Mental Health Team Guidance

Document	Mental Health Team Guidance
Purpose	To show the process and system functionality for Mental Health Teams.
Version	V3.0
Owner	ICT Business Transformation Team / Adults System Support
Last Updated	18/07/2023

Contents

Guide Information

Areas of blue font contain details of the Wakefield Council agreed process

Areas highlighted in yellow contain details of the Care Act 2014 assessment and eligibility process

Areas of red font contain mandatory checks before completion.

Purpose

The purpose of this guide is to provide comprehensive information and guidance on Adult Social Care in Wakefield. It combines Caredirector guidance, Wakefield's processes, and the relevant Care Act legislation to support teams in carrying out their responsibilities in a lawful manner. While this guide covers essential aspects, it is not exhaustive, and practitioners should refer to the Care Act (2014) for complete information.

In cases where an individual has needs, a Care Act assessment is necessary. The assessment process follows the guidelines outlined in the Care Act (2014) and is illustrated in the process map developed by the Social Care Institute for Excellence. CMHT (Community Mental Health Team) is responsible for fulfilling the Care Act duties on behalf of the Local Authority, and adherence to the legislation is of utmost importance.

By following the guidance provided and complying with the Care Act (2014), practitioners can ensure that assessments and eligibility determinations are conducted appropriately and in accordance with legal requirements.
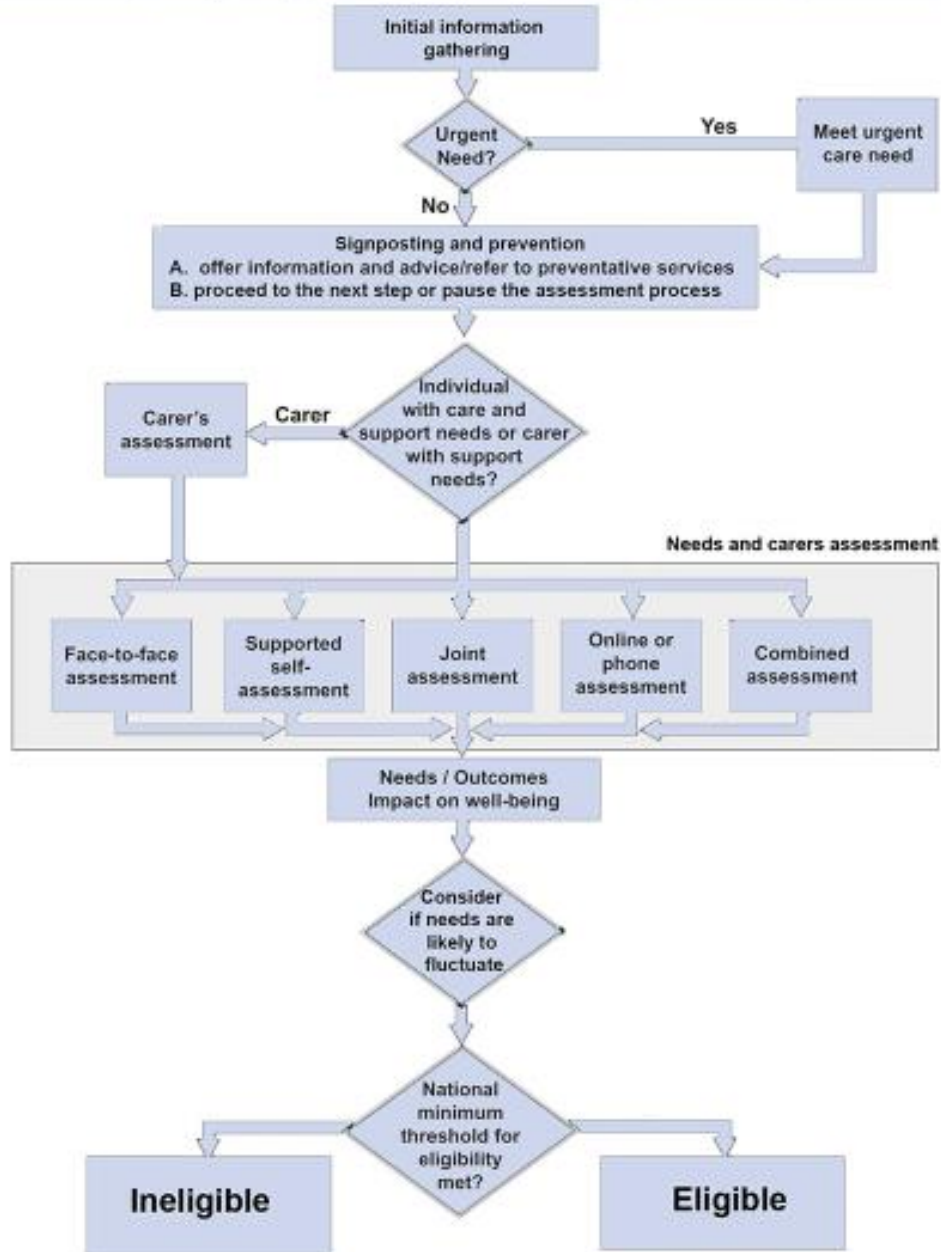
Wakefield Process

The agreed process in Wakefield is for referrals (Cases) to come directly to the Community Mental Health Team via Single point of access for anyone under 65 and Rapid access for over 65's. This is the primary agreed route for referrals to mental health services. The Single point of access/ Rapid access will undertake a short piece of work around the service user's mental health. If longer term mental health support is needed a referral is, then made to the most appropriate mental health service to support the service user and their carer. The community mental health teams are required to undertake statutory duties on behalf of the Local Authority should they be identified whilst working with someone's mental wellbeing. If an individual has an appearance of needs, there is a duty to assess that individual. Wakefield Council use Caredirector social care record system to record Care Act (2014) interventions, the system contains all the assessment and support/care planning tools required to record assessment, eligibility determinations, support planning and commissioned services.

If an individual has an appearance of need but does not have an open Case on Caredirector, a Case must be created to record the assessment and eligibility determination on the relevant documentations' tools. The creation of the Case is currently an admin function with the CMHT. It is a requirement of the Care Act that assessments, eligibility determinations and support planning must be recorded. This is also required should a service users carer require a carers assessment.

Assessment and Eligibility Process

Consider these six themes at each stage:

Mental Capacity	Advocacy & Participation Support	Impact on the family and carers	Safeguarding	Strengths -based Approach	Proportionate and Appropriate

Initial information gathering

Urgent Need? — **Yes** → Meet urgent care need

No ↓

Signposting and prevention
A. offer information and advice/refer to preventative services
B. proceed to the next step or pause the assessment process

Individual with care and support needs or carer with support needs?

Carer → Carer's assessment

Needs and carers assessment

Face-to-face assessment	Supported self-assessment	Joint assessment	Online or phone assessment	Combined assessment

Needs / Outcomes
Impact on well-being

Consider if needs are likely to fluctuate

National minimum threshold for eligibility met?

Ineligible — **Eligible**

Data restriction/ Code of Conduct

If you become aware that a relative or any other person known to you has a record in Caredirector, it is important to promptly inform your manager. Once notified, your manager will take the necessary steps to ensure the record is locked down in Caredirector through the eForms by Adults System Support.

Locking down the record means implementing additional security measures to restrict access and safeguard the confidentiality of the individual's information. This action is taken to protect the privacy and integrity of the record and prevent unauthorized access as well as protect the person who has declared the relative/ person known.

By notifying your manager and following the appropriate procedures, you contribute to maintaining the security and compliance of Caredirector and ensure the confidentiality of sensitive information.

Mental Health Access to Caredirector

1. All employees require training on Caredirector – access is restricted without it. (Manager) submit training request here: External

2. Please check if you have "Remote Desktop" app. If not, contact your external IT support desk and they will download it.
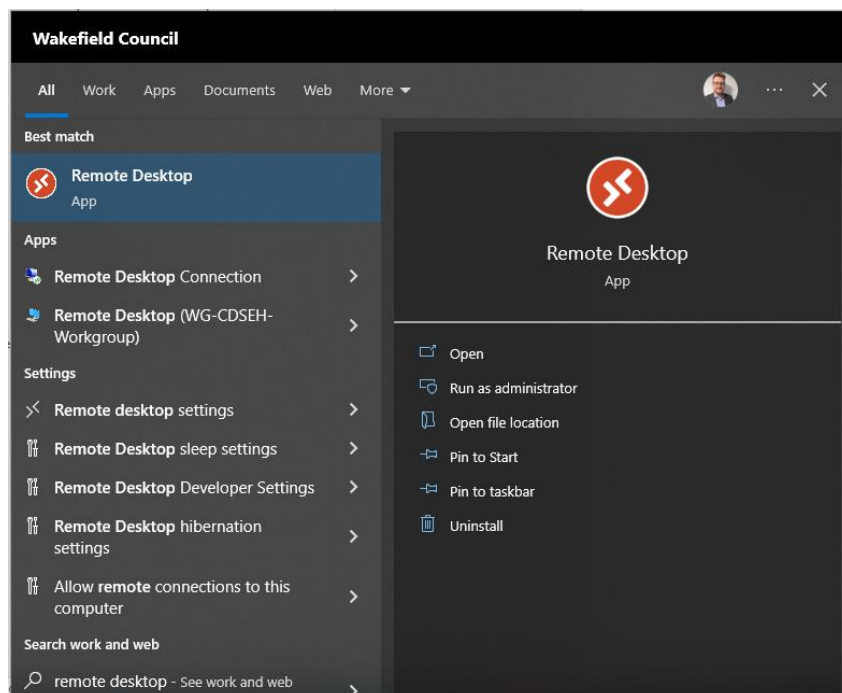
3. When you can access "Remote Desktop" check for "Caredirector V6". If you cannot see this option, contact Adults System Support through our eForms system requesting access: [External](#)

   a. Include your name, email address, contact number (work mobile not office), someone else in your team who already has access.

   b. Please allow up to 10 days for this to be ready and Adults System Support will be in touch to give the next stage.

Practitioner

Finding Allocated Cases

1. The primary purpose of Caredirector is to provide a comprehensive overview of an individual's care journey and effectively manage it. It accomplishes this by allowing users to add various components such as forms, activities, and other relevant information. Caredirector serves as a centralized platform where all aspects of a person's care can be documented, tracked, and managed. It enables healthcare professionals and caregivers to have a holistic view of the individual's care, facilitating better coordination, decision-making, and ensuring that their care needs are met effectively.

2. A practitioner holds the responsibility of effectively managing their case load and ensuring that Caredirector is consistently updated with relevant information. This includes documenting any conversations, events, or developments pertaining to the individual's care. It is essential to keep Caredirector up to date with the current situation, progress, and future for the person under their care. By maintaining accurate and timely records, practitioners contribute to the overall continuity of care and enable effective collaboration among the care team.

3. Managers or team leaders typically assign cases to practitioners, and these allocated cases are displayed on the practitioners' home screen dashboards in Caredirector. When practitioners open Caredirector, their home screen will show a dashboard specifically tailored for them, which includes a section called "My Cases." This section provides an overview of the cases assigned to the practitioner, allowing them to easily access and manage their workload. The My Cases dashboard provides practitioners with a centralized view of the cases they are responsible for, enabling efficient case management and timely follow-up on tasks and actions.

4. The "My Cases" section on the home screen in Caredirector provides practitioners with a convenient way to view and manage their assigned cases. It consists of two widgets: Primary Cases and Secondary Cases.

   a. Primary Cases: This widget displays cases where the practitioner is assigned as the Responsible User. These are the cases for which the practitioner has direct responsibility, and they should actively work on and monitor these cases.

   b. Secondary Cases: This widget shows cases where the practitioner is involved as a secondary participant or has a supporting role. While not personally responsible for these cases, practitioners may need to stay informed about their progress and contribute as needed.

5. The separation between Primary Cases and Secondary Cases helps practitioners prioritize their workload and focus on the cases they are primarily responsible for. There should only be one primary social care case open at any one time. However, a safeguarding case, mental health act could be open at the same time.

6. Select the relevant person from your list by clicking anywhere on that row this will open the **Case Record.**

7. **Details** tab next to **Timeline** in the middle row will open why the person was referred and will provide information about it.

8. **Details** will also show who is the responsible user and responsible team. Due to the reason that this **Case** showed in your **Home Screen** dashboard under **Case Involvement** this will mean that you are the **Responsible User** for this case.

a. An alternative way of finding this information is by expanding the **person banner** to show the **Case** responsible user/ team as well as their current address and contact information.

9. If this was under the **Secondary User** widget, then your name will appear: **Menu > Related Information > Involvements**
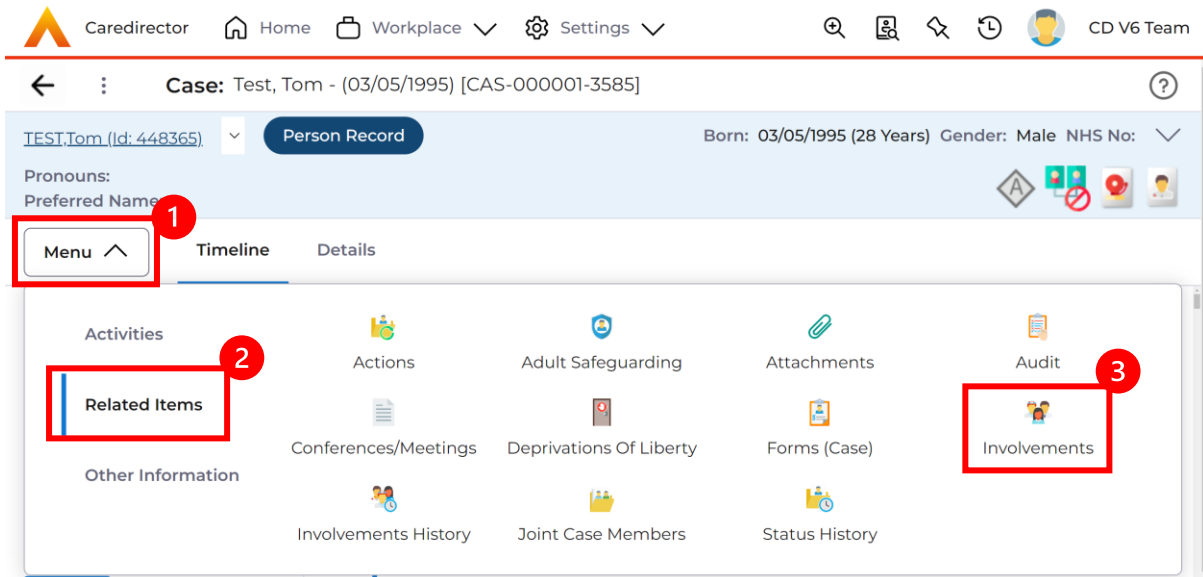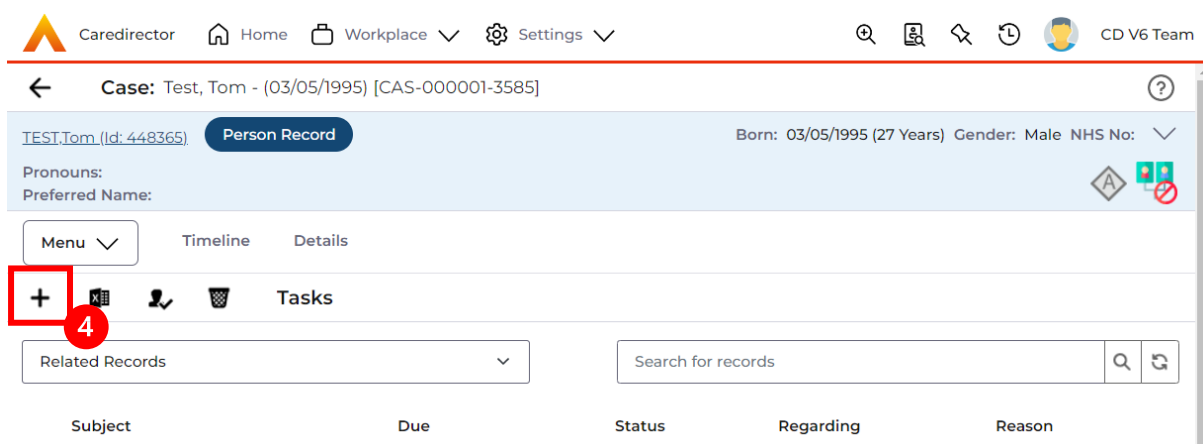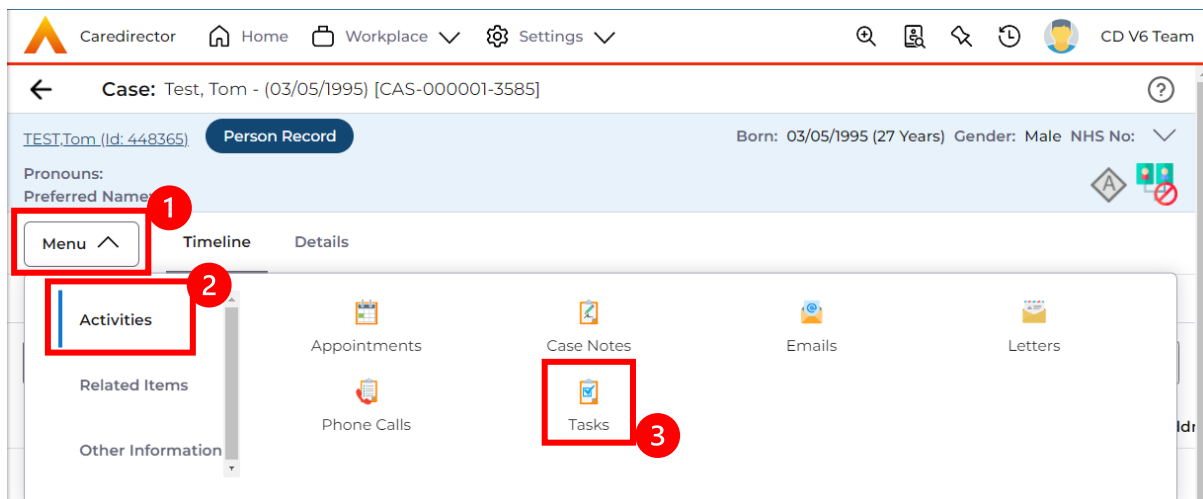
Case Record

From this **Case Record** you will be responsible for updating and creating **Activities** and **Forms** to show the journey of the person and display what is currently happening.

Activities

1. To create an **Activity,** select **Menu > Activities** then select the appropriate activity. These are what each mean:

    a. **Tasks/Case Notes**: To note an event or action that requires recording on this case. (This generally means something that does not need further actioning).

2. Please use the relevant activity to record the required information. To create a current activity, select the activity and select **Create New Record** from the toolbar.

3. Allocating an activity to the appropriate person is crucial when there is a specific action required. By assigning it to the correct individual on Caredirector, it will be visible in their "My Activities" or "Team Activities" section for them to address. The initial step in this process is changing the responsible user to the desired person using the Lookup Function. This allows for seamless assignment and ensures that

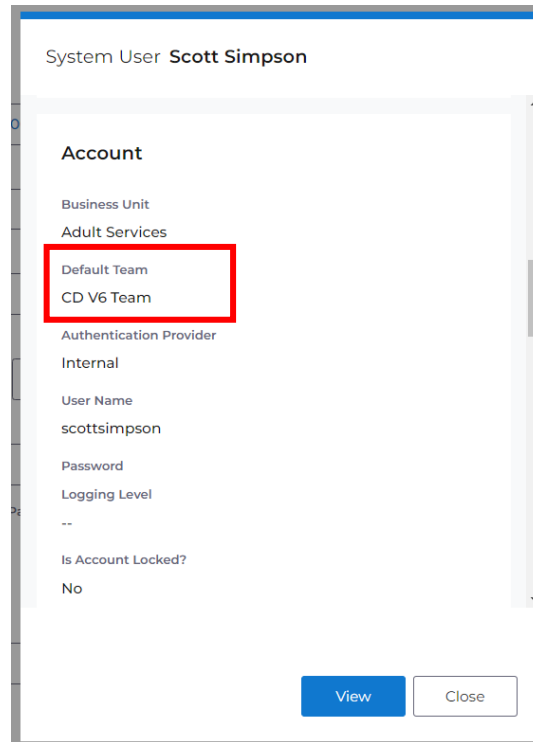4. However, if that person is not known, select the **X** and leave blank and instead just focus on the **Responsible Team**.
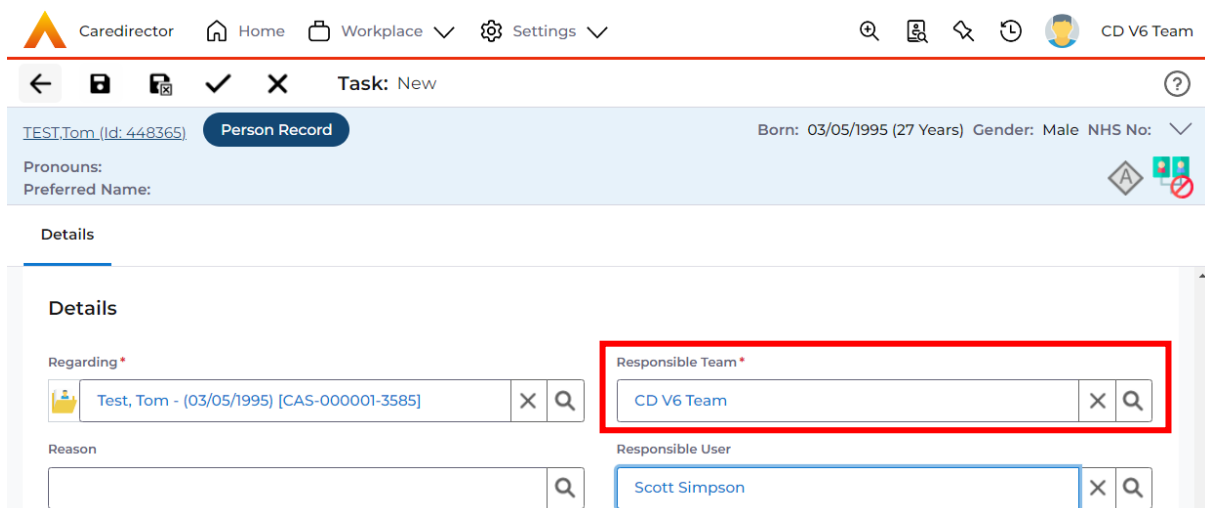

5. If you do know, who this is going to be sent to, but you do not know what team they are part of. A quick way of checking is to select their name (it should be in blue).
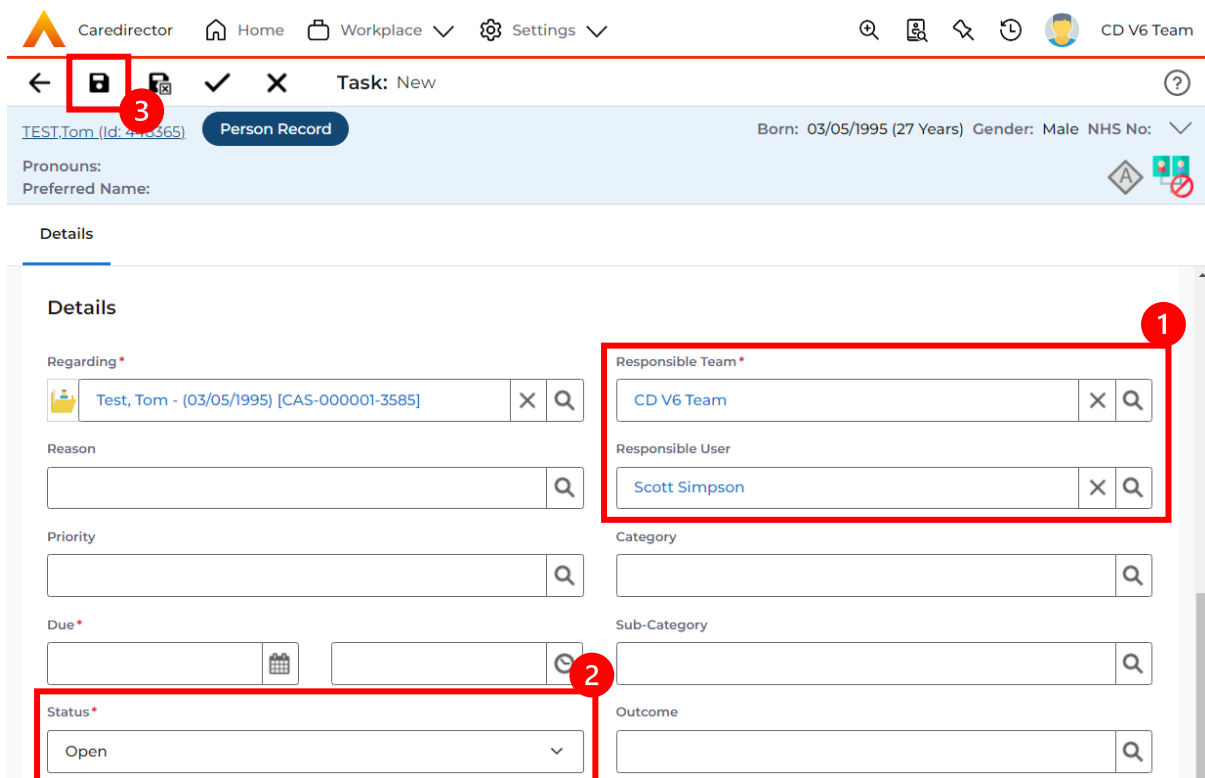
6. Once clicked, it will show their system user profile and most importantly, their default team.

7. Use that information, to input the mandatory field **Responsible Team**.

8. Once the system knows who and which team you want to send it to, leave the **Status** as **Open**. If it is set as **Completed,** then it will just stay where you put it but will not show on the person/ team's dashboard. Then select **Save.**
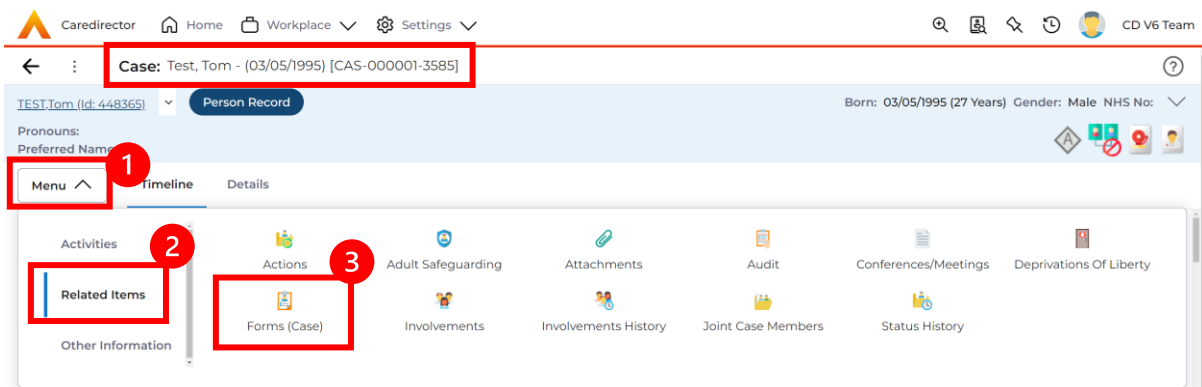

9. Anything that you will need to do will pop up on your dashboard.

10. There may be times where you need to view all activities. This is useful if you want to see a clear picture of everything and that person's journey. To do this, go to **Person Record > All Activities > Clear Filters > Search**
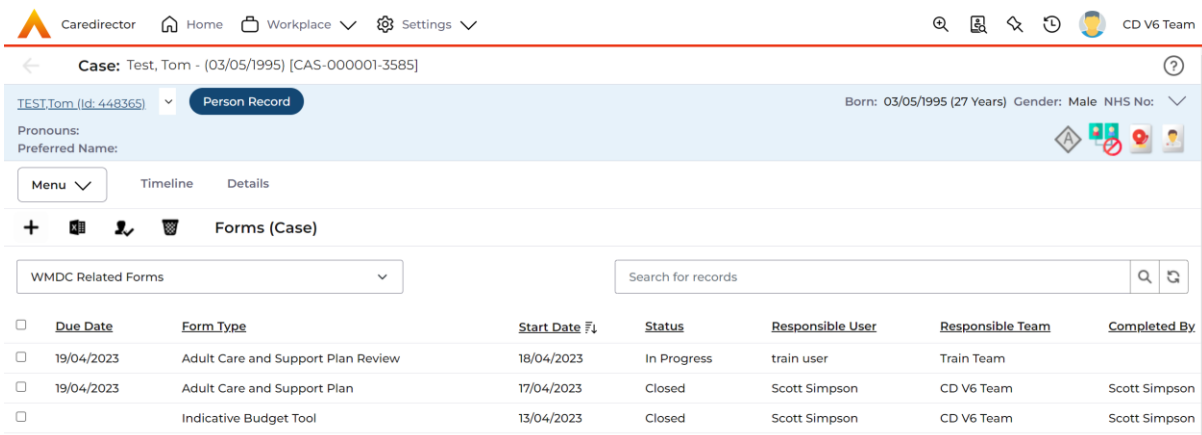
Forms (Case)

1. This section specifically addresses forms within Caredirector and provides guidance on various considerations when collaborating with them. The Form guide contains detailed information on creating, editing, and cloning form data. It is a valuable resource for understanding the specific functionalities and processes related to forms within Caredirector.

2. Forms are created in a **Case Record**. This is where you go to create a **Form**. **Case Record > Menu > Related Items > Forms (Case)**

3. Once selected, it will give a list of current forms that have already been created on this case and the ability to create a new one.

a. If a form has already been created, you can view and edit the form by selecting the **Pencil Icon (Edit)** which is available whilst the form is set as **In Progress** or to view the form use the **Eye Icon (View Only)** which is available whilst the form is set as **Closed**.

Pencil Icon (Edit)

Eye Icon (View Only)

b. To create a new form, select **Create New Record** on the **toolbar.** Please note: For most forms, you cannot create two of the same form whilst the **Status** is set as **In Progress** or **Complete,** they must be **Closed**.

4. Once the form creation screen is open, we need to tell Caredirector what form is going to be created and who is responsible for it. Select the **Form Type** using the **Lookup Function** and the **Responsible User**. Select **Save** and you will notice the **Pencil Icon** will appear.

a. If the responsible user is a practitioner, then it will show under the **My Forms** dashboard on the **home screen.**

5. Once a form has been created, edited and all the information inputted, it will need to be set to complete. To do this:
   Forms (Case) > Open Form > Status > Complete and press save.

6. If the form requires closure from manager, the form will become visible on the managers home screen for them to **Close**, if not then the form will automatically close.

Indicative Budget Tool Form

The allocation of a clear upfront indicative (or 'ball-park') budget at the start of the planning process will help people to develop the plan and make appropriate choices over how their needs are met. You must inform the individual that this amount may change depending on the agreed outcomes in meeting needs and the individual's financial contribution, with the potential of the support plan being £0 costing.

1. The indicative Budget tool is on Caredirector can be found within Forms (Case).

2. The Indicative Budget tool is flexible and accessible to allow practitioners to use on different assessment interventions.

3. The indicative budget is based on The Care Acts National Eligibility Criteria outcomes. This requires practitioners to use their professional judgement in assessing the severity of the eligible needs and the impact on wellbeing (with amalgamated guidance). Practitioner's professional judgement will be quality assured by Team managers through the recorded assessment intervention (Conversations Record or Interim and/or Support Plan).

4. The new costing formulas will create a unique banding amount based on individual's needs.

5. The Indicative Budget Tool is not to be used to identify the final personal budget amount it is only to be used to inform the support planning process.

Adult Conversation Record Form

Once the Adult Conversation Record has been created and edited, please ensure the appropriate short- & long-term support information is entered within the form itself.

Activity Type	New Client – Support Request
Route of Access to Services	Community / Other Route
Sequel to Request for Support	Long-term support – Community Based or as appropriate

Please note: These options function as skip logic for when the 'Is the client current in receipt of Long-Term Support Services commissioned or provided by Wakefield MDC?' question has been answered **No.**

The Care Act 2014 provides the Local Authority (and others performing duties on their behalf) with the power to meet urgent need without undertaking an assessment or deciding of eligibility, regardless of the person's ordinary residence.

There will be instances where it is obvious that immediate action is required, and in such cases, it is likely that the assessment will be paused to be resumed later so a fuller assessment can be conducted.

Circumstances under which needs could be classified as urgent include, for example:

1. people who are terminally ill

2. rapid deterioration in an adult's condition

3. the occurrence of an accident

4. a specific issue such as a stroke

5. evidence of a safeguarding issue

6. unsafe living quarters

This applies equally to adults with care and support needs and to carers with support needs.

Eligibility criteria for adults with care and support needs under the Care Act 2014
When determining eligibility, Local Authorities (and others performing duties on their behalf) must consider the following three conditions.

Condition 1
The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

This includes if the adult has a condition because of physical, mental, sensory, learning, or cognitive disabilities or illnesses, substance misuse or brain injury.

Condition 2
As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section 'Eligibility outcomes for adults with care and support needs.'

Local Authorities (and others performing duties on their behalf) must also be aware that 'being unable' to achieve an outcome includes any circumstances where the adult is:

1. unable to achieve the outcome without assistance. This includes where an adult would be unable to do so even when assistance is provided. It also includes where the adult may need prompting. For example, adults may be physically able to wash but need reminding of the importance of personal hygiene.

2. able to achieve the outcome without assistance but doing so causes the adult significant pain, distress, or anxiety. For example, an older individual with severe arthritis may be able to prepare a meal but doing so will leave them in severe pain and unable to eat the meal.

3. able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others. This would include, for example, cases where the health or safety of another member of the family, including a child, could be endangered when an adult attempts to complete a task or an activity without relevant support.

4. able to achieve the outcome without assistance but takes significantly longer than would normally be expected. For example, a physically disabled adult can dress themselves in the morning, but it takes them a long time to do this, leaves them exhausted and prevents them from achieving other outcomes.

Local Authorities (and others performing duties on their behalf) must consider whether the adult is unable to achieve the complete range of outcomes contained in the criteria when making the eligibility determination.

There is no hierarchy to the eligibility outcomes – all are equally important.

Condition 3
Because of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing, determining whether:

1. the adult's needs impact on at least one of the areas of wellbeing in a significant way or

2. the cumulative effect of the impact on the area of wellbeing means that they have a significant impact on the adult's overall wellbeing.

Interim Support Plan - Care Act (2014) Core Duties

The Local Authority (and others performing duties on their behalf) must:

1. seek to establish the total extent of needs through the assessment before considering the person's eligibility for care and support;

2. undertake proportionate and appropriate assessments of any adult or carer with an appearance of need, irrespective of any presumptions of the eligibility of the person's needs or financial situation

3. give the person, from their first contact with the Local Authority (and others performing duties on their behalf), as information as possible about the assessment process, in a format that is accessible to the person.

This applies equally to adults with care and support needs and their care workers.

Information gathered at first contact at this stage might usefully establish the basic facts about:

1. whether the person has the capacity to understand and articulate their own needs

2. whether the person has difficulty communicating their needs (e.g., due to autism or profound and multiple learning disabilities, mental health needs or dementia).

3. whether the person faces any safeguarding issues.

4. the person, their needs, expected outcomes in day-to-day life and the overall impact of the current circumstances on their wellbeing.

5. the Local Authority (and others performing duties on their behalf) could also consider whether the person has an immediate network of support and how this network contributes to the individual achieving their desired outcomes.

6. It is important for the Local Authority (and others performing duties on their behalf) to consider that of the people who qualify for independent advocacy under the Care Act may also qualify for a mental capacity advocate (MCA). The same advocate can therefore supply support as an advocate under the Care Act and the Mental Capacity Act. This ensures that the person receives seamless advocacy support and avoids them having to repeat their stories for support under different legislation to different advocates.

The Local Authority (and others performing duties on their behalf) must:

1. consider whether the individual's needs impact upon their wellbeing and show the impact of this on the adult's desired outcomes.

Client Level Data
Purpose & Forms

1. The new Client Level Dataset is a key project in the journey to transforming adult social care data. The new mandatory data collection will supply more timely, detailed data and will, for the first time, enable linked health and social care data, plugging the gaps in our knowledge of how people move between health and social care, how they experience these transitions and the resulting care outcomes. The data collection will enable prompt monitoring of demand and, also the provider market. This will be vital over the coming year when economic pressures are likely to affect both.

2. CLD holds details of the main events and interventions in an adult's journey through the Social Care system when they approach us as a Local Authority for funded care. It will be possible to assess differences in demand and service use by age, gender and ethnicity and describe variations in costs by provider and service type. The new data collection is mandatory from 1st April 2023 with our first submission due July 23.

3. The CLD specification holds 50 data fields, 33 of which are mandatory from April 2023 and made up of the data required to reproduce key ASC activity statistics currently reported via the SALT return, which CLD will supersede in 2025.

4. These are the **Forms** that **Client Level Data** has been introduced in.
   a. Adult Interim Support Plan
   b. Carers Support Plan Review
   c. Adult Conversation Record
   d. Occupational Therapy Conversation Record
   e. Occupational Therapy Review
   f. Adult Care and Support Plan Review
   g. Reablement Physiotherapy Input Form
   h. Carers Conversation Record
   i. Occupational Therapy Referral (Secondary Allocation)
   j. Sensory Impairment Referral (Secondary Allocation)
   k. Referral for Reablement – Outreach/Discharge Support
   l. Mental capacity assessment/ best interest
   m. Mental health act
   n. Continuing health care checklist

5. Underneath **Office Use Only** section is where this section is held.

Client Level Data

Event type

Event outcome

SALT Data

Is the client currently in receipt of Long Term Support Services commissioned or provided by Wakefield MDC? (equipment is not deemed as long term support)

Yes ○   No ○

6. To find more information about "Client Level Set Data," you can go to TriX and perform a search using that term. TriX is a resource that supplies additional documentation and guidance on diverse topics related to the system. By searching for "Client Level Set Data," you should be able to access relevant materials and resources related to that topic.

Financial Assessment - What must local authorities do after an eligibility determination for the Care Act 2014?

1. The information below applies to **Financial Assessment Forms** linked in this section, you will need the **Form Type** as:

   a. Financial Assessment (NRS) - For non-residential care i.e., domiciliary care, assisted technology, day support

   b. Financial Assessment (Respite) - For respite care

   c. Financial Assessment (Residential) - For long-term 24-hour care

   You will enter these inside of **Form Type**

Whether or not the Local Authority (and others performing duties on their behalf) decides that an adult with care and support needs or a carer with support needs has eligible needs, it must inform the individual of its eligibility determination and the reasons for it. It must also provide the individual with a written record of the determination and reasoning.

If **no eligible needs** have been found, the Local Authority (and others performing duties on their behalf) must provide information and advice for the individual on:

1. what can be done to meet or reduce the needs that are not eligible

2. what services are available in the community that can support the individual in meeting those needs

3. what can be done to prevent or delay the development of needs in the future.

See further detail on supplying information and advice in the Care Act Statutory Guidance.

If **but not all** the individual's needs are eligible, the Local Authority (and others performing duties on their behalf) must:

1. supply information and advice for the individual about the needs that are not eligible:

2. inform what can be done to meet or reduce those needs

3. inform what services are available in the community that can support the individual in meeting the needs

4. inform what can be done to prevent or delay the development of needs in the future
5. consider how the eligible needs will be met

6. conduct a financial assessment where it proposes to make a charge for meeting those needs.

If the individual has **eligible needs**, the Local Authority (and others performing duties on their behalf) must:

1. consider how those needs will be met

2. conduct a financial assessment where it proposes to make a charge for meeting the needs.

In all cases, any **preventative measures** should be considered, regardless of the outcome of the eligibility determination, such as telecare, enablement/reablement.

The Local Authority (and others performing duties on their behalf) should bear in mind that **eligibility may change over time** due to changing circumstances or needs e.g., moving location, changing general practitioner.

The Local Authority (and others performing duties on their behalf) must establish whether the adult/carer is **ordinary resident** in its area and meet eligible needs of those individuals who are ordinary residents.

In Wakefield, the referral process for a financial assessment is entirely managed within CareDirector. Diverse types of care require specific financial assessments:

1. Non-residential care: A Financial Assessment (NRS) needs to be completed. For non-residential care i.e., domiciliary care, assisted technology, day support
2. Respite care: A Financial Assessment (Respite) needs to be completed.
3. Long-term 24-hour care: A Financial Assessment (Residential) needs to be completed.

Once you have filled in the necessary details in the form, you should change the status of the form to "Complete." For respite and residential care, this action triggers a notification to your manager, who must sign off on the form. Once signed off, the Personal and Assessment Team will be notified, and they will proceed with the financial assessment. However, the NRS form does not require additional sign-off, and once completed, it automatically notifies the Personalisation and Assessment Team to conduct the financial assessment.

An online self-assessment on finance is being rolled out. Please tick the box should a service user/ relative use this function so that the finance team can move their assessment on quicker.

A copy of the LPA should be seen and attached to the case referral. See attachments.

Please note that even when an individual falls under Section 117, a Financial Assessment Referral Form is **still necessary** as the team will conduct benefits work and ensure that the relevant services are made aware to not involve the service user for support. For more detailed information about the statutory requirements regarding care and support planning and review of the care and support plan, please refer to the Care Act guidance.

The personal budget
(https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

11.7 Everyone whose needs are met by the Local Authority (and others performing duties on their behalf), whether those needs are eligible, or if the Authority has chosen to meet other needs, must receive a Personal Budget as part of the care and support plan, or support plan. The Personal Budget is a valuable tool that gives the person clear information about the money that has been given to meet the needs shown in the assessment and recorded in the care and support plan. An indicative amount should be shared with the person, and anybody else involved, at the start of care and support planning, with the final amount of the Personal Budget confirmed through this process. The detail of how the Personal Budget will be used is set out in the care and support plan, or support plan. At all times, the wishes of the person must be considered and respected. For example, the Personal Budget should not assume that people are forced to accept specific care options, such as moving into care homes, against their will because this is perceived to be the cheapest choice.

The following documents must be completed to generate a Personal Budget, record the care and support required and to request a Financial Assessment:

1. Adults Conversation Record

2. Adults Support Plan - Once the Adults Support Plan has been completed a notification will go to the Support Services Dashboard for a Service Provision recording.

3. Financial Assessment Referral (NRS), (Residential) or (Respite) – once the FA Referral Form has been completed for (NRS) and closed for (Residential and Respite) a notification will go to the FA Team to conduct a Financial Assessment

Safeguarding Information

1. Having knowledge of the location where safeguarding information is stored is crucial when dealing with mental health or safeguarding cases. It ensures that relevant information can be accessed and utilized appropriately. To find this:
Case Record > Menu > Related Items > Adult Safeguarding
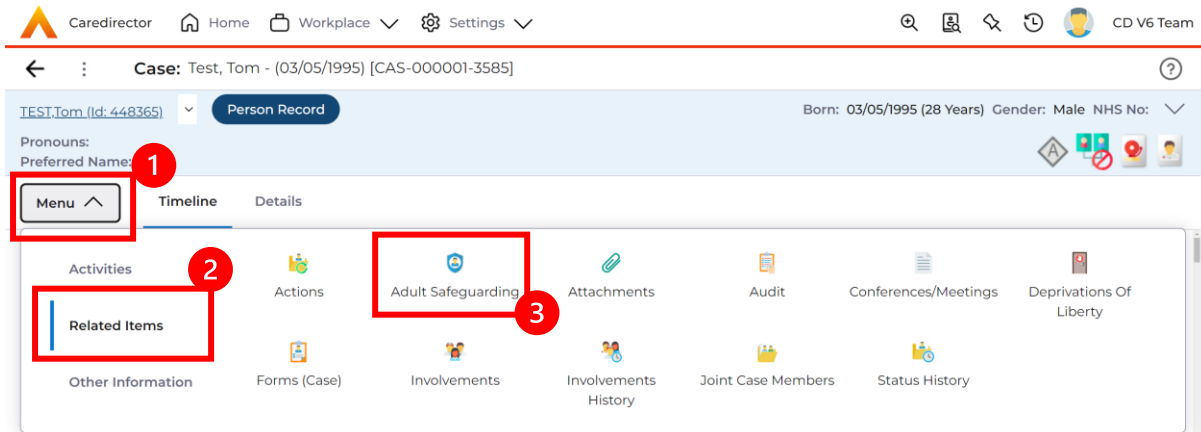
2. From this point, you have two options: you can either create a new entry or review an existing one. Choose the appropriate action based on your needs and requirements.

Transfer Requests

1. Transfer requests can happen if a case requires to be sent to another team to continue work. This can happen for a variety of reasons however, to do this – the **Responsible Team/ Responsible User** requires changing. To find this go to: **Case Record > Details > Assignment Information**.

2. If you have been actively working on the case, your name will be listed in the Responsible User field along with your team in the Responsible Team field. Please note that the Lookup function will be disabled (greyed out) for the Responsible Team field but not for the Responsible User field. This indicates that changing the Responsible User to another team member within the same team is a straightforward process.

3. However, changing the Responsible Team requires a slightly different approach and additional steps to be taken. Go to **Case Record > Details > Assign this record to another team**

4. When selected, it will bring up **Responsible Team** option to change. Choose the relevant team by selecting, changing the **Look into Lookup View** and select from the list. The **Responsible User Decision** works in two parts if you know who this is being transferred to and if you do not know who it is being transferred to.
   a. If you do know select **Change on Current Record Only** and enter their name in the new field.
   b. If you do not know select **Clear on Current Record Only**

Assign

Responsible Team *

Adult Safeguarding Team   ✕   🔍

Responsible User Decision *

⌄

Do not change
Change on current record only
Change on current and child records
Clear on current record only
Clear on current and child records

5. Select **Save** and once done, this will now automatically change the **Assignment Information** to the new **Responsible Team/ Responsible User** (if selected)**.**

Closures

1. When the **Case Record** requires closing, go to:
   Case Record > Details > Assignment Information > Case Status.

2. There are options to choose from inside the **Case Status**.

3. Before proceeding with the closure, it is important to perform checks to ensure that all necessary requirements are met. Such as ensuring there is a closing summary on a task note of the rationale for involvement, what outcomes have been achieved/ support offered and reason for closure. Please follow these steps:

   a. Activities: Check that all activities are marked as completed. To do this, go to Menu > Activities and review each activity type to ensure they are set to the "Completed" status.

   b. Forms: Verify that all forms are closed. Go to Menu > Related Items > Forms (Case) and ensure that all forms associated with the case are marked as closed.

   c. Deprivations of Liberty: Make sure that any Deprivations of Liberty have an actual authorization end date and that the specified time has passed. Access Menu > Related Items > Deprivations of Liberty to verify this.

   d. Involvements: Check that all involvements have an end date and that the specified time has passed. However, note that the Responsible Team and Responsible User in the Involvements section, which match the ones in Detail > Assignment Information, should not have an end date. Leave them with their respective start dates.

4. Once you have verified these areas, return to Details > Assignment Information > Case Status and change it to the relevant option. Selections may prompt additional fields for you to review and provide a reason. After making the necessary changes, save the record, and it will be automatically sent to your manager for authorization.

Mental Health Act Assessment
1. The primary location for completing Mental health act assessments is on Caredirector.

2. The closing of a mental health act assessment will be undertaken by the allocated mental health act assessor.

Person Record

1. The **Case Record** is the primary area where you will spend your time working. It encompasses all aspects related to the case, and any updates or relevant information should be documented in this section of the system. On the other hand, the Person Record contains more comprehensive information about the individual in general, providing a broader overview of their details.

2. As a reminder, to search for a person record simply, select:
   Person Search Icon > Enter their information or ID > Search
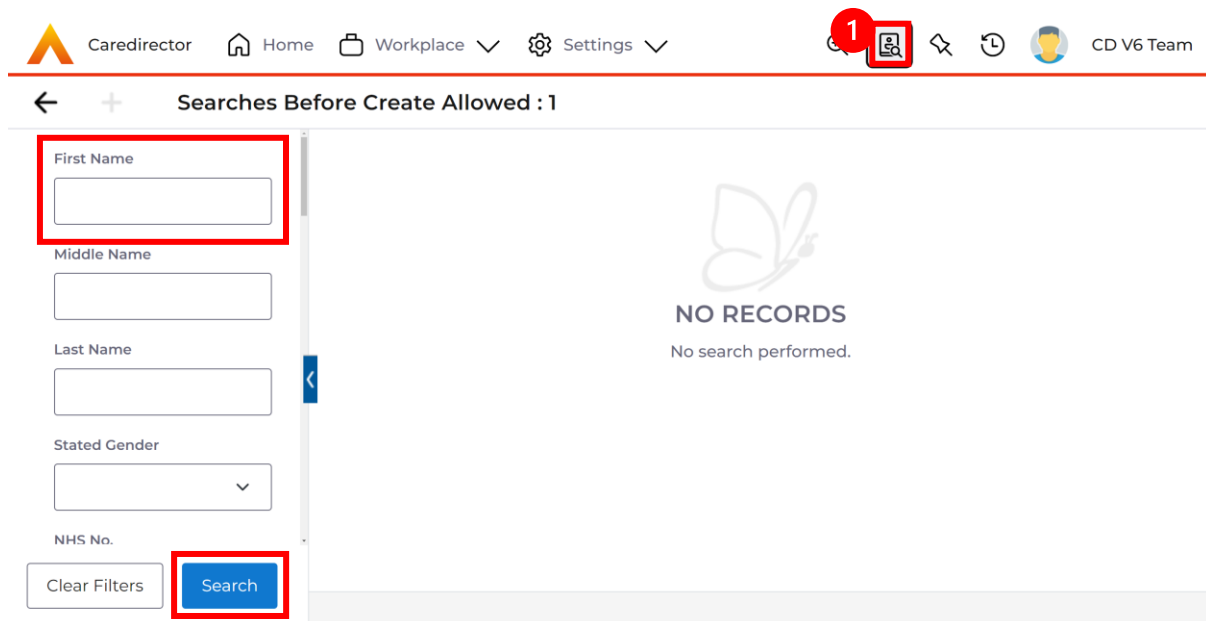
3. However, while using this booklet, you will find yourself inside the Case Record. To navigate to the Person Record, locate the blue underlined hyperlink within the Person Banner. This hyperlink is available in various records if it is linked to the respective person. By clicking on this hyperlink, you will be directly taken to the person record.
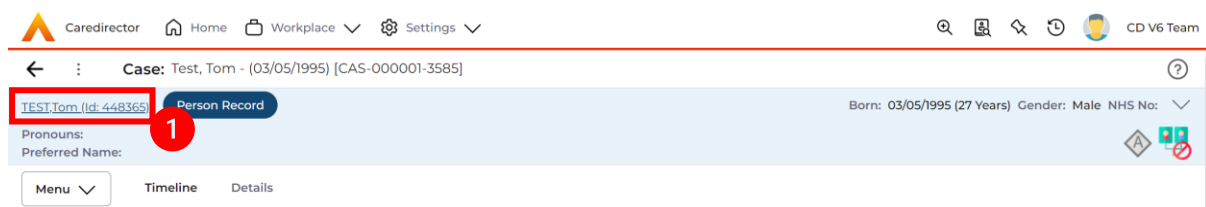
Visiting the person

1. There are occasions where you need to visit the person. For safety and access, two areas of Caredirector focuses on keeping the practitioners safe and to gain access to the property/ facility.

Alerts and Hazards

1. Alerts and Hazards are a way to keep you informed if there is a potential hazard when visiting the individual. This will be indicated by a **red bell icon** on the **Person Banner**.
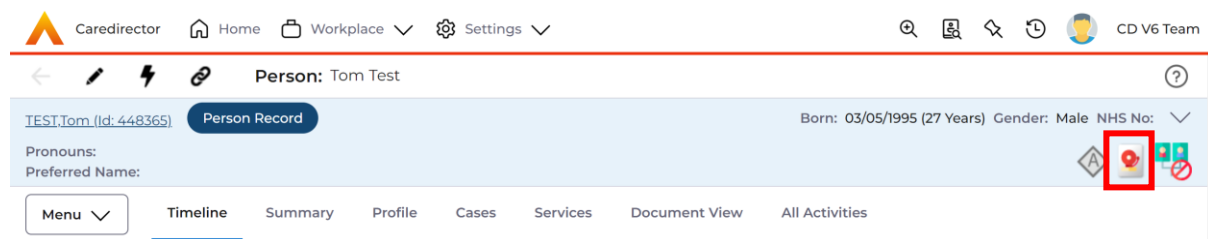
2. To access further information, go to:
   Menu > Related Items > Alerts and Hazards
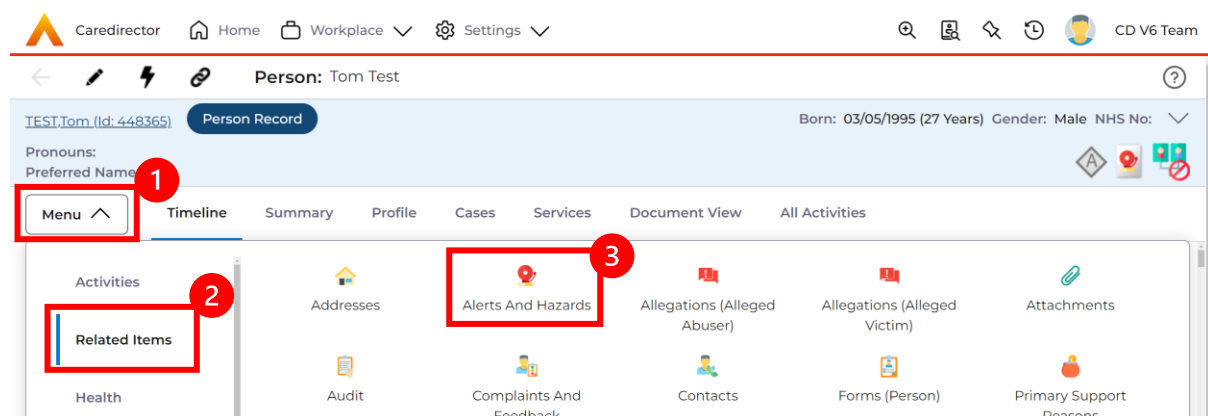
3. This will show a list of the alerts and if you click on one it will show the details.

Key Safe

1. Sometimes, there may be an access code required to gain access to a property. To find this
Person Record > Edit Button (Pencil Icon)
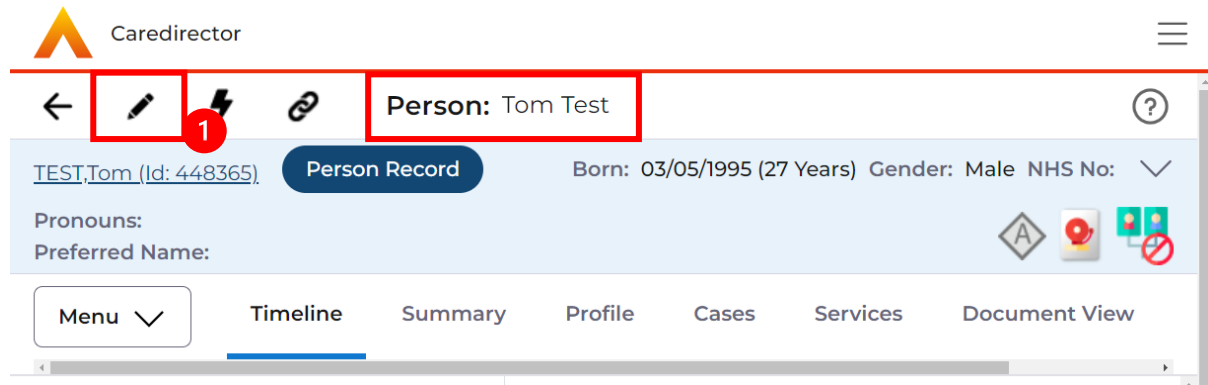
2. Scroll down until you see **Access Information**
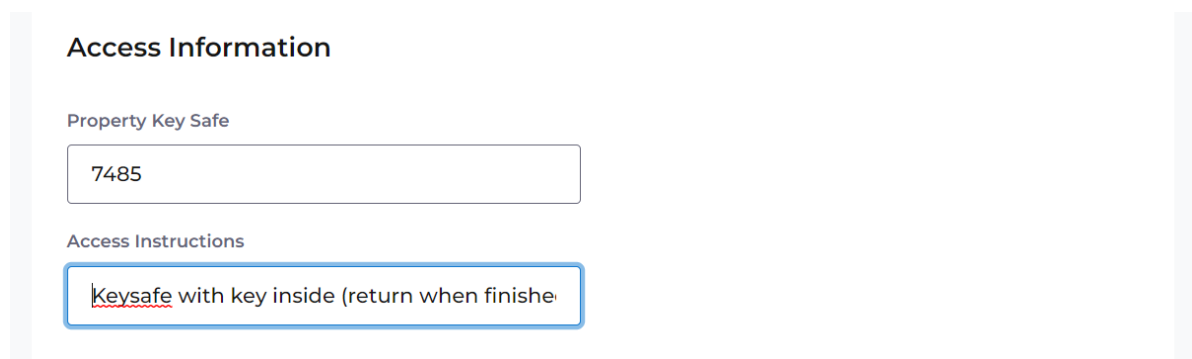
Relationships (External Contact Information)

1. There are instances when the point of contact may not be the person you are currently working on. To view the details of an external contact and their relationships, there are two methods available. However, I will demonstrate the preferred method for you. Go to:
   Person Record > Person Banner > Dropdown Arrow > Select Person
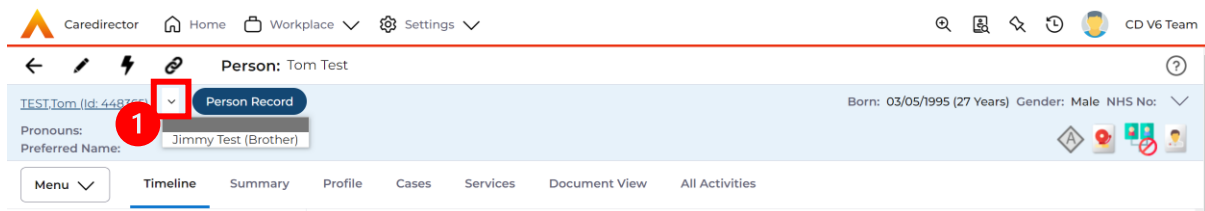
2. Once you select the other person from the dropdown list, this will navigate to the other person's record. Use the dropdown arrow to view contact information.
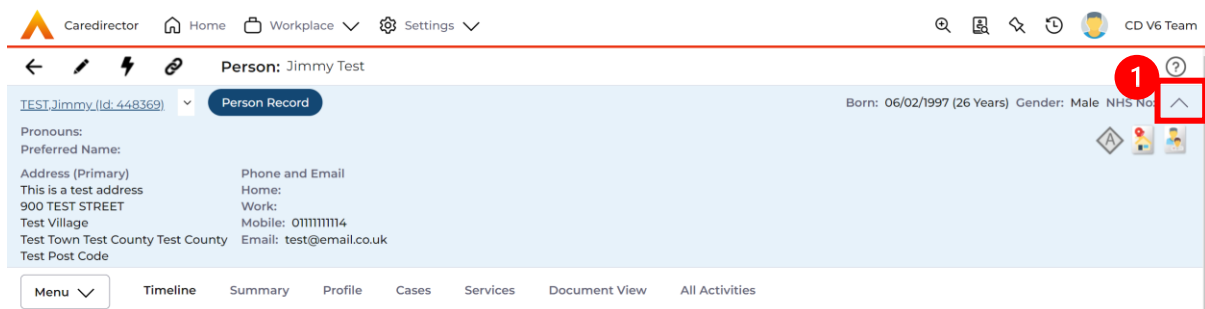
3. Use this contact information.

Attachments

1. Attachments are generally added by Admin but to view them go to the:
   Person Record > Menu > Related Items > Attachments
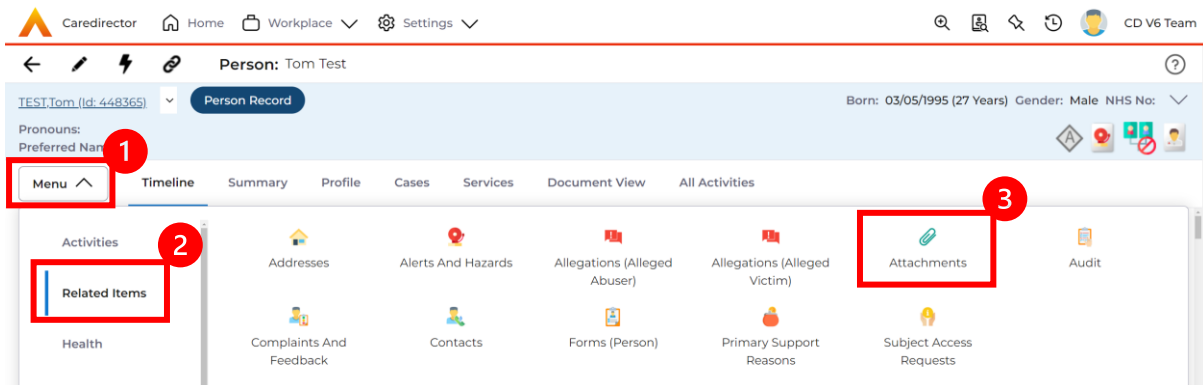
2. When opened, it will show if there are any attachments available. If there is select one, and the document to open is under the **File** field.
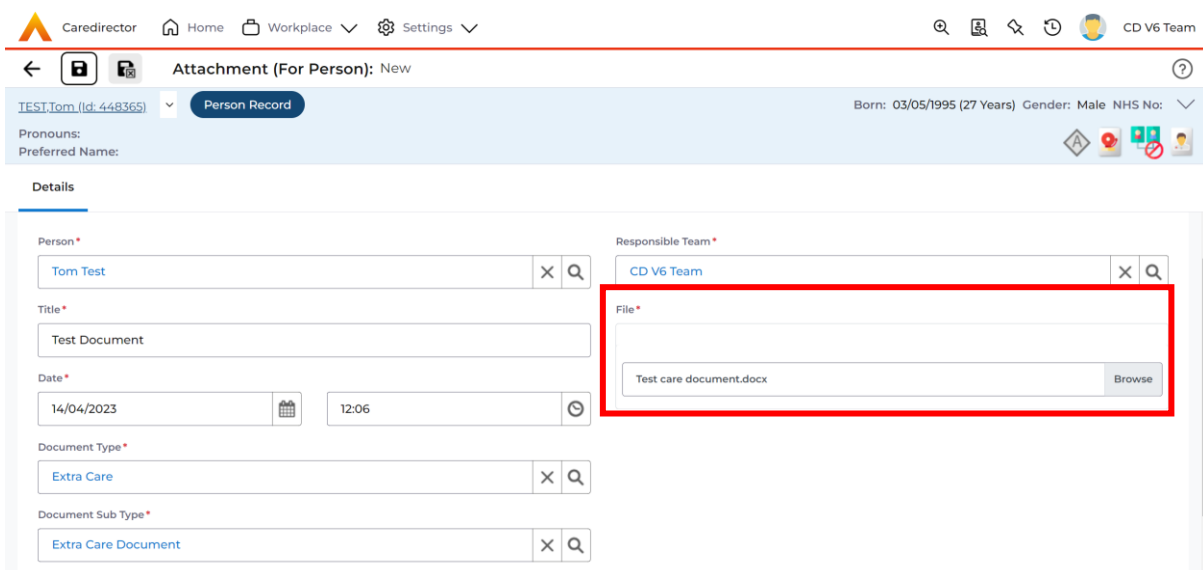
Section 117 Entitlement (CURRENTLY NOT USED)

1. Locate the **Person Record**, select **Menu**, **Mental Health Act,** and then **Section 117 Entitlements**. Please ensure that the date of the 117 is the date of when the person was sectioned under SECTION 3 of the mental health act.
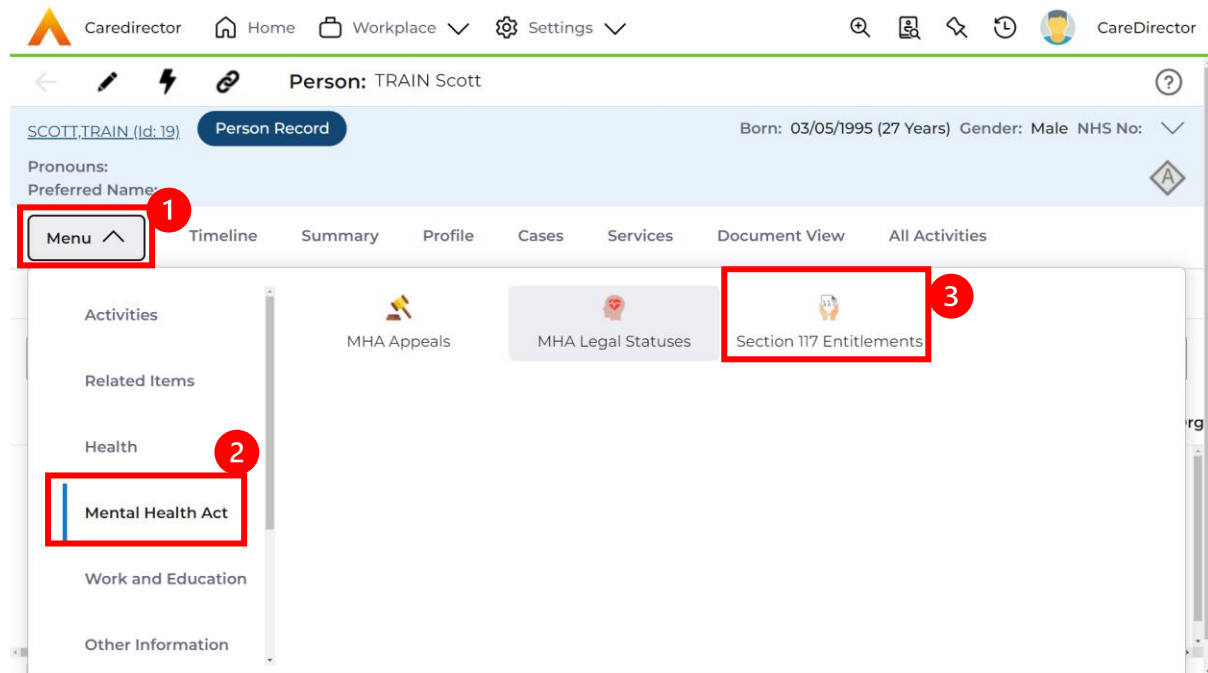
2. Then select **Create New Record** from the toolbar.
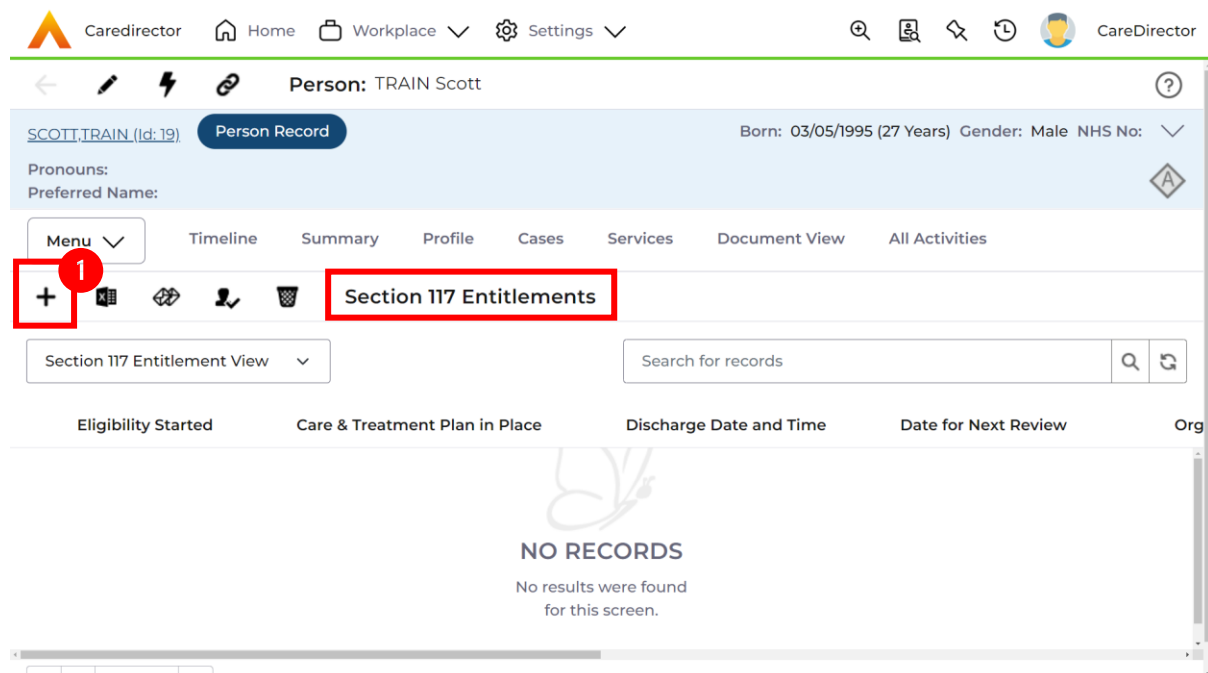
3. Fill in the relevant fields. When finished, select **Save**.
   Please note please do not fill in **Organisation Responsible for S117**.

Service Provisions

1. The Service Provision booklet is accessible on TriX; however, it is typically the responsibility of the admin on the team to populate and maintain it. To view this, go to:
   Person Record > Services

2. There will be a list of Service Provisions here and you can open them to view the information you need.

3. Once a service provision has been inputted by admin this should then be authorised by the team manager/team leader who will have received notification to authorise

All Activities

1. There may be times where you need to view all activities. This is useful if you want to see a clear picture of everything and that person's journey. To do this, go to **Person Record > All Activities > Clear Filters > Search**

2. With activities on the person record, you can view them the same way as a case record, but this is read only. Activities should be created on the **Case Record.**
Person Record > Menu > Activities

Admin

1. As an Admin/CSO, your role entails handling cases, activities, service provisions, managing phone calls, managing attachments, and creating person records to establish relationships.

2. You will primarily work from your Home Screen dashboards and conduct searches for individuals using the service.

    a. The Home Screen provides access to completing activities.

    b. The Person Record enables you to perform various actions such as creating attachments, adding contact information, key safe numbers, relationships, service provisions, alerts, hazards, and updating personal information.

    c. The Case Record allows you to add forms and activities.

Activities

1. As an Admin, your primary workflow will originate from the home screen. This screen will display the activities, cases, and service provisions that require your attention or allocation. It serves as a centralized hub for monitoring and managing your tasks.

2. **Team Activities** will show any open activities that require actioning or allocating to the relevant person. Here you can create or select one from the list to open it. When opened, there will not be a **Responsible User** inputted and the **Status** will be set as **Open**.

3. If you can complete the activity, please feel free to proceed. Perform the necessary steps for the activity, set the status as "**Completed**," and remember to **save** your changes. If the activity needs to be assigned to someone else, you can add them using the Lookup Function located next to the **Responsible User** field. However, if the activity needs to be forwarded to another team, please note that the Lookup Function will be unavailable and greyed out. In such cases, to change the team assignment, navigate to the toolbar and select "**Assign this record to another team**."
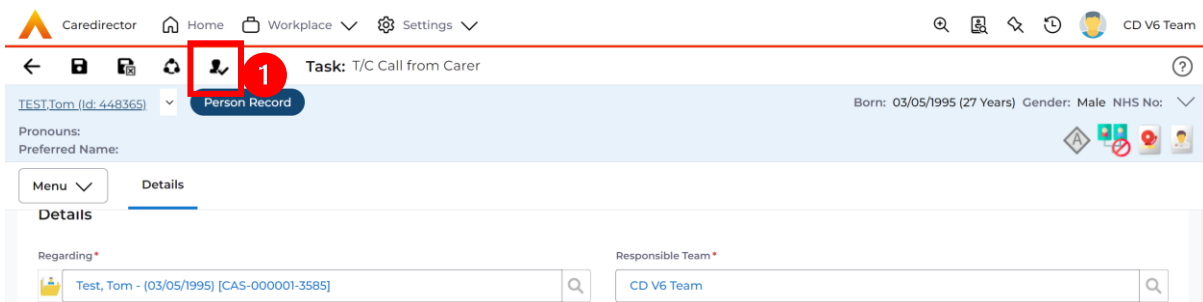
6. When selected, it will bring up **Responsible Team** option to change. Choose the relevant team by selecting, changing the **Look into Lookup View** and select from the list. The **Responsible User Decision** works in two parts if you know who this is being transferred to and if you do not know who it is being transferred to.
    a. If you do know select **Change on Current Record Only** and enter their name in the new field.
   b. If you do not know select **Clear on Current Record Only**
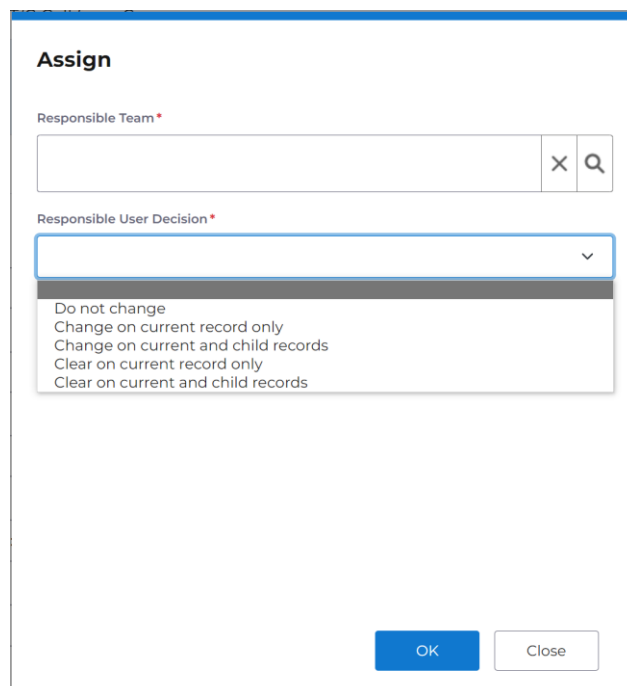
7. Click **OK** when done, and this will automatically change the **Responsible Team** and **Responsible User** to select ones. However, when creating a brand-new activity this can be done via the lookup function. This is only relevant to those activities that have already been created.

8. The Home Screen also has **My Activities** which works the same way as **Team Activities,** but it will have you as the **Responsible User** instead.
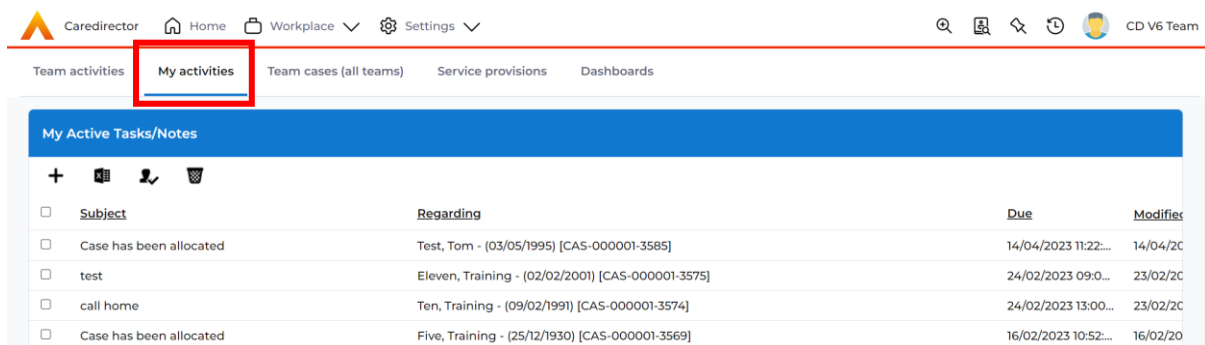
Team Cases (All Teams)

1. This is the designated location to track Team Cases based on their status and contact reason. Here, you can determine if any cases need to be assigned to practitioners and identify the collective contact reason for all cases. The term "(All Teams)" indicates that it encompasses the work of both Admin involved in the Mental Health Teams.
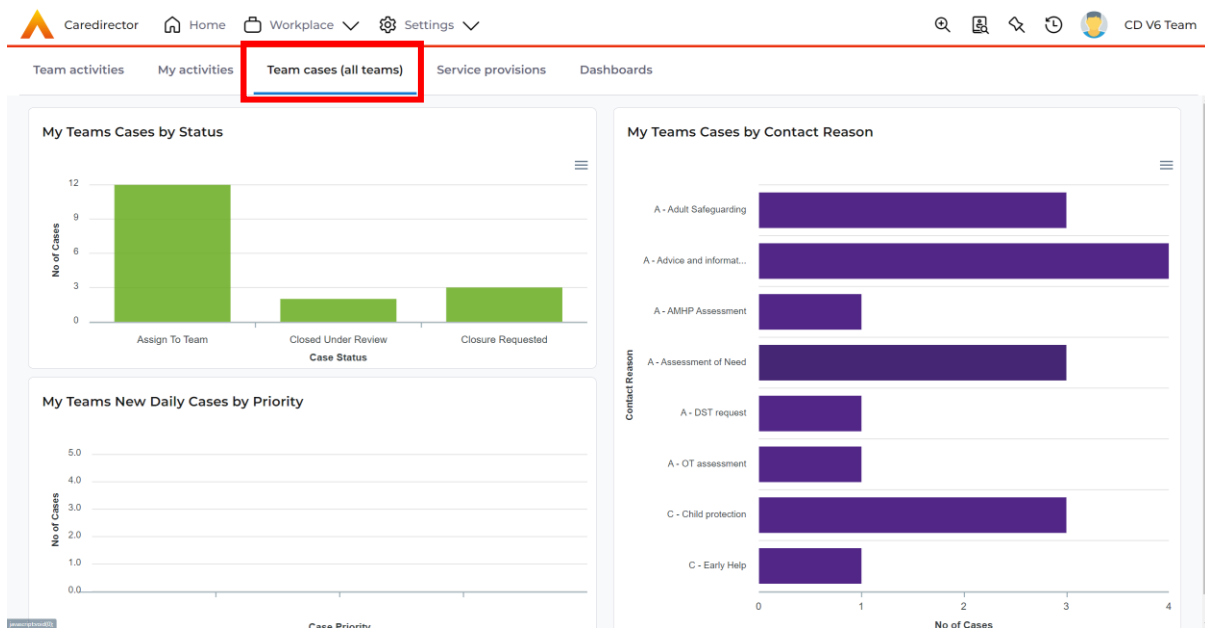
Person Record

1. A person record serves as the section where you can add attachments, enter/update information, review service provisions, and obtain an overview of what is happening for the individual in question.

2. As a reminder, to search for a person record simply, select:
   Person Search Icon > Enter their information or ID > Search

Creating a new Person Record (Contact Centre Staff Only)

1. When the person is not known to the service, a person record will be necessary. This record is used to link a contact, create a new case, and establish relationships for existing individuals. To do this:
   Person Search > Search for the person (avoid duplication) > Create New Record (if person already created, ignore creation steps, and move to adding numbers and linking to person).

2. On this screen, you can enter various information about the person, including their address, key safe number, contact details, and personal information. It is important to provide as information as possible when creating a person record. Once you have entered all the relevant details, you can save the record by selecting the "Save" option.
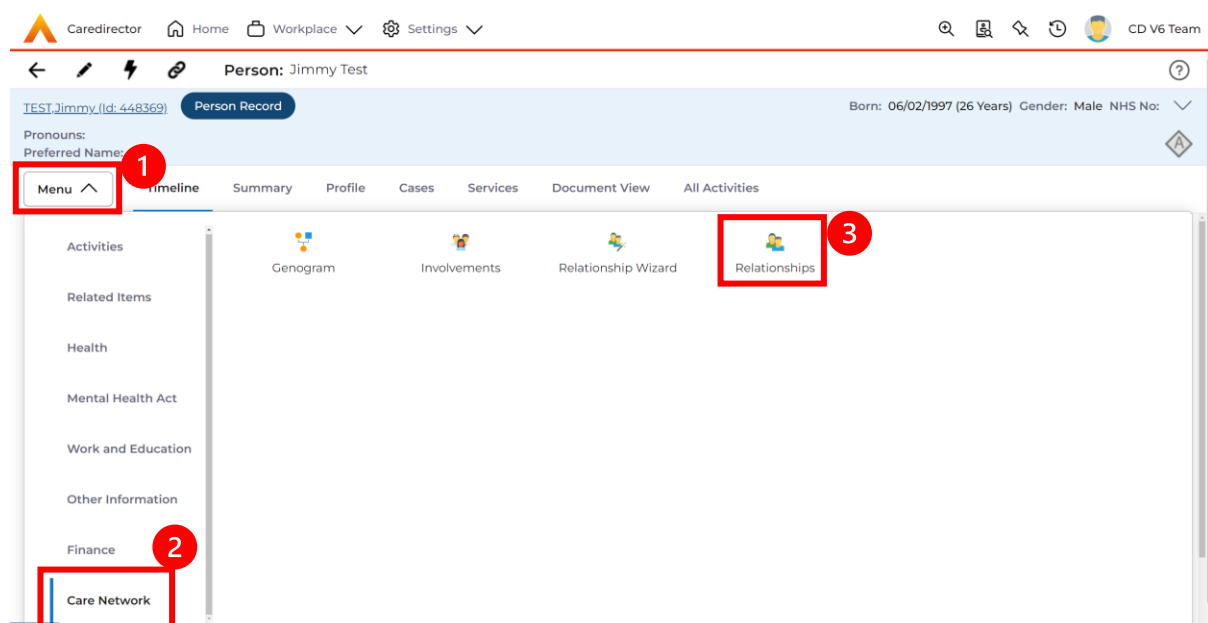
Visiting the person

When accessing the person record, there are important tasks and considerations for admin. These include creating and updating various sections to ensure comprehensive coverage for the person. By following these steps, not only will it assist the practitioner, but it will also ensure that all relevant areas are addressed for that individual.
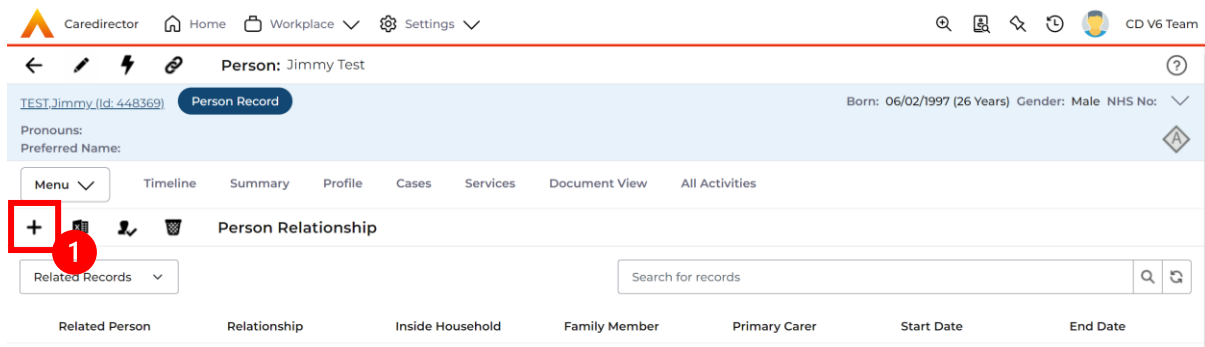
Creating Relationships (External Contact Information)

1. You can establish relationships between individuals in Caredirector. If that person is not on Caredirector then you will have to ask for the person to be added by the contact centre. It is important to note that this person does not need a Case Record or Service Provision record to be created. To create the link, a new person record must be created and linked to the person in question. Now that we have created our new person, we want to connect them to the existing user as their point of contact. To establish the link between these two individuals, a relationship needs to be created within the person record (it can be done by anyone, it doesn't matter who). Please follow these steps:
Person Record > Menu > Care Network > Relationships

2. **Create New Record**

3. Inside this section:
   a. The Primary Person will be entered in automatically.
   b. **Is a**, is what the Primary Person is to the other person.
   c. The **To** field is the other person already created onto the system (in this case our point of contact).
   d. Within Reciprocal Relationship section will be the opposite.
   e. Nature of Relationship to Primary Person have different fields, so please read and choose accordingly.
   f. Select **Save** when finished.

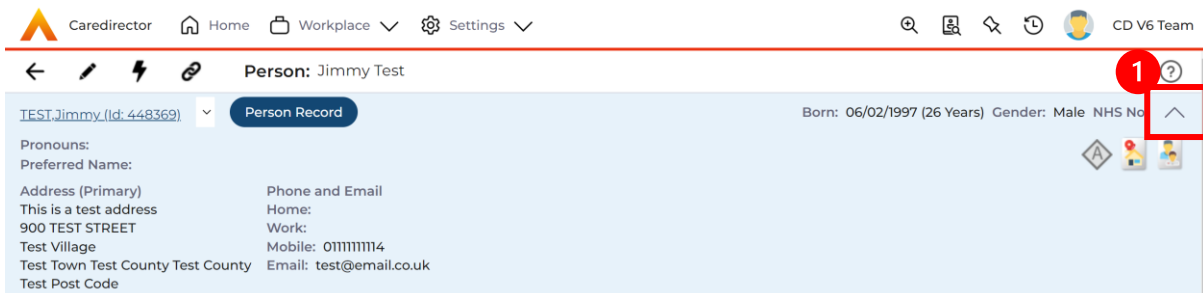4. When saved the link has been made, and a downward arrow will appear on the **Person Banner**. This can be clicked to show the other person and to navigate through to the other person.

5. When clicked, use the arrow on the far-right hand side to show current address and contact information. This is useful if they are the person's point of contact.

Updating Contact Information

1. There may be times to update someone's contact information, if this is required:

   Person Record > Edit > Update > Save

Attachments

1. Attachments go onto the **Person Record**. Attachments can be different material, just understand you can either upload one or multiple files to a single person (not multiple) at one time.
2. To find attachments:
   Person Record > Menu > Related Items > Attachments > Create New Record

3. To upload one attachment:
   Create New Record

a. This will open the creation screen, add a suitable **Title, Date** and categorise it correctly using the **Document Type/ Sub Type**. Any issues what to class it under please refer to this: **Attachment Naming Convention**

b. Next, select **Browse** to find the attachment uploaded onto your computer. Once found, select it and it will appear. Then select **Save**.

4. If uploading multiple attachments to the same person record at once: Select the **Upload Multiple Files** option
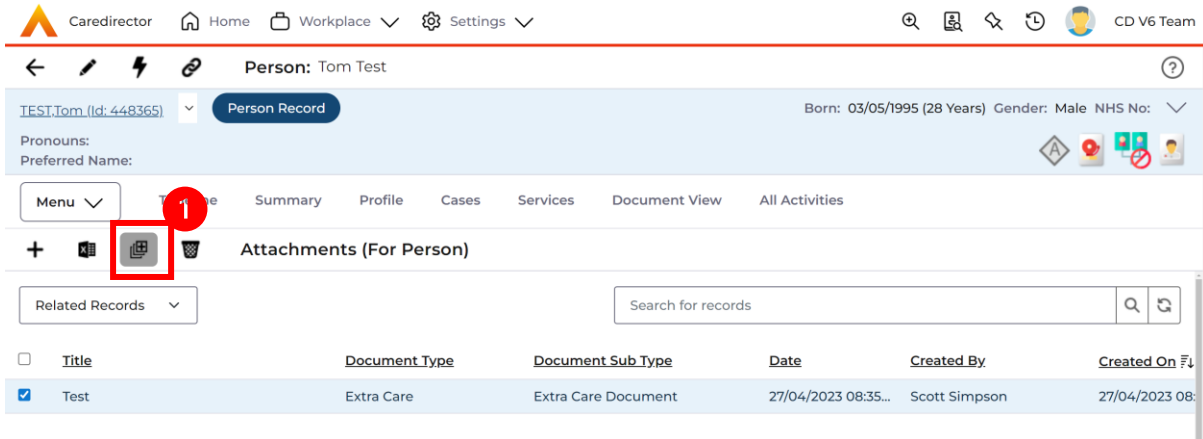
5. This works the same way; you will be given the option to place under a category. Please note: if they do not fall under the same title and category they are uploaded as separate entities, so you can go back in and change after to suit the correct category and name. Select or click and drag documents into the box to upload and select **Start Upload**.
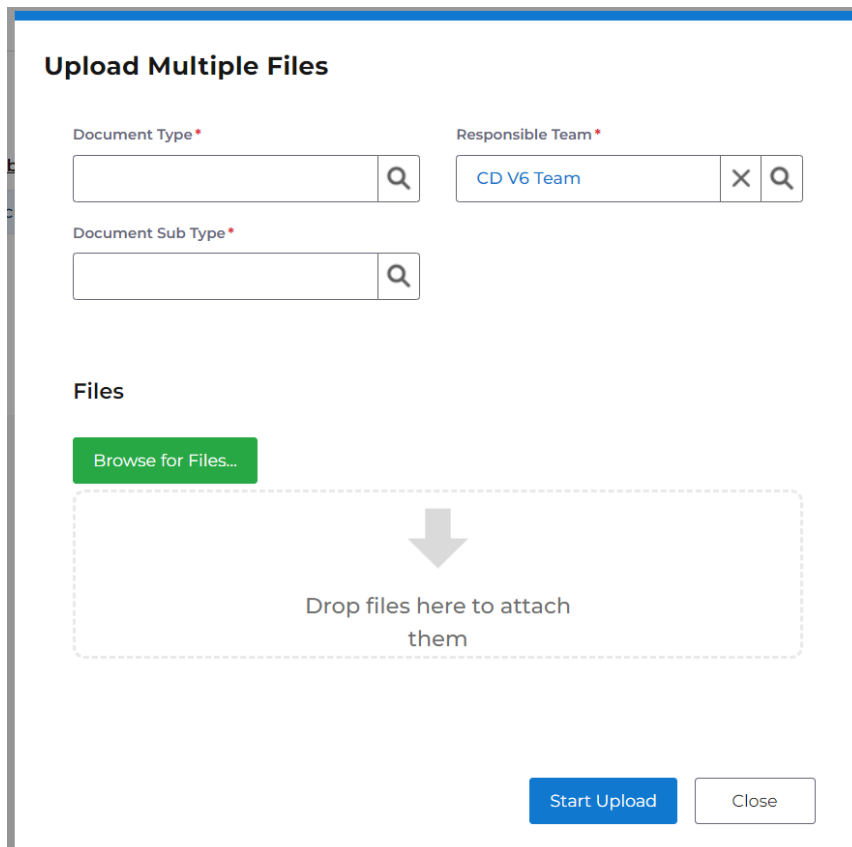
Attachment Naming Convention

1. When uploading **Attachments,** it is important to categorise correctly.

Document Type / Name	Document Type	Document Sub Type	Naming and dating Document
Adult Conversation Record Agreement Signature Page	Assessment and Care Management	Signature Page	Conversation Record Agreement signature (date of signing)
Adult care and Support Plan Agreement Signature Page	Assessment and Care Management	Signature Page	Care and Support Plan Agreement Signature (date of signing)
Adult Interim Support Plan Agreement Signature Page	Assessment and Care Management	Signature Page	Interim Support Plan Agreement Signature (date of signing)
Adult Care and Support Plan Review Agreement Signature Page	Assessment and Care Management	Signature Page	Care and Support Plan Review Agreement signature (date of signing)
Adult Consent Signature V7	Assessment and Care Management	Signature Page	Consent form signed (date of signing)
Adult Carers Assessment Agreement Signature Page	Assessment and Care Management	Signature Page	Carer's Assessment Agreement Signature (date of signing)
Accident and Incident Reports	Assessment and Care Management	Other Document	Name of report (date)
Adaptations Referral	Assessment and Care Management	Other Document	Adaptations Referral (date of referral)
Adaptations External Access Form	Assessment and Care Management	Other Document	Adaptations Referral Access Form (date of referral)
Adaptations Metal Handrail Form	Assessment and Care Management	Other Document	Adaptations Mental Handrail Form (date of referral)
Age UK Referral	Assessment and Care Management	Other Document	Age UK Referral (date of referral)
Allied Irish Bank Card Service User Agreement	Finance	Other Correspondence	Allied Irish Bank Card Agreement (date of referral)
Approved Mental Health Assessment Report	Assessment and Care Management	Other Document	Approved Mental Health Report (date of document)

Assessment for External Access	Assessment and Care Management	Other Document	Assessment of External Access (date of document)
Bayfield's Referral	Sensory Impairment	Sensory Impairment Document	Bayfield's Referral (date of referral)
Best Interest Meeting Minutes	Assessment and Care Management	Other Document	Best Interest Meeting Minutes (Date) (date of meeting)
Carers Support Plan Signature Page	Assessment and Care Management	Other Document	Carers Support Plan Agreement signature (date of signature)
Carers Conversation Record Signature Page	Assessment and Care Management	Other Document	Carers Conversation Record Agreement signature (date of signature)
Carers Alert Form	Assessment and Care Management	Other Document	Carers Alert form (date of signature)
Care Planning Meeting minutes	Assessment and Care Management	Other Document	Care Planning Meeting Minutes (Date) (date of meeting)
Certificate of Visual Impairment	Sensory Impairment	CVI	CVI (insert registration details SI or SSI & date of registration) (date of registration)
Client Annual Reviews (from providers/schools)	Assessment and Care Management	Other Document	Annual Review (provider name & date of review) date of review
Clinic report letters (pre and post), psychology letter, physiotherapy letters, any NHS letters	Assessment and Care Management	Other Document	(Name of clinic) report / letter (date of letter)
Community OT Letters 1 to 7	Occupational Therapy	Occupational Therapy Document	COT Letter 1/2/3 (date of letter)
Court Attendance Notices	Legal	Other Legal Document	Court Attendance Notice (date of notice)
Court Orders	Legal	Other Legal Document	Court Order (date of order)
CVI Registration Letters	Sensory Impairment	CVI	CVI letter (insert number) (date of letter)
Direct Payment Agreement	Finance	Other Correspondence	Direct Payment Agreement signature (date of signature)

DLA Forms	Assessment and Care Management	Other Document	DLA forms (date of forms)
DOLs Documentation	DoLs	DoLs Document	DOLs (name of doc, date of doc)
ECLO Assessment	Sensory Impairment	Sensory Impairment Document	ECLO Assessment (date of assessment)
Education, Health and Care Plans	Assessment and Care Management	Other Document	Name of care plan (date of care plan)
Epilepsy Summary (Chart)	Assessment and Care Management	Other Document	Epilepsy Summary date of document (date of document)
GP/Nursing Reports	Assessment and Care Management	Other Document	Name of GP / Nursing Reports (date of document)
Guidelines & Recommendations (Medical)	Assessment and Care Management	Other Document	Name of Document (date of document)
Health Action Plan/ VIP Card	Assessment and Care Management	Other Document	Health Action Plan/ VIP Card (date of document)
Horizon Referral	Assessment and Care Management	Other Document	Horizon Referral date (date of referral)
Horizon Discharge Summary	Assessment and Care Management	Other Document	Horizon Discharge Summary date (date of document)
Lasting Power of Attorney Documents	Legal	Other Legal Document	LPA Finance / Health & Wellbeing (date of document)
ISF Paperwork	Finance	Information	ISF Paperwork – date (date of paperwork)
Live Well Referral	Assessment and Care Management	Other Document	Live Well Referral (date of document)
Medication Change/Medication List/Medication Protocol	Assessment and Care Management	Other Document	Name of document – date (date of document)
Mental Capacity Assessments/ Mental Capacity Court Orders	Legal	Other Legal Document	Name of Document & date (date of document)
NHS Support Tool	Continuing Healthcare	Continuing Healthcare Document	NHS Decision Support Tool & date (date of signature)

NHS Continuing Healthcare Checklist	Continuing Healthcare	Continuing Healthcare Document	NHS CHC Checklist (date of signing)
NHS CHC Panel Outcome	Continuing Healthcare	Continuing Healthcare Document	NHS CHC Panel Outcome (date of letter)
NHS DST Review	Continuing Healthcare	Continuing Healthcare Document	NHS DST Review (date of review)
Non-Contact Letter	Assessment and Care Management	Other Document	Non-contact letter (date of letter)
Moving & Handling Plan	Assessment and Care Management	Other Document	Moving and Handling Plan (date of document)
OT Adult Conversation Record Agreement Signature Page	Occupational Therapy	Occupational Therapy Document	OT Adult Conversation Record Agreement Signature (date of signing)
OT Adult Care and Support Plan Review Agreement Signature Page	Occupational Therapy	Occupational Therapy Document	OT Adult Care and Support Plan Review Agreement (date of signing)
PiP Paperwork	Finance	Finance Information	PiP name of document (date of document)
PIC form	Assessment and Care Management	Other Document	PIC Referral (date of referral)
Photos or diagram of steps/access for WDH/Adaptations	Assessment and Care Management	Other Document	Photo of (insert description ((date of document)
Professionals Meeting Minutes	Assessment and Care Management	Other Document	Professionals Meeting Minutes (Date) (date of meeting)
Quote for Equipment	Occupational Therapy	Occupational Therapy Document	WES quote for Equipment (date of document)
Residential/Respite Your Provisional Financial Assessment Contribution	Finance	FA Residential	Resi/respite YPFCA signature (date of signing)
Residential/Respite Care Your Provisional Financial Assessment Contribution Top Up Fees	Finance	FA Residential	Resi/respite YPFCA top up fees signature (date of signing)

Returned signature page from Conversation record/OT Review	Occupational Therapy	Occupational Therapy Document	Conversation/OT Review Signature page (today's date)
Reviews – Other Providers	Assessment and Care Management	Other Document	Name of Provider – Review date (date of review)
Risk Assessment	Assessment and Care Management	Other Document	Risk Assessment details date (date of signature)
Short Breaks Panel	Assessment and Care Management	Other Document	Short Breaks Panel date (date of panel)
Speech and Language Report	Assessment and Care Management	Other Document	SALT Report (date of document)
Support Letter	Assessment and Care Management	Other Document	Support Letter - Review (date of letter)
Tenancy Agreement Tribunal Letters	Assessment and Care Management	Other Document	Tenancy Agreement Tribunal letter (date of letter)
Talking Newspaper Referrals	Sensory Impairment	Sensory Impairment Document	Talking Newspaper Referral (date of referral)
Wakefield Equipment Store Equipment Request Form	Occupational Therapy	Occupational Therapy document	WES equipment requests form (date of referral)
Wakefield Equipment Store Equipment Justification Form	Occupational Therapy	Occupational Therapy Document	WES equipment justification form (date of referral)
WDH Adaptations	Occupational Therapy	Occupational Therapy Document	WDH Adaptations Referral (date of referral)
WDH Adaptations Feasibility Request Form	Occupational Therapy	Occupational Therapy Document	WDH Feasibility (date of document)
WDH Adaptations Feasibility Minor Works Form	Occupational Therapy	Occupational Therapy Document	WDH Minor Works Form (date of document)
Deaf Registration Letters 1-2	Sensory Impairment	Sensory Impairment Document	Deaf Registration Letter (date of letter)
SI Letters and Template Letters	Sensory Impairment	Sensory Impairment Document	Letter (Type/Subject) (date of letter)

Deaf Registration Referral Form	Sensory Impairment	Sensory Impairment Document	Deaf Registration Referral Form (date)
Key Safe Referrals	Assessment and Care Management	Other Document	Key Safe Referral (date)
West Yorkshire Fire Service Referral	Assessment and Care Management	Other Document	WYFRS Referral (date)
RNIB Emotional Support Referral	Sensory Impairment	Sensory Impairment Document	RNIB Emotional Support Referral (date)
Wakefield Deaf Society Referral	Sensory Impairment	Sensory Impairment Document	WDS Referral (date)
WDSA (Wakefield District Sight Aid) Referral	Sensory Impairment	Sensory Impairment Document	WDSA Referral (date)
Deaf Registration Referral Form	Sensory Impairment	Sensory Impairment Document	Deaf Registration Referral Form (date)
Carers Contingency Plan	Assessment and Care Management	Other Document	Carers Contingency Plan (date)
Pricing Matrix	Assessment and Care Management	Other Document	Pricing Matrix (date)
Invoices / Receipts / Claims for SUs / Carers	Finance	Financial Information	Invoice or Receipt (company / name) (date)
Handyman Service (HRS)	Assessment and Care Management	Other Document	Referral Handyman Services (date)

Adding Alerts and Hazards

1. Recording a risk or hazard can help practitioners remain aware of any potential risks during a home visit. To do this:
Person Record > Menu > Related Items > Alerts & Hazards

2. Here, you can view a list of recorded risks or create a new one.

3. When creating a new risk, make sure to provide all the necessary details and clearly state that the individual or situation is exposed to a risk or represents a risk. Once you have finished, click on the "Save" button.

Key Safe

1. When creating a new person record, it is important to include essential information. However, if additional information is discovered later, it is vital to update the record to provide the practitioner with comprehensive details, especially when conducting home visits.

2. To do this:
   Person Record > Edit (Pencil) > Access Information > Save

Address

1. Updating a person's address is necessary when there is a change in their residence. It is important to keep this information accurate and up to date to maintain a record of their previous and current addresses. Please note that if there are already two primary addresses recorded, you will need to resolve this issue before adding a new address.

2. You can find the current primary address by selecting the down arrow on the person banner.
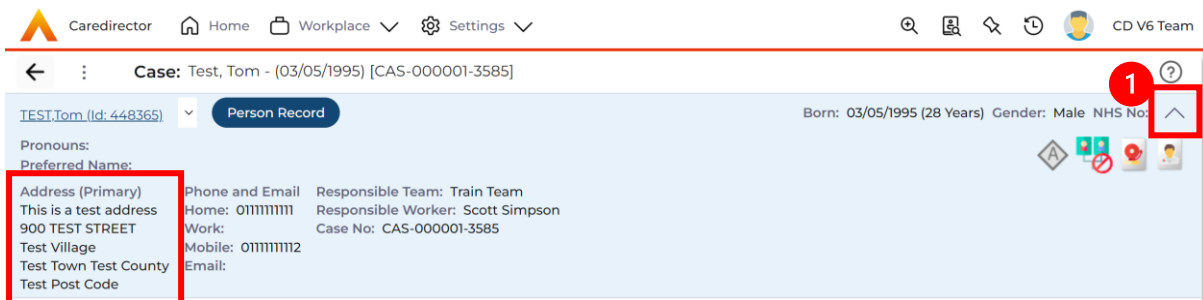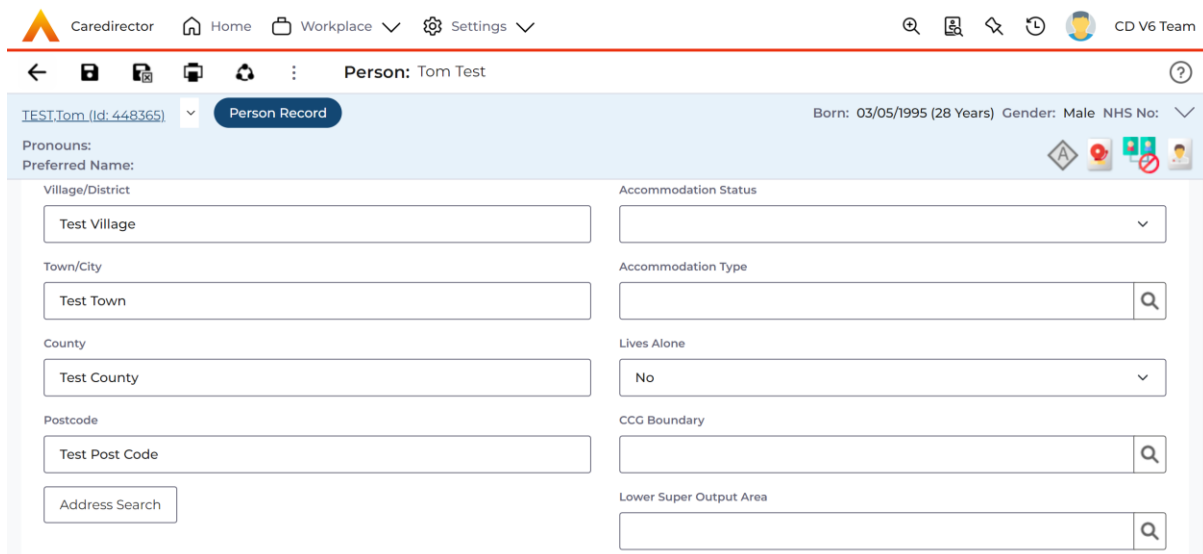
3. To create a new address, go to the:
Person Record > Menu > Related Items > Address
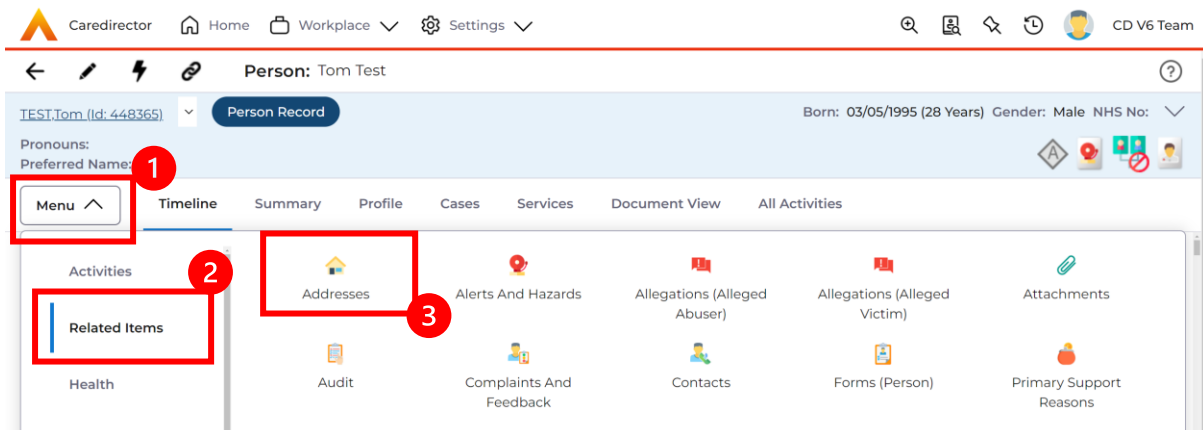
4. To create a new record for an old address that the person has lived at, follow these steps:
   a. Click on the "Create New Record" icon on the toolbar.
   b. Provide the correct information for the address in the gazetteer.
   c. Select "Save" to save the address details.
   d. Make sure to enter an end date for this address since it is not their current address.

5. To create a new primary address for a person, follow these steps:
   a. Go to the person's record.
   b. Click on the "Edit" icon on the toolbar.
   c. Scroll down to the "Address Information" section.
   d. Enter the new address by using the "post code" and "address search" fields.
   e. Click on "Save" to save the changes.
   f. The system will automatically enter an end date for the old primary address and add the new address as a new entry.

All Activities

1. There may be times where you need to view all activities. This is useful if you want to see a clear picture of everything and that person's journey. To do this, go to **Person Record > All Activities > Clear Filters > Search**

2. With activities on the person record, you can view them the same way as a case record, but this is read only. Activities should be created on the **Case Record.**
Person Record > Menu > Activities

Service Provisions

If the national eligibility criteria are met, a Care and Support plan must be completed to illustrate how the individual's eligible needs will be met. On CareDirector, the Adults Care and Support Plan is the document used. This should detail how needs will be met (through universal services, privately) and the details of any commissioned service that is required. Once the Care and support plan is signed off by a manager, admin is notified via their Dashboard on CareDirector to input Service Provisions for the commissioned care required. There is a separate full-Service Provision Guidance Booklet to refer to when inputting Service Provisions.

In Wakefield, the recording of Service Provisions is an admin function and authorisations of the service provisions a team leader or team manager's function. Both these functions are separate and will have different authorisations/ permissions.

If you complete the Adult Conversation Record and an individual does not have eligible needs, the CareDirector Referral can be closed fully. If an individual has eligible needs, the Referral must remain open irrespective of whether those needs are being met with commissioned care. See page 23 for guidance re. closing Referrals under Review (those pending annual review). This function is used for Referrals where individuals have ongoing eligible needs but do not need to be allocated to a practitioner for active intervention.

1. Service Provision booklet is available on **TriX** however these are usually put on by the **admin** on the team. To view this, go to:
   **Person Record > Services**

2. There will be a list of Service Provisions here and you can open them to view the information you need.

Case Record

1. Within the case record, the role of an Admin (Administrative/Client Service Officer) entails responsibilities, including:

    a. Creating or Updating Activities: Admin are responsible for creating new activities or updating existing ones within the case record. These activities serve to address specific events, tasks, or updates related to the person's care. By creating or updating activities, Admin/~~CSOs~~ ensure that essential information is captured and tracked within Caredirector.

    b. Requesting Actions from Other Teams or Users: Admin/~~CSOs~~ use Caredirector as a platform to request actions or tasks to be performed by other teams or individual users. They communicate the requirements or instructions within the system, ensuring that the requested tasks are properly assigned and completed by the designated team or user.

2. By fulfilling these responsibilities within the case record, Admin/~~CSOs~~ contribute to effective information management, communication, and coordination of activities within Caredirector. Their actions help ensure that events and updates are properly documented, communication is facilitated, and tasks are appropriately assigned and executed, ultimately supporting the delivery of quality care and services for the individuals involved.

Who is the case allocated to?

1. To determine the allocation of a case, you can find the corresponding case record and select the down arrow on the person banner. This action will provide you with the relevant information regarding the case allocation.
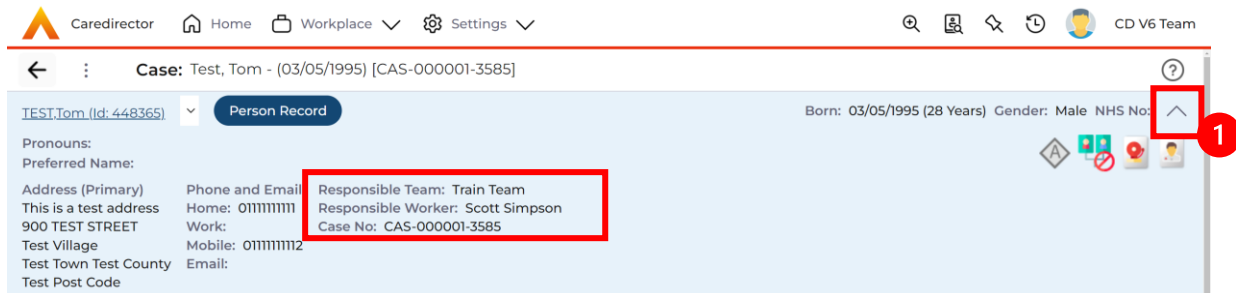
Safeguarding Information

3. Having knowledge of the location where safeguarding information is stored is crucial when dealing with mental health or safeguarding cases. It ensures that relevant information can be accessed and utilized appropriately. To find this: **Case Record > Menu > Related Items > Adult Safeguarding**
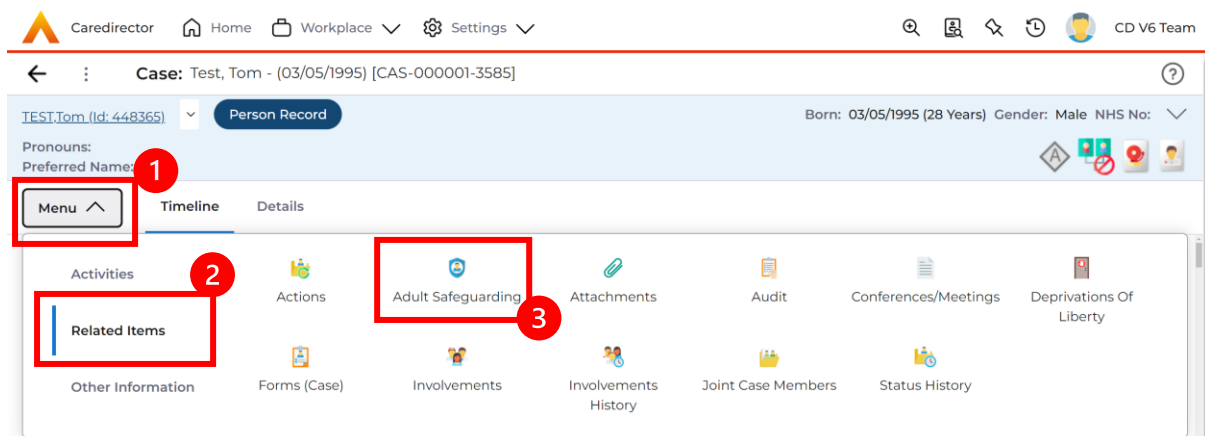
4. From this point, you have two options: you can either create a new entry or review an existing one. Choose the appropriate action based on your needs and requirements.

Activities

1. To create an **Activity,** select **Menu > Activities** then select the appropriate activity. These are what each mean:

    a. **Tasks/ Case Note**: To note an event or action that requires recording on this case. Anything that requires further actioning, this can be used to send activities to and from other system users on Caredirector.

2. Please use the relevant activity to record the required information. To create a recent activity, select the activity and select **Create New Record** from the toolbar.

3. Allocating an activity to the appropriate person is crucial when there is a specific action required. By assigning it to the correct individual on Caredirector, it will be visible in their "My Activities" or "Team Activities" section for them to address. The initial step in this process is changing the responsible user to the desired person using the Lookup Function. This allows for seamless assignment and ensures that

4. However, if that person is not known, select the **X** and leave blank and instead just focus on the **Responsible Team**.

5. If you do know, who this is going to be sent to, but you do not know what team they are part of. A quick way of checking is to select their name (it should be in blue).
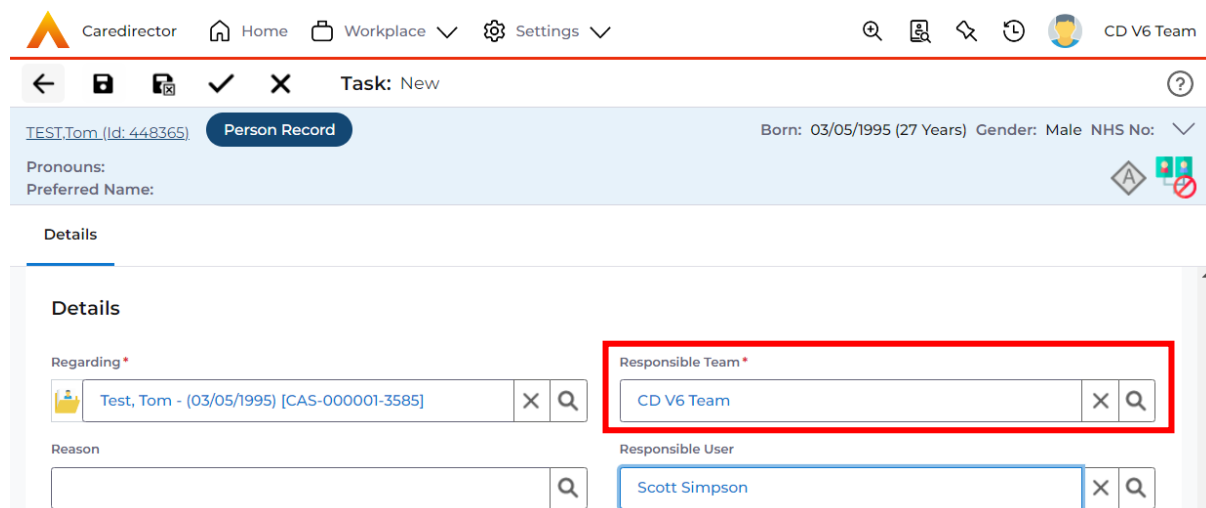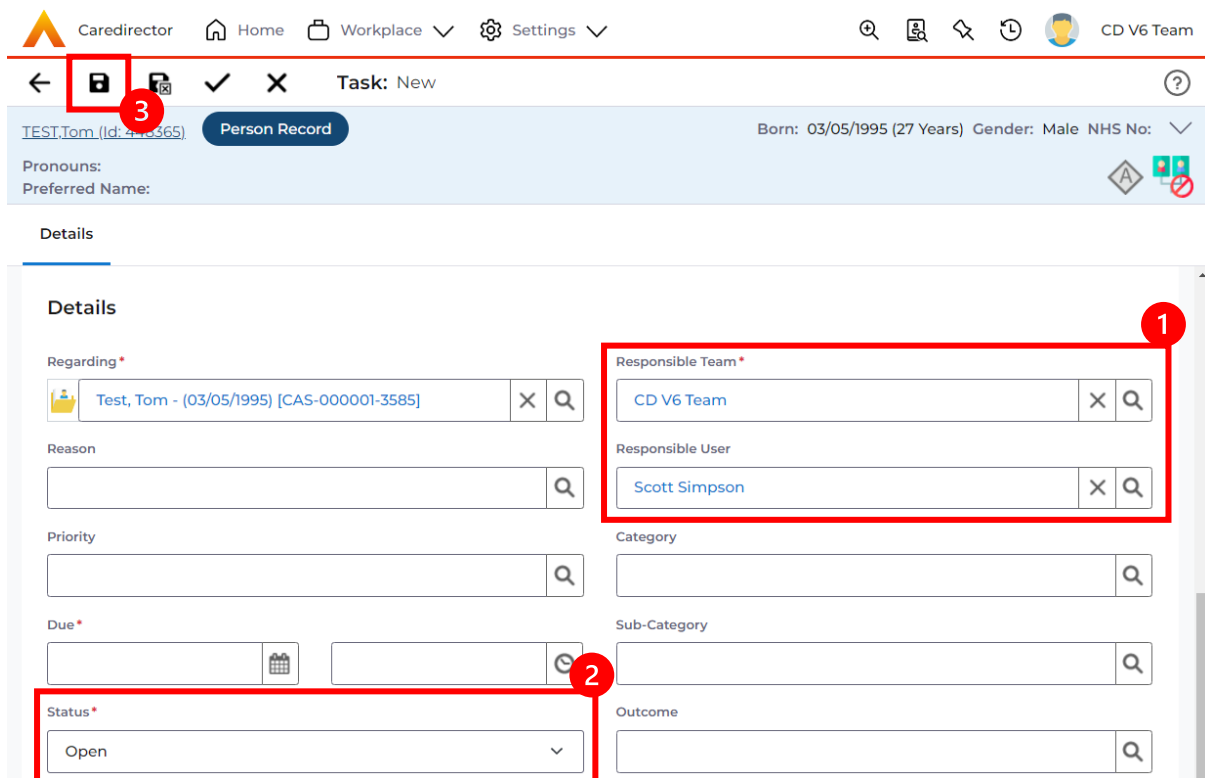
6. Once clicked, it will show their system user profile and most importantly, their default team.

7. Use that information, to input the mandatory field **Responsible Team**.

8. Once the system knows who and which team you want to send it to, leave the **Status** as **Open**. If it is set as **Completed,** then it will just stay where you put it but will not show on the person/ team's dashboard. Then select **Save.**
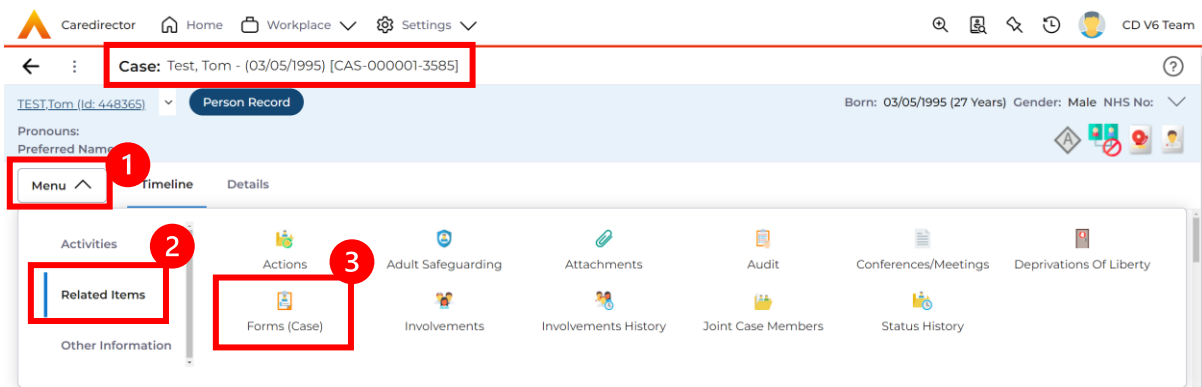

9. Anything that you will need to do will pop up on your dashboard.

10. There may be times where you need to view all activities. This is useful if you want to see a clear picture of everything and that person's journey. To do this, go to **Person Record > All Activities > Clear Filters > Search**
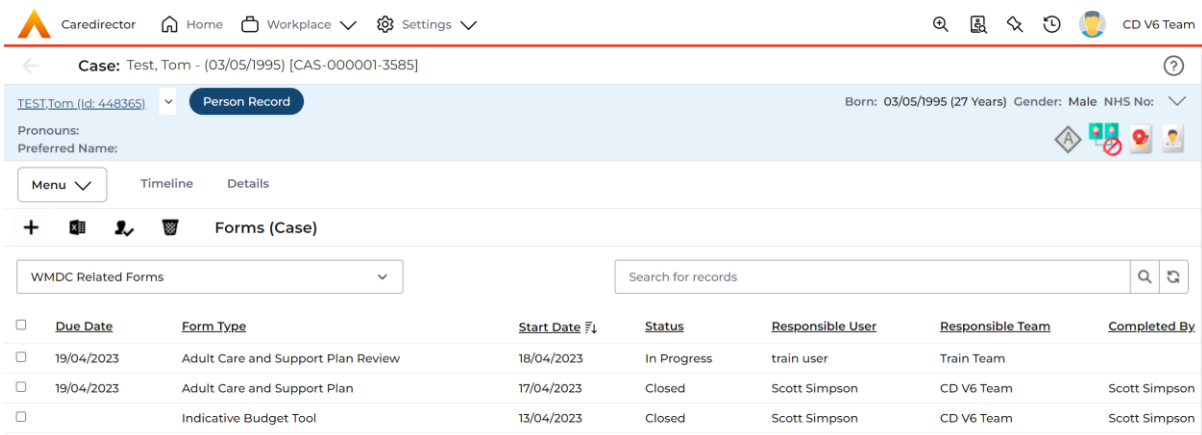
Forms (Case)

1. There may be instances when you need to create, print, or complete forms within the system. The following instructions will assist you in navigating through the relevant sections and performing these actions effectively. For additional help with individual forms, please use the **Forms** section located on TriX.

2. Forms are created in a **Case Record**. This is where you go to create a **Form**. **Case Record > Menu > Related Items > Forms (Case)**

3. Once selected, it will give a list of current forms that have already been created on this case and the ability to create a new one.

a. If a form has already been created, you can view and edit the form by selecting the **Pencil Icon (Edit)** which is available whilst the form is set as **In Progress** or to view the form use the **Eye Icon (View Only)** which is available whilst the form is set as **Closed**.
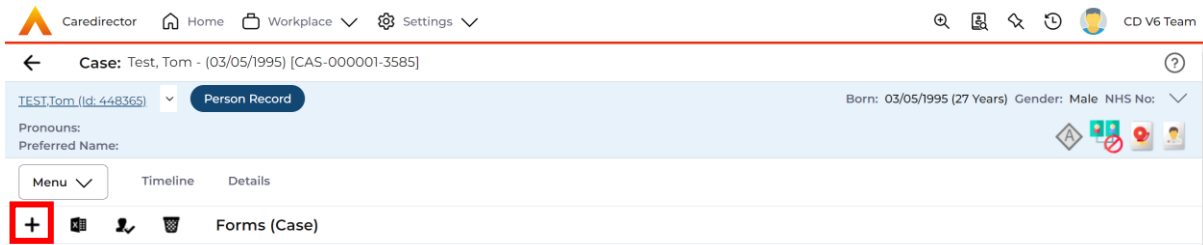
Pencil Icon (Edit)

Eye Icon (View Only)

b. To create a new form, select **Create New Record** on the **toolbar.**
Please note: For most forms, you cannot create two of the same form
whilst the **Status** is set as **In Progress** or **Complete,** they must be
Closed.

4. Once the form creation screen is open, we need to tell Caredirector what form
is going to be created and who is responsible for it. Select the **Form Type**
using the **Lookup Function** and the **Responsible User**. Select **Save** and you
will notice the **Pencil Icon** will appear.

a. If the responsible user is a practitioner, then it will show under the **My
Forms** dashboard on the **home screen.**

5. Once a form has been created, edited and all the information inputted, it will need to be set to complete. To do this:
   Forms (Case) > Open Form > Status > Complete and press save.

6. If the form requires closure from manager, the form will become visible on the managers home screen for them to **Close**, if not then the form will automatically close.

Client Level Data
Purpose & Forms

1. The new Client Level Dataset is a key project in the journey to transforming adult social care data. The new mandatory data collection will provide more timely, detailed data and will, for the first time, enable linked health and social care data, plugging the gaps in our knowledge of how people move between health and social care, how they experience these transitions and the resulting care outcomes. The data collection will enable timely monitoring of demand and, also the provider market. This will be vital over the coming year when economic pressures are likely to impact both.

2. CLD contains details of the main events and interventions in an adult's journey through the Social Care system when they approach us as a Local Authority for funded care. It will be possible to assess differences in demand and service use by age, gender and ethnicity and describe variations in costs by provider and service type. The new data collection is mandatory from 1st April 2023 with our first submission due July 23.

3. The CLD specification contains 50 data fields, 33 of which are mandatory from April 2023 and made up of the data required to reproduce key ASC activity statistics currently reported via the SALT return, which CLD will supersede in 2025.

4. These are the **Forms** that **Client Level Data** has been introduced in.
    a. Adult Interim Support Plan
    b. Carers Support Plan Review
    c. Adult Conversation Record
    d. Occupational Therapy Conversation Record
    e. Occupational Therapy Review
    f. Adult Care and Support Plan Review
    g. Reablement Physiotherapy Input Form
    h. Carers Conversation Record
    i. Occupational Therapy Referral (Secondary Allocation)
    j. Sensory Impairment Referral (Secondary Allocation)
    k. Referral for Reablement – Outreach/Discharge Support
    l. Mental health act record
    m. Mental capacity assessment/ best interest decision

5. Underneath **Office Use Only** section is where this section is held.

Client Level Data

Event type

Event outcome

SALT Data

Is the client currently in receipt of Long Term Support Services commissioned or provided by Wakefield MDC? (equipment is not deemed as long term support)

Yes ○   No ○

6. To find more information about "Client Level Set Data," you can go to TriX and perform a search using that term. TriX is a resource that provides additional documentation and guidance on diverse topics related to the system. By searching for "Client Level Set Data," you should be able to access relevant materials and resources related to that topic.

Version Control

Version	Change	Author	Date
V1	INITIAL START - Finding Allocated Cases dashboard has changed.	SS	25/01/2023
V2	Roles have now been included - Practitioner - Admin The information from V5 guidance has now been incorporated within how to's.	SS	19/05/2023
V3	Changes made by Scott Simpson and Debra Turner. • How referral come to the Mental Health Team. • Crossed out CS as we don't have these. • Reference to online self-assessment on finances / LPA information • Responsibilities of inputting service provisions • Responsibility that it's the team manager that authorises support plans/ finance forms / service provisions. • Page 66 are all these things still to be uploaded as some of the forms to be uploaded are now in forms section in care director i.e., continuing health checklist/ mental health act assessment. • closing a mental health act assessment case is to be undertaken by the allocated mental health act assessor • clearer that a mental health act assessment should be primary stored on care director • Added how to gain access as a mental health user to Caredirector • Improve overall readability and clairty	SS/ DT	18/07/2023