope}} \text{ x } 100$$

Stage 4 – Identify outcomes in the 12 weeks following the discharge into reablement (part 1 numerator)

1. The following follow-up events are identified:
    - Readmission: clients who have a hospital admission date within 12 weeks after the discharge date and where the admission method indicates an emergency admission. These are selected using the following:
        - hospital admission date is within 12 weeks of the initial discharge date
        - exclude patients with a 0-day length of stay (day cases)
        - include only unplanned (emergency and non-elective) admissions
    - Long-term support: clients with a long-term residential or nursing care service in CLD which started within 12 weeks of the discharge date
    - Death: clients with a date of death in CLD within 12 weeks of the discharge date. (Please note this is an interim approach until we can access the ONS deaths data).
2. Count the number of distinct discharges into reablement where none of the above events occurred. **This is the part 1 numerator – total number of discharges into reablement where the person remained in the community within 12 weeks of discharge.**
3. Overall outcome for part 1 is calculated by:

$$\frac{\text{Discharges into reablement where the person remained in the community within 12 weeks}}{\text{Total discharges where reablement was provided}} \text{ x } 100$$

Notes for interpretation

- Please note this metric is new for 2024/25, replacing the previous SALT metric which measured whether people were still at home 91 days after hospital discharge. This metric continues to measure outcomes for people who received reablement after hospital discharge, but is a distinctly different metric and, therefore, not directly comparable with the previous 2D measure. Some of the key differences:
    - this metric incorporates new dimensions to the outcome such as avoidance of hospital readmission
    - this metric measures across a 12-month period, compared to the previous metric covering 3 months.
    - this metric captures events throughout the 12-week follow-up period, whereas the previous metric only considered the 91st day following hospital discharge.
    - this metric relies on linking CLD to SUS via the NHS number to determine those who received reablement after hospital discharge; previously this was reported via SALT and was derived from local reporting and often additional context.
- This metric does not capture people who self-fund and organise their own care with no involvement from the local authority after discharge. Such individuals will be most prevalent in local authorities with higher levels of income and wealth which may affect these local authorities' results.
- Date of death is identified from CLD, which may have incomplete coverage. Therefore, the ONS mortality dataset will be used in future, once available.

ASCOF 2E

The proportion of people who receive long-term support who live in their home or with family.

Part 1 – Clients with a learning disability aged 18 to 64
Part 2 - All Clients disaggregated by age group: 18 to 64 and 65 and over

1. Using the joined submissions table (see section on processing the data for analysis), filter to records of long-term support provided during the year by:

   Client Type = 'Service User'
   Service Type = 'Long Term Support: Residential Care' or 'Long Term Support: Nursing Care' or 'Long Term Support: Community' or 'Long Term Support: Prison'
   Event end date is greater that the reporting period start date or null (ongoing)

   Null event end dates are replaced with '9999-01-01' at this stage for ease of processing.

2. Join the data to the latest person details table to obtain the latest accommodation status, gender, date of birth and date of death (if applicable). The person's age is then calculated at the end of their latest service or the reporting period end date if the service is still open. Those aged under 18 are then removed. At this stage metric specific filters are applied:

   Part 1 – Primary Support Reason = 'Learning Disability' and age between 18 and 64
   Part 2 – All primary support reasons and ages 18 and above

3. Calculate the numerator and denominator:
   - Denominator – count the number of people in the final table; this includes anyone with an unknown or invalid accommodation status or gender.
   - Numerator – count the number of people whose accommodation status is categorised as 'living in their home or with family'. See appendix 7 for the categorisation.

   Figures are disaggregated by age and gender; those with Other/Unknown/Null gender or unknown age are included in total counts.

   Outcome is calculated by numerator / denominator * 100

Notes for interpretation

- For 24/25 onwards, ASCOF 2E has been expanded to include part 1- clients aged 18-64 with a learning disability, and part 2- all clients, disaggregated by those aged 18-64 and 65+.

- Only valid accommodation statuses are included in the numerator. Invalid and unknown statuses are included in the denominator. An attempt is made to infer ‘unknown’ accommodation statuses from the latest service type and service component information (see appendix 6 for more detail about mapping accommodation status).
- Accommodation status is routinely collected for clients with a learning disability (as this was a requirement with SALT), but not for all clients regardless of primary support reasons. Therefore, data quality is expected to be lower for part 2, though it should improve over time.

ASCOF 3D

The proportion of people using social care who receive self-directed support, and those receiving direct payments. This is split into 4 parts:

1a – clients receiving self-directed support (at year end)
1b – carers receiving self-directed support (in the year)
2a – clients receiving direct payments (at year end)
2b – carers receiving direct payments (in the year)

Prior to creating the client and carer metrics, the joined submissions table (see section on processing the data for analysis) is joined with the latest person details table to obtain each person's date of birth and date of death (if applicable). The person's age at the end of the reporting period is then calculated.

Client based measures (parts 1a and 2a)

1. Using the table created above, filter to clients with a long-term service open at the end of the period:

   Client Type = Service User
   Service Type = 'Long Term Support: Residential Care' or 'Long Term Support: Nursing Care' or 'Long Term Support: Community' or 'Long Term Support: Prison'
   Date of death is after the reporting period end date or is null
   Event start date is on or before the reporting period end date and
   Event end date is on or after the reporting period end date, or is null (open services)

2. For clients receiving multiple long-term services at the end of the year, deduplicate based on a hierarchy which considers both the service type and delivery mechanism (see appendix 5):

   a. Clients with Service Type = 'Long Term Support: Community' and either Service Component = 'Direct Payment' or Delivery Mechanism = 'Direct Payment' are assigned the same rank.
   b. Choose the record with the lowest rank (highest in the hierarchy) per client.

3. Clients aged under 18 at the reporting period end date are removed from the table.

4. Calculate numerators and denominators:

   Part 1a and 2a denominator - count the number of people where:
   Service Type = 'Long Term Support: Community'

   Part 1a numerator - count the number of people where:
   Service Type = 'Long Term Support: Community' and either
   Delivery_Mechanism = 'Direct Payment' or 'CASSR Managed Personal Budget' or,
   Service_Component = 'Direct Payment'

   Part 2a numerator – count the number of people where:
   Service Type = 'Long Term Support: Community' and either

Delivery_Mechanism = 'Direct Payment' or,
Service_Component = 'Direct Payment'

All counts are disaggregated by age (18 to 64 and 65 and over) based on the age at the end of the reporting period. Those with an unknown age are included in total counts.

Carer based measures (parts 1b and 2b)

1. Using the joined table created above, filter to carers receiving support, which is identified by 3 different ways:

   Client Type = ‘Carer’, ‘Unpaid carer’, ‘Carer known by association’ or ‘Unpaid carer known by association’ and:
   a. Service Type = ‘Carer Support: Direct to Carer’ or ‘Carer Support: Support involving the person cared-for’
      OR
   b. Service Type is null and Event Outcome = ‘NFA – Information & Advice / Signposting only’
      OR
   c. Service Type is null and Event Type = ‘Assessment’ or ‘Review’

2. Select those receiving support during the year, where:
   a. Event start date is on or before the reporting period end date and
   b. Event end date is on or after the reporting period start date or is null (ongoing services) and
   c. Exclude anyone with a date of death prior to the reporting period start date.
3. For carers receiving multiple forms of support during the year, deduplicate based on the hierarchy in appendix 8 using the combination of event type, service type, service component, event outcome and delivery mechanism. The support type with the lowest rank (highest in the hierarchy) for each carer is retained.
4. Carers aged under 18 at the reporting period end date are removed from the table.
5. Calculate numerators and denominators:

   Part 1b and 2b denominator – count the number of people where:

   Support provided = ‘Direct Payment’, 'CASSR Managed Personal Budget' or 'CASSR Commissioned Support only'

   Part 1b numerator – count the number of people where:

   Support provided = ‘Direct Payment’ or 'CASSR Managed Personal Budget'

   Part 2b numerator – count the number of people where:

   Support provided = ‘Direct Payment’

All counts are disaggregated by age (18 to 64 and 65 and over) based on the age at the end of the reporting period. Those with an unknown age are included in total counts.

Notes for interpretation

- Delivery mechanism is not currently mandatory and is therefore blank for many records. In Release 2 of the CLD specification, delivery mechanism has become mandatory to hopefully improve the completeness and quality of information on self-directed support.
- The direct payment measure (part 2) captures when ‘direct payment’ is recorded in either the service component or delivery mechanism fields. The self-directed payment measure (part 1) captures all the people receiving direct payments but also includes those with a ‘CASSR Managed Personal Budget’ which is only recorded in delivery mechanism. When the delivery mechanism field is null/invalid we cannot determine other aspects of self-directed payments, hence only direct payments identified via the service component field appear in both metrics.
- This metric does not currently include carers whose support is recorded in CLD via the cared-for person’s record, where only the carer’s personal details are recorded on the ‘unpaid carers known by association’ record (no event information). This metric will be improved in future iterations to ensure these people are included.
- While many authorities have improved their unpaid carer data, we recognise this remains a challenge for some. Following our review of the July CLD submissions, the national number of unpaid carers recorded in CLD for 2024/25 remains significantly below the figure reported through SALT last year. There is particularly poor coverage of universal services. Therefore, to avoid misinterpretation, ASCOF 3D parts 1b and 2b for carers will be excluded from the ASCOF publication for 24/25.

Appendix 1: Summary of methodology changes from the central transformation principles

The changes in blue indicate those made since the previous version of the methodology was published.

Measure	Change	Rationale
All measures	Person ID methodology	The DHSC methodology for person IDs is now being used for all ASCOF measures. This uses the pseudonymised traced NHS number in the first instance, if this is missing then the local authority provided NHS number. If both NHS number fields are missing, the local authority person identifier is used. This methodology is consistent with that used in the local authority CLD dashboard and DHSC's monthly adult social care statistics publication.
ASCOF 2A	Removed the requirement for a prior request	Local authorities provided feedback that linking a reablement service to the prior request is not always feasible due to case management system processes and the ability to accurate link requests to related subsequent activity. In response, local authorities supported removing this requirement for this measure.
	Change to using the latest submission for each quarter joined together, rather than using all data ever submitted	The previous method processed all submissions provided by a local authority. Given submissions cover a rolling 12-month period, with 9 months of events superseded each quarter, the data in the latest submission is more accurate and often, of better quality than previous submissions. The improved methodology selects the latest file covering the latest 12 months and appends data in 3-month periods using the latest submission for that quarter.
	Definition for clients not previously in receipt of support	These clients were previously identified based on whether they were in receipt of long-term support at the time of their request. Given the prior request is no longer a requirement for this measure these clients are identified based on whether they received local authority arranged or provided long term care in the 3 months (91 days) prior to their reablement. This is based on feedback from local authorities that a much shorter period than 12 months is more appropriate for identifying the relevant cohort.
	Re-categorised some of the final outcomes	The following outcomes were previously included in the numerator and the denominator, however, are now being excluded: • Admitted to hospital • Proceed to end of life care
	Improved methodology for determining short term outcomes sequels	Local authorities provided feedback that the previous method of creating sequel chains resulted in identifying much longer-term outcomes than this metric intends to measure. The revised process for identifying sequels has been developed in collaboration with the CLD reference group and only considers activity which occurred during the reablement and in the 7 days following the reablement end date, focusing on immediate outcomes.

Measure	Change	Rationale
	Demographic information is obtained from a table of latest person details	This ensures the most up to date information is used and it is consistent for the same person across different metrics.
	Excluded short-term support: residential or nursing care from the numerator	The provision of short-term residential or nursing care after reablement signals that further support is initially required and it is likely that arrangements for long-term residential or nursing care are underway.
	Combined steps 4 and 5 for identifying sequels	This change ensures the event outcome from the ST-Max episode is evaluated alongside the outcomes from any non-service events occurring during the sequel period, as well as assessment or review events near the end of the ST-Max. All outcomes are therefore treated with equal importance, and the most meaningful information can be selected according to the event outcome hierarchy.

Measure	Change	Rationale
ASCOF 2B & 2C	New client definition	Feedback from local authorities supported a central definition of a 'break' period between two long term residential and nursing services, after which a person becomes a new admission again. A break period of 12 months was agreed with local authorities.
	Change to using the latest submission for each quarter joined together, rather than using all data ever submitted	The previous method processed all submissions provided by a local authority. Given submissions cover a rolling 12-month period, with 9 months of events superseded each quarter, the data in the latest submission is more accurate and often of better quality than previous submissions. The improved methodology selects the latest file covering the latest 12 months and appends data in 3-month periods using the latest submission for that quarter.
	Exclude any services where the service component suggests it is not a long term residential or nursing placement	This is based on local authority feedback to ensure additional 1:1 packages or short-term placements are not considered as new admissions.
	Exclude any admissions with 'NFA – self-funded client (inc. 12 wk disregard)' event outcome	Where an individual only receives local authority funded support for a limited time before going on to self-fund their care, these are excluded. This is to ensure admissions are only those where the local authority funds or organises the care in the long term and prevents any double counting if these people were to return to the local authority due to depleted funds.

	Demographic information is obtained from a table of latest person details	This ensures the most up to date information is used and it is consistent for the same person across different metrics.
	Age definition – change to using age on admission rather than at reporting period end	Feedback from local authorities supported the age being defined on the event start date of the long term residential or nursing service. This ensures age remains consistent regardless of which period being is being analysed.
ASCOF 2E	Demographic information is obtained from a table of latest person details	This ensures the most up to date information is used and it is consistent for the same person across different metrics.
	Produce figures for both part of the metric (18 to 64 for LD and all clients by both age groups)	Updated in line with the handbook and based on local authority feedback for clarification of cohorts.
	Settled/unsettled categorisations no longer used, in preference of 'Living in their home or with family' or not.	For the purposes of ASCOF, the previous classifications are no longer appropriate – particularly where a care home for an older person would be considered 'unsettled'. The new categorisations better align with the handbook and for measuring independence.
	Taking the latest known person details from the joined submission from any event	Person details (accommodation status and gender) were previously derived from the latest long term service event. Using most recent available details better aligns with SALT principles and reduces the number of people with an unknown accommodation status.
	Introduced other/unknown genders into the totals.	Increases the scope of the collection.
	Cleaning the accommodation status field and deriving accommodation status where possible from service information	These changes improve the data quality of the accommodation status field by reducing the number of people with an unknown accommodation status. Accommodation status is either derived from an invalid entry or the information captured in the service type and component fields. This mapping has recently been enhanced to include the categories 'unknown - presumed at home' and 'unknown - presumed in the community'.

ASCOF 3D	Demographic information is obtained from a table of latest person details	This ensures the most up to date information is used and it is consistent for the same person across different metrics.
	Delivery mechanism is reassigned 'direct payment' when present in the service component	'Direct payment' in the 'Service Component' field is assumed to be more reliable than the information in the delivery mechanism field for the client-based metrics.

Appendix 2: Event outcome hierarchy (ASCOF 2A)

Event Outcome	Hierarchy
Admitted to hospital	1
NFA - Moved to another LA	2
NFA - 100% NHS funded care	3
NFA - Self-funded client (inc. 12wk disregard)	4
NFA - Information & advice / signposting only	5
NFA - Support declined	6
NFA - Deceased	7
Service ended as planned	8
NFA - Support ended: other reason	9
NFA - No services offered: other reason	10
NFA- Other	11
Progress to reablement/ST-Max*	12
Progress to assessment*	13
Progress to re-assessment / unplanned review*	14
Progress to financial assessment *	15
Progress to support planning / services*	16
No change in package*	17
Provision of service*	18
Progress to end of life care*	19

*This hierarchy matches that outlined in the CLD guidance. For the purposes of determining sequels for ASCOF 2A, these ‘intermediate’ outcomes are considered ‘unable to classify’ as it cannot be determined whether further long-term support was required. For this reason, these starred event outcomes are deprioritised in favour of other event outcomes when determining the sequels.

Appendix 3: Deriving sequels to ST-Max for ASCOF 2A

The sequels to the ST-Max are identified by processing the data in a stepwise manner. If the outcome of the ST-Max is not determined in the first step, then it will move onto the next step in the process and so forth until an outcome can be identified. The detailed data processing steps are outlined below.

Step 1: Date of death

1. Using the table of ST-Max episodes joined to all other events, select those where the date of death (from the latest person details table) occurred either during the ST-Max service or within the 7 days after the ST-Max end date.
2. Set the outcome for these ST-Max episodes as 'NFA – Deceased' and sequel type = 1.

Step 2: Admitted to hospital

1. Select the ST-Max episodes where the event outcome of the ST-Max cluster is 'Admitted to hospital'.
2. Set the outcome for these ST-Max episodes as 'Admitted to hospital' and sequel type = 2.

Step 3: Service received

1. Find the ST-Max episodes where other events were either open on the ST-Max end date or started within the 7 days following the ST-Max end date.
2. From these, identify those who received at least one service during this sequel period.
3. If multiple services exist following a single ST-Max episode, select the one with the lowest rank (highest in the hierarchy). The service hierarchy is detailed in appendix 5.
4. Set the outcome for these ST-Max episodes as the service type and sequel type = 3.

Step 4: Concluding event outcome information from either ST-Max episode, non-service events in the sequel period or assessment or review events near the end of the ST-Max episode

1. For each ST-Max episode select all the following where available:
    a) The event outcome on the ST-Max episode where it is concluding (usable). This applies to all ST-Max episodes regardless of whether they have non-service events in the sequel period. See appendix 4 for a list of the concluding event outcomes.

b) Concluding event outcome/s from any non-service events in the sequel period.

c) Concluding event outcome/s from assessment or review events that occurred in the last 14 days of the ST-Max episode (referred to as nested events).

2. For each ST-Max, choose the event outcome with the highest ranking in the hierarchy, considering the event outcomes from the ST-Max, the non-service events within the sequel period and any assessments or reviews at the end of the ST-Max all together. These are then assigned a sequel type of 4a, 4b or 4c respectively. The event outcome hierarchy can be found in appendix 2.

Step 5: Equipment delivered during the reablement

1. Of the remaining ST-Max episodes where a sequel has not yet been identified, find those where equipment was delivered during the reablement.
2. Set the outcome for these ST-Max episodes as 'Short term support: ongoing low level'. This is based on local authority feedback and assumes that equipment delivered as part of the reablement service is left behind to support the individual.

Step 6: Unable to classify

1. For any remaining ST-Max episodes, the outcome will be set as the event outcome of the ST-Max and sequel type = 6. These will all be deemed 'unable to classify', as the event outcome suggests further support may be required, but it cannot be determined whether any immediate support was provided.

Appendix 4: ASCOF 2A outcomes

Service Type	Event outcome	Numerator	Denominator
Long Term Support: Nursing Care			✓
Long Term Support: Residential Care			✓
Long Term Support: Community			✓
Long Term Support: Prison			✓
Short Term Support: Ongoing Low Level		✓	✓
Short Term Support: Other Short Term		✓	✓
Short Term Support: Residential or Nursing Care			✓
	NFA - Information and advice/Signposting only	✓	✓
	NFA - Deceased		
	NFA - 100% NHS funded care		
	NFA - Self-funded client (including 12 week disregard)		
	NFA - Support declined		
	Service ended as planned	✓	✓
	NFA - moved to another LA	✓	✓
	NFA - Other	✓	✓
	NFA - No services offered: Other reason	✓	✓
	NFA - Support ended: Other reason	✓	✓
	Admitted to hospital		
	Progress to end of life care*		
	No change in package*		
	Progress to assessment*		
	Progress to financial assessment*		
	Progress to re-assessment/unplanned review*		
	Progress to reablement/ST-Max*		
	Progress to support planning/services*		
	Provision of service*		
	Any invalid event outcomes*		

*These outcomes are considered ‘unable to classify’ and excluded from the numerator and denominator as it cannot be determined whether further long term support was required or not.

Appendix 5: Service type and delivery mechanism hierarchy (ASCOF 2A and ASCOF 3D)

Service Type	Delivery mechanism	ASCOF 2A Hierarchy	ASCOF 3D Hierarchy
Long Term Support: Nursing Care		1	1
Long Term Support: Residential Care		2	2
Long Term Support: Community	Direct Payment (also identified through service component)	3	3
Long Term Support: Community	CASSR Managed Personal Budget	3	4
Long Term Support: Community	CASSR Commissioned Support	3	5
Long Term Support: Community		3	6
Long Term Support: Prison	CASSR Managed Personal Budget	4	7
Long Term Support: Prison	CASSR Commissioned Support	4	8
Long Term Support: Prison		4	9
Short Term Support: Ongoing Low Level		5	NA
Short Term Support: Other Short Term		6	NA

Appendix 6: Service information mapping to accommodation status (ASCOF 2E)

The mapping below is used when a person's accommodation status is 'Unknown', in order to infer their likely accommodation based on the services they received. If a person is in receipt of multiple services, a hierarchy is applied in the order they are listed below.

Service Type	Service Component	Mapped accommodation status	Living at home or with family
Long Term Support: Nursing Care	(any service component)	Registered nursing home	No
Long Term Support: Residential Care	(any service component)	Registered care home	No
(any service type)	Extra care housing	Sheltered housing, extra care housing or other sheltered housing	Yes
(any service type)	Shared Lives	Shared Lives scheme	Yes
(any service type)	Community supported living	Supported accommodation / supported lodgings / supported group home	Yes
Long Term Support: Community	Home Support	Unknown - presumed at home	Yes
Long Term Support: Community	(any service component except those listed above)	Unknown - presumed in community	No
Long Term Support: Prison	(any service component)	Prison / Young offenders institution / detention centre	No

Appendix 7: Accommodation status mapping (ASCOF 2E)

Accommodation Status	
Supported accommodation / supported lodgings / supported group home	Living at home or with family (supported)
Shared Lives scheme	
Approved premises for offenders released from prison or under probation supervision	
Sheltered housing / extra care housing / other sheltered housing	
Owner occupier or shared ownership scheme	Living at home or with family (unsupported)
Tenant	
Tenant - private landlord	
Settled mainstream housing with family / friends	
Mobile accommodation for Gypsy / Roma and Traveller communities	
Unknown - presumed at home	
Acute / long-term healthcare residential facility or hospital	Not living at home or with family (supported)
Registered care home	
Registered nursing home	
Prison / Young offenders institution / detention centre	
Rough sleeper / squatting	Not living at home or with family (unsupported)
Night shelter / emergency hostel / direct access hostel	
Refuge	
Placed in temporary accommodation by the council (inc. homelessness resettlement)	
Staying with family / friends as a short-term guest	
Other temporary accommodation	
Unknown - presumed in community	
Unknown	

Appendix 8: Carer support hierarchy (ASCOF 3D)

Event Type	Service Type	Delivery Mechanism / Service component	Event outcome	Hierarchy
Service	Carer Support: Direct to Carer	Direct payment		1
Service	Carer Support: Direct to Carer	CASSR Managed Personal Budget (and service component is not direct payment)		2
Service	Carer Support: Direct to Carer	CASSR Commissioned Support (and service component is not direct payment)		3
Service	Carer Support: Direct to Carer	Unknown (and service component is not direct payment)		4
Assessment Review Request			'NFA - Information & Advice / Signposting only'	5
Assessment Review			Not 'NFA - Information & Advice / Signposting only'	6
Service	Carer Support: Support involving the person cared-for			6