Admin & CSO

Document	Admin & CSO
Purpose	A role-based resource tailored towards the Admin & CSO role.
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Owner	ICT Business Transformation Team / Adults System Support Team
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Contents

Purpose

The purpose of this guide is to provide a comprehensive overview of the admin/CSO role from a system perspective. It outlines the different areas you will focus on and the suggested route to find the next step. Additionally, it covers key tasks that are part of your daily responsibilities. However, please note that this guide is not exhaustive and may vary based on team processes. It is important to communicate with your team and managers to clarify specific duties. You can use this guide as a helpful resource for following the provided instructions.

If you have suggestions for improving the resource or if your team requires a team-specific guide, please reach out to AdultsSystemSupport@wakefield.gov.uk. We can schedule a Microsoft Teams call to gather the necessary information and address your team's needs.

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.

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.

Admin/ CSO

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.

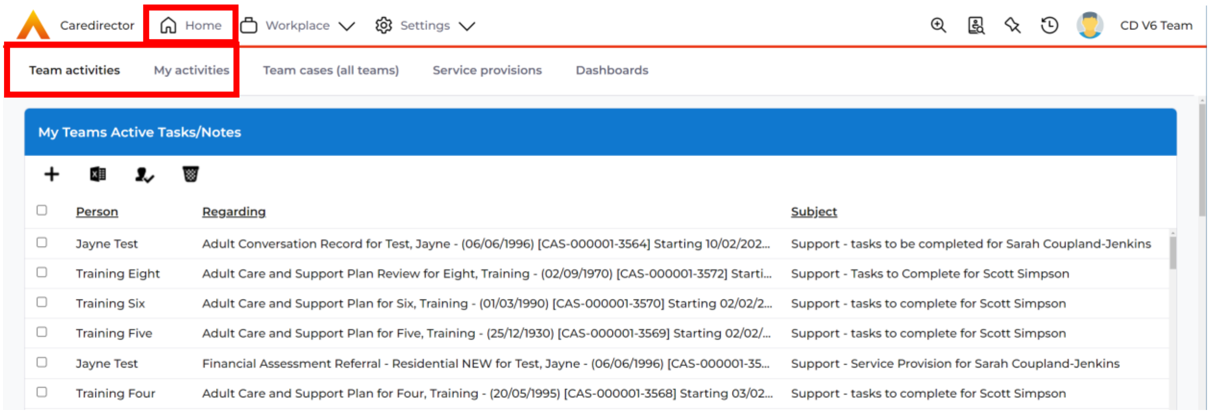
2. You will primarily work from your Home Screen dashboards and conduct searches for individuals using the service.
   a. The Home Screen provides access to completing activities.

   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.

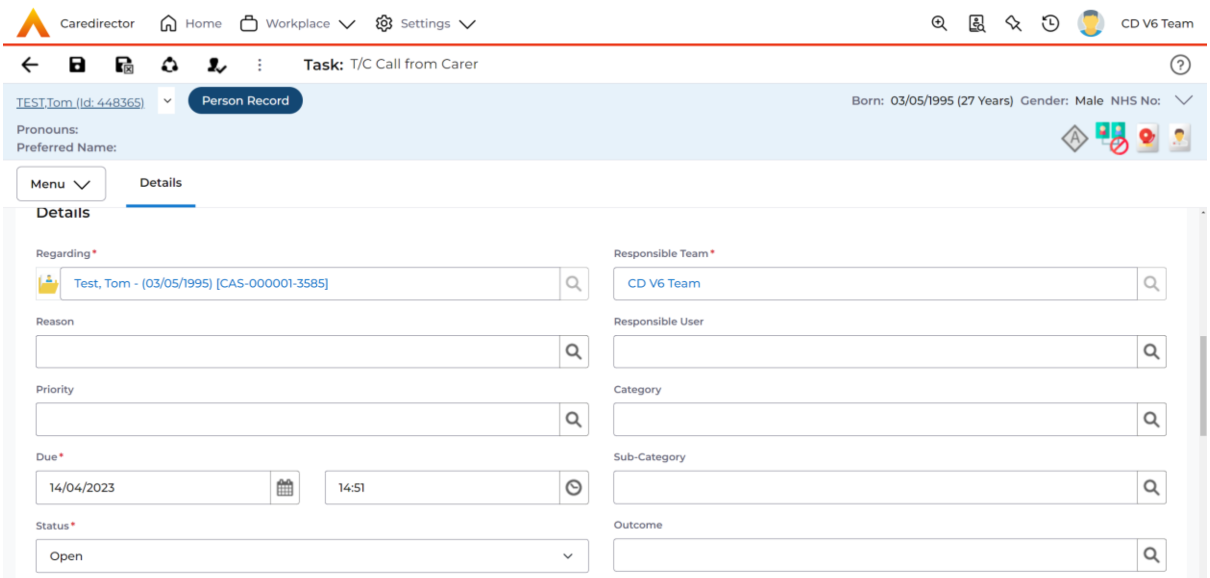
   c. The Case Record allows you to add forms and activities.

Activities

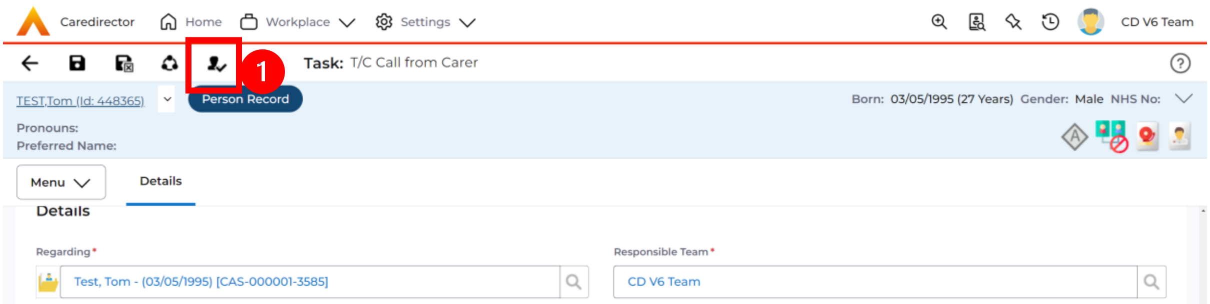
1. As an Admin/CSO, your primary workflow will originate from the home screen. This screen will display the activities, cases, and service provisions that require your attention or allocation. It serves as a centralized hub for monitoring and managing your tasks.



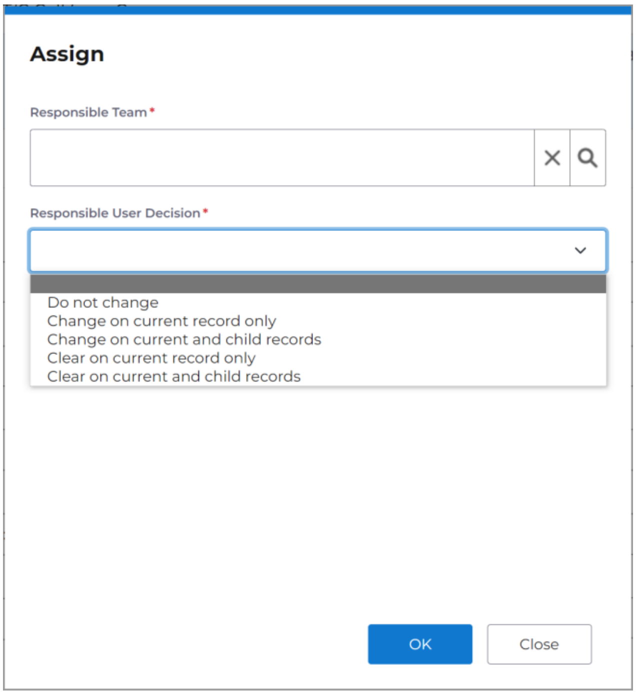
2. **Team Activities** will show any open activities that require actioning or allocating to the relevant person. Here you can create or select one from the list to open it. When opened, there will not be a **Responsible User** inputted and the **Status** will be set as **Open**.



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**."

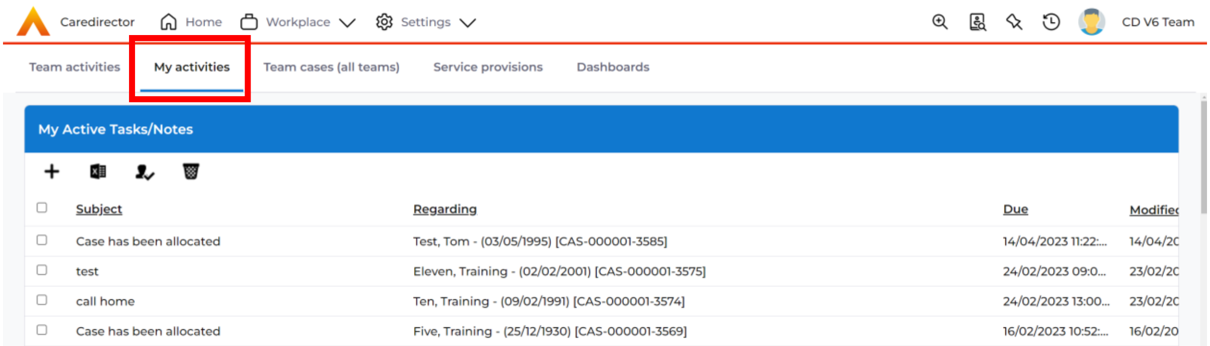


1. When selected, it will bring up **Responsible Team** option to change. Choose the relevant team by selecting, changing the **Look In** to **Lookup View** and select from the list. The **Responsible User Decision** works in two parts if you know who this is being transferred to and if you do not know 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**



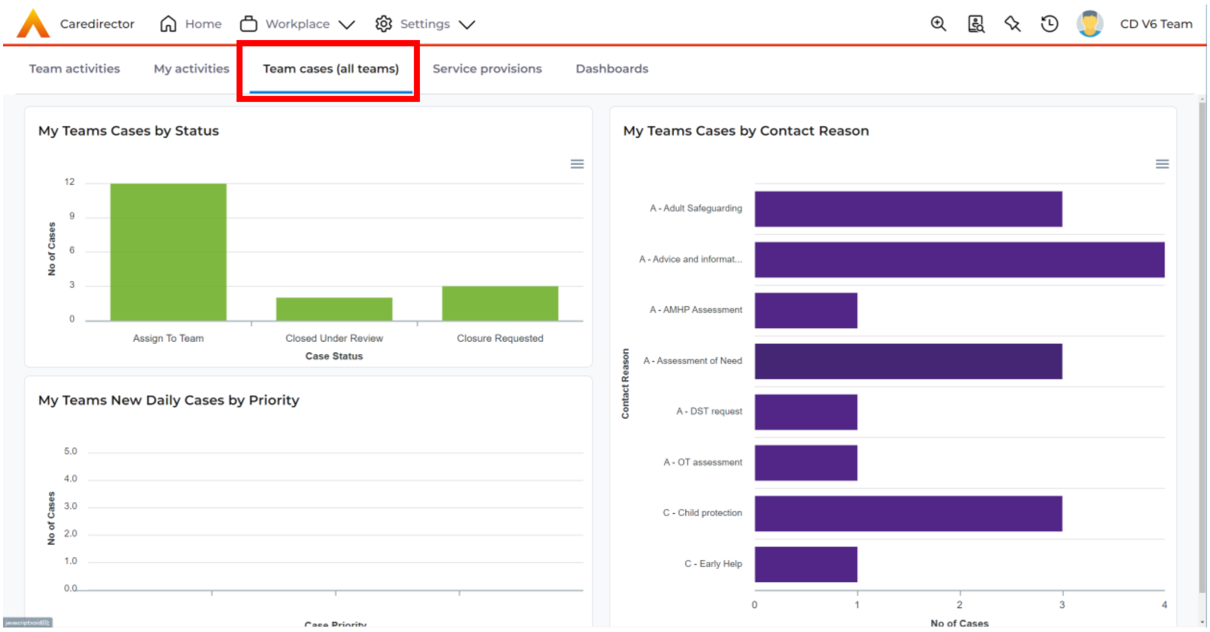
2. Click **OK** when done, and this will automatically change the **Responsible Team** and **Responsible User** to select ones. However, when creating a brand-new activity this can be done via the lookup function. This is only relevant to those activities that have already been created.

3. 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)

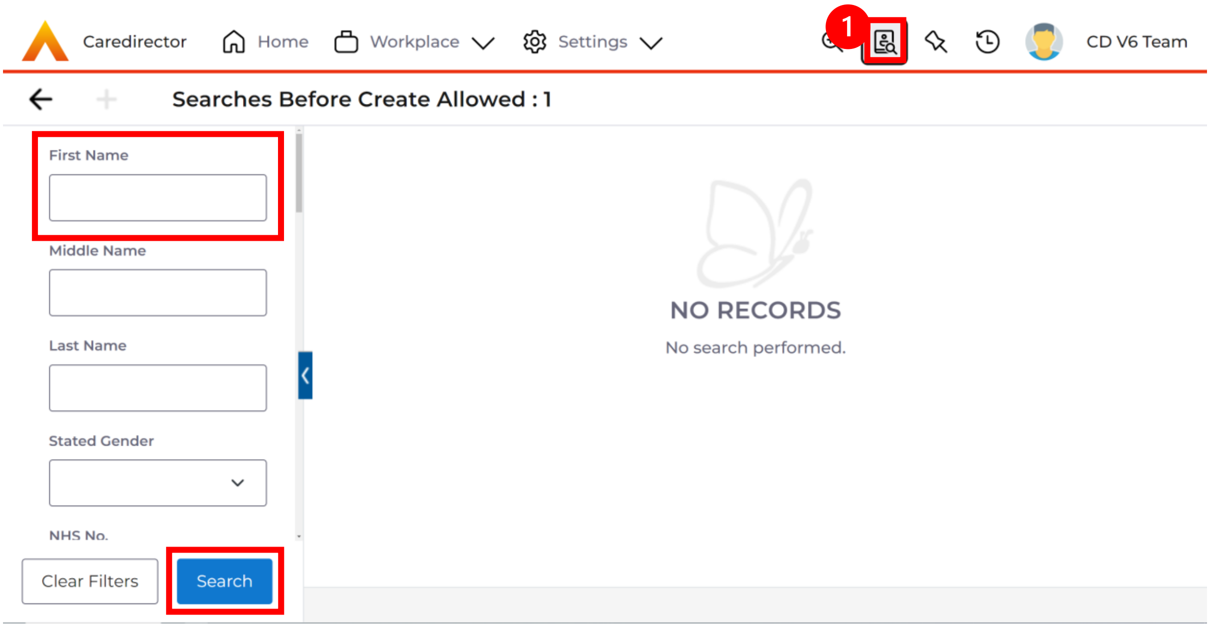
1. This is the designated location to track Team Cases based on their status and contact reason. Here, you can determine if any cases need to be assigned to practitioners and identify the collective contact reason for all cases. The term "(All Teams)" indicates that it encompasses the work of both Admin/CSOs involved in your team and any other teams you are associated with.



Person Record

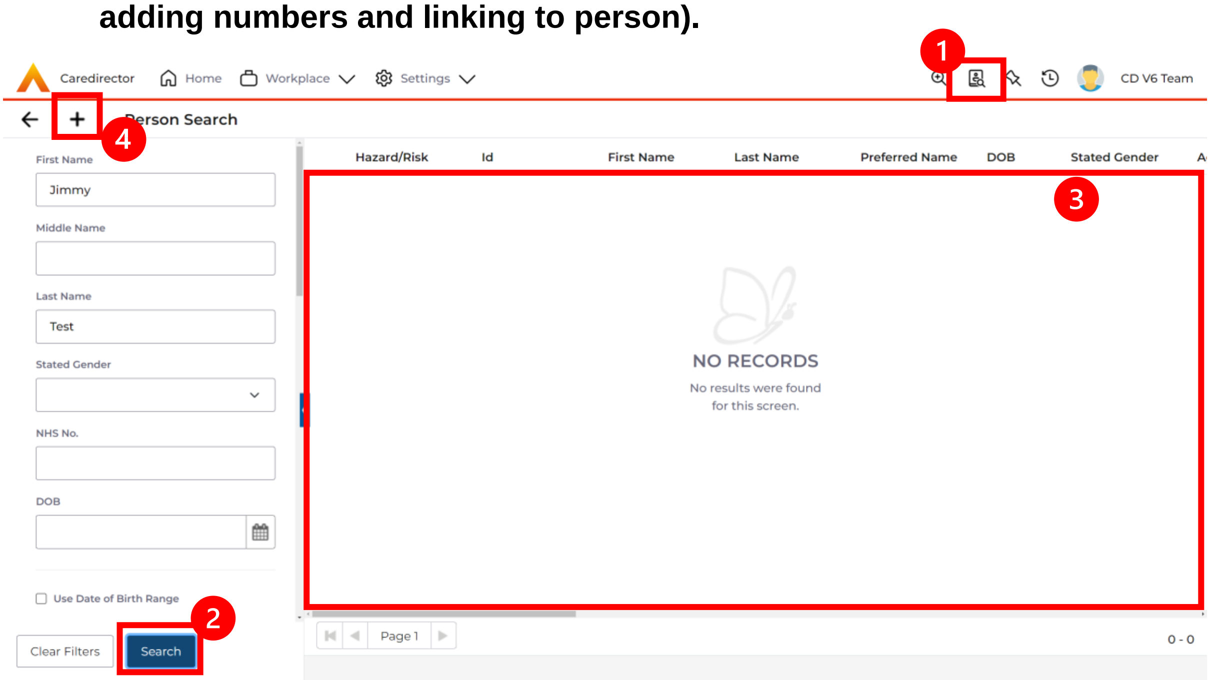
1. A person record serves as the section where you can add attachments, enter/update information, review service provisions, and obtain an overview of what is happening for the individual in question.

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

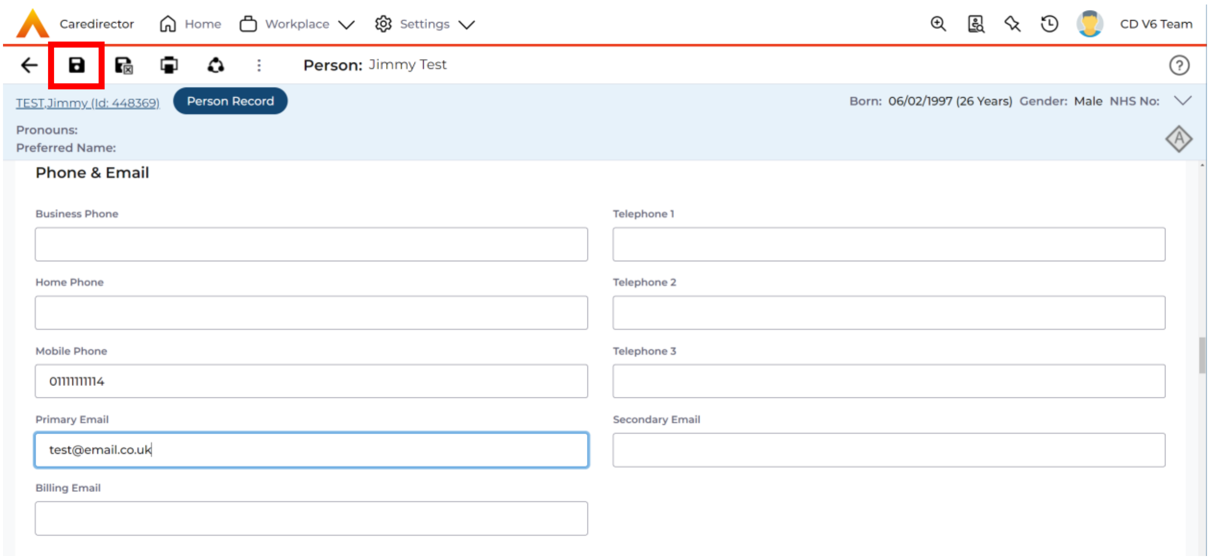


Creating a new Person Record (Contact Centre Staff Only)

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 much 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.

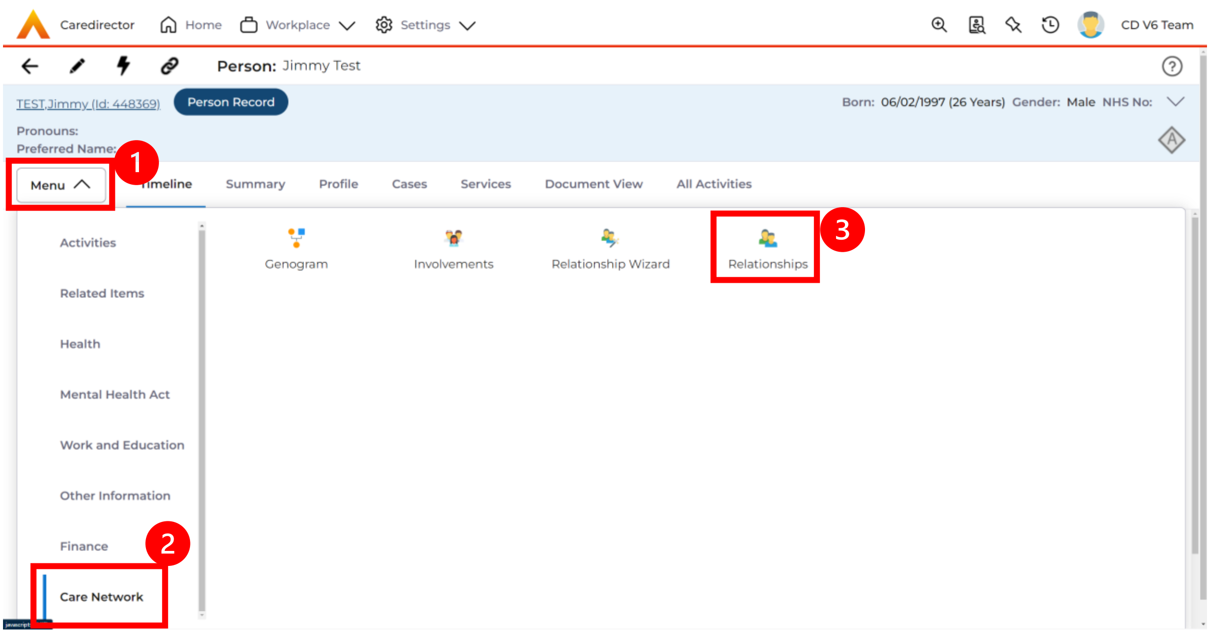


Visiting the person

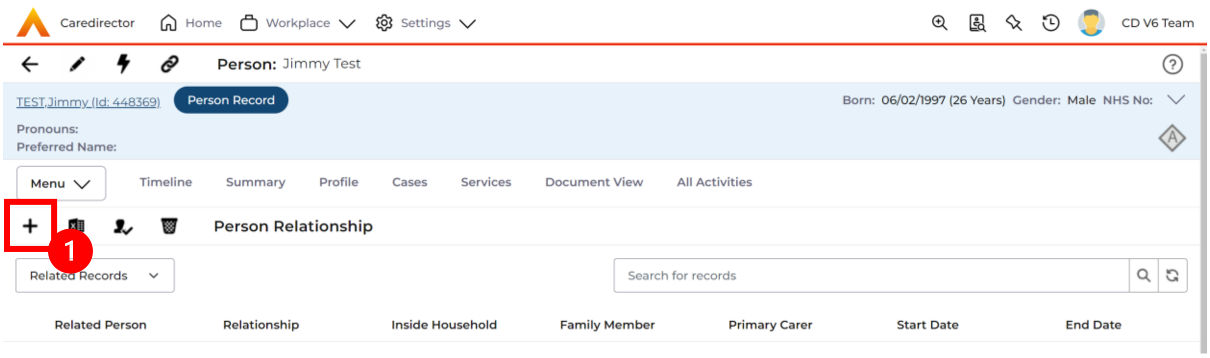
When accessing the person record, there are several important tasks and considerations for the Admin/CSO role. These include creating and updating various sections to ensure comprehensive coverage for the person. By following these steps, not only will it assist the practitioner, but it will also ensure that all relevant areas are addressed for that individual.

Creating Relationships (External Contact Information)

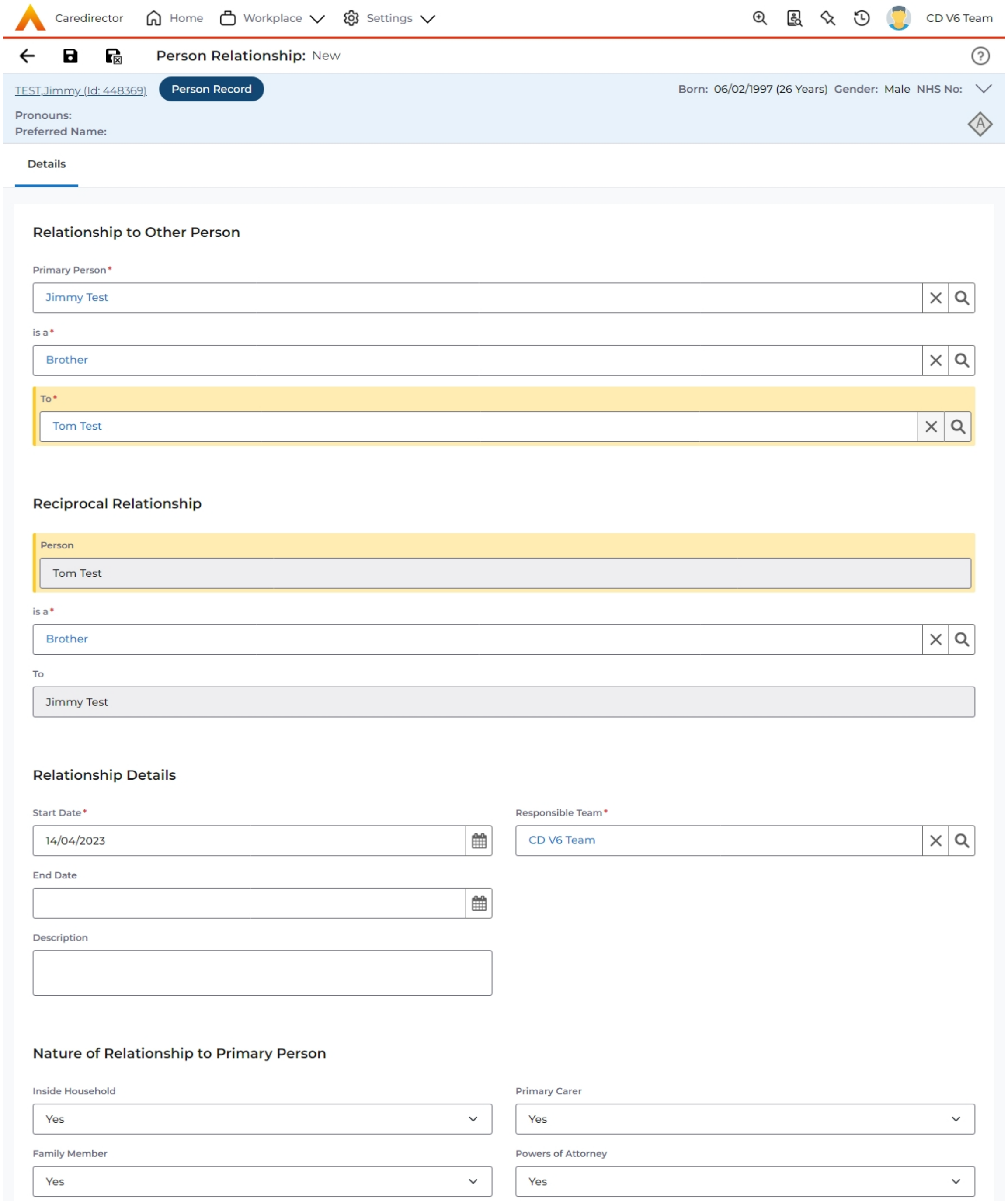
1. You can establish relationships between individuals in Caredirector. If that person is not on Caredirector then you will have to ask for the person to be added by the contact centre. It is important to note that this person does not need a Case Record or Service Provision record to be created. To 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**

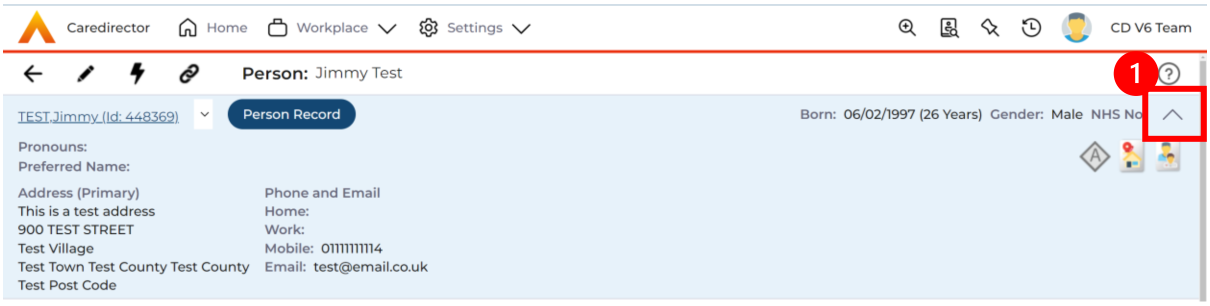


3. Inside this section:
   a. The Primary Person will be entered in automatically.
   b. **Is a**, is what the Primary Person is to the other person.
   c. The **To** field is the other person already created onto the system (in this case our point of contact).
   d. Within Reciprocal Relationship section 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.


Caredirector
Home
Workplace
Settings
CD V6 Team
Person Relationship: New
TEST,Jimmy (Id: 448369)
Person Record
Born: 06/02/1997 (26 Years) Gender: Male NHS No:
Pronouns:
Preferred Name:
Details
Relationship to Other Person
Primary Person*
Jimmy Test
is a*
Brother
To*
Tom Test
Reciprocal Relationship
Person
Tom Test
is a*
Brother
To
Jimmy Test
Relationship Details
Start Date*
14/04/2023
Responsible Team*
CD V6 Team
End Date
Description
Nature of Relationship to Primary Person
Inside Household
Yes
Primary Carer
Yes
Family Member
Yes
Powers of Attorney
Yes

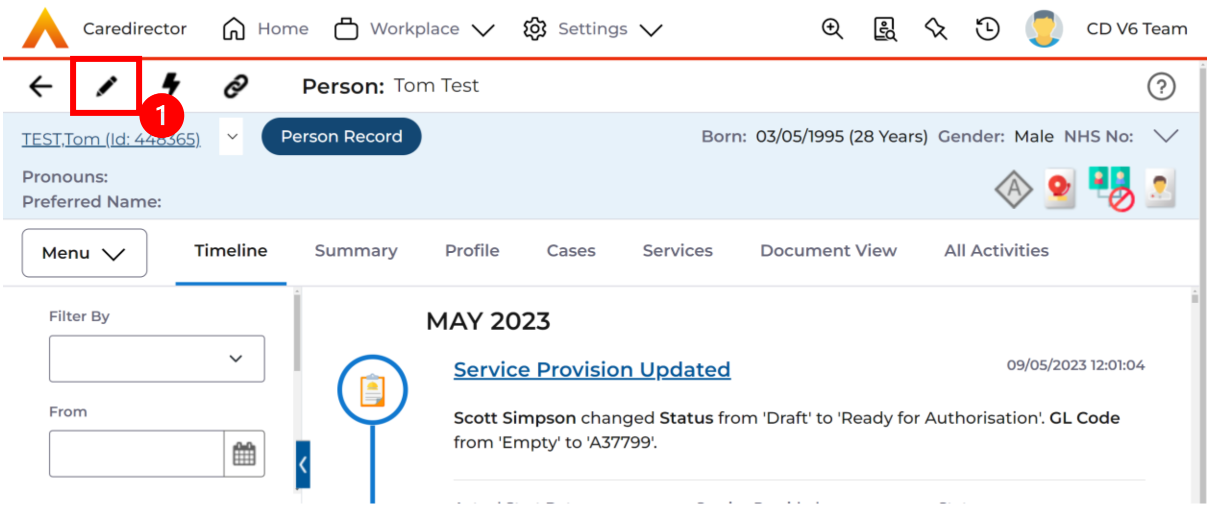
4. When saved the link has been made, and a downward arrow will appear on the **Person Banner**. This can be clicked to show the other person and to navigate through to the other person.

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.



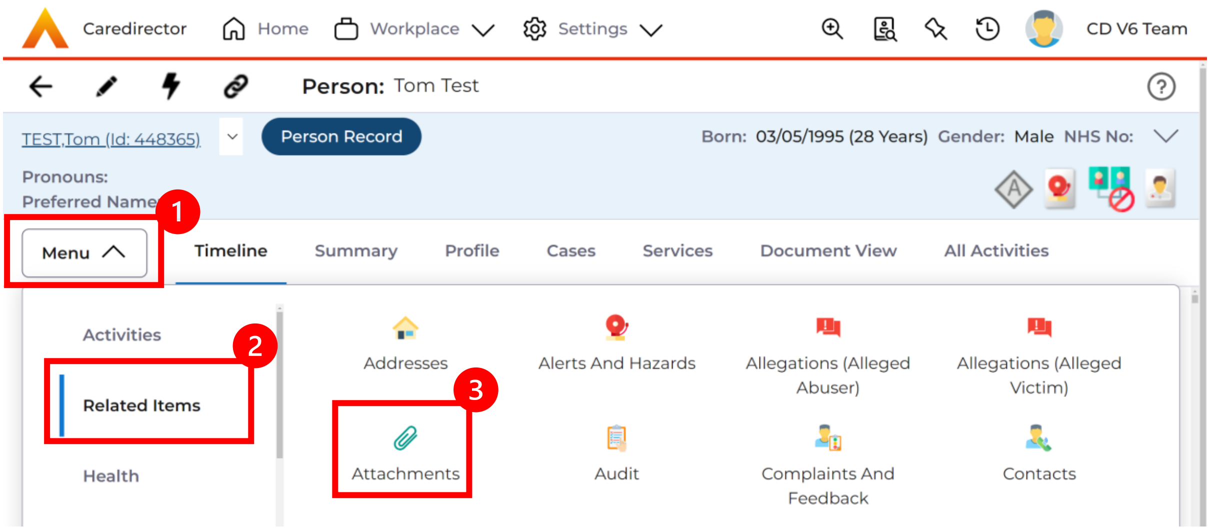
Updating Contact Information

1. There may be times to update someone's contact information, if this is required:
   Person Record > Edit > Update > Save

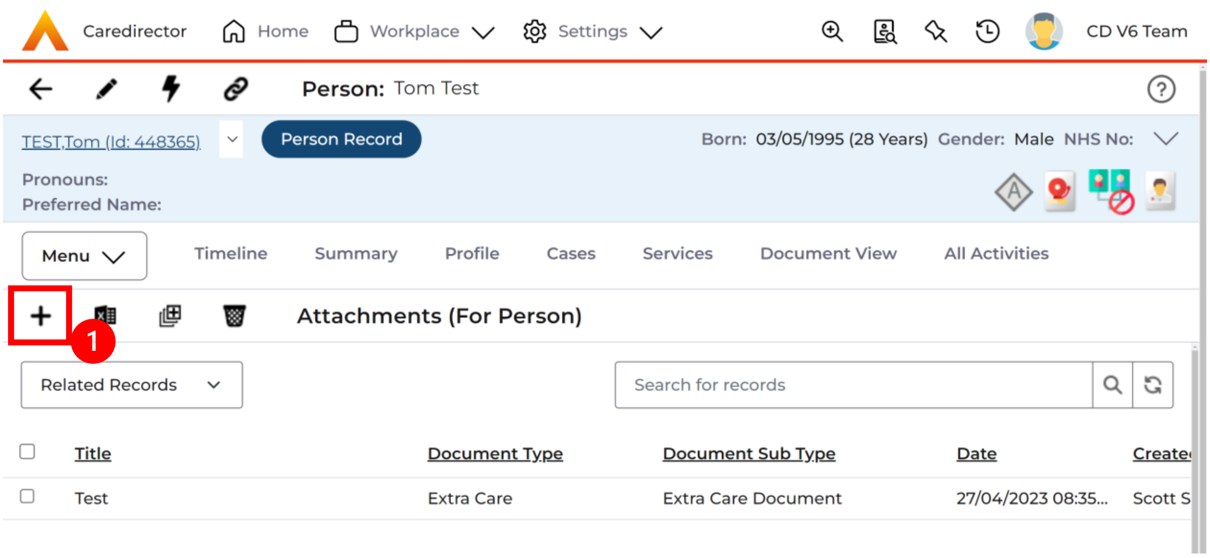


Attachments

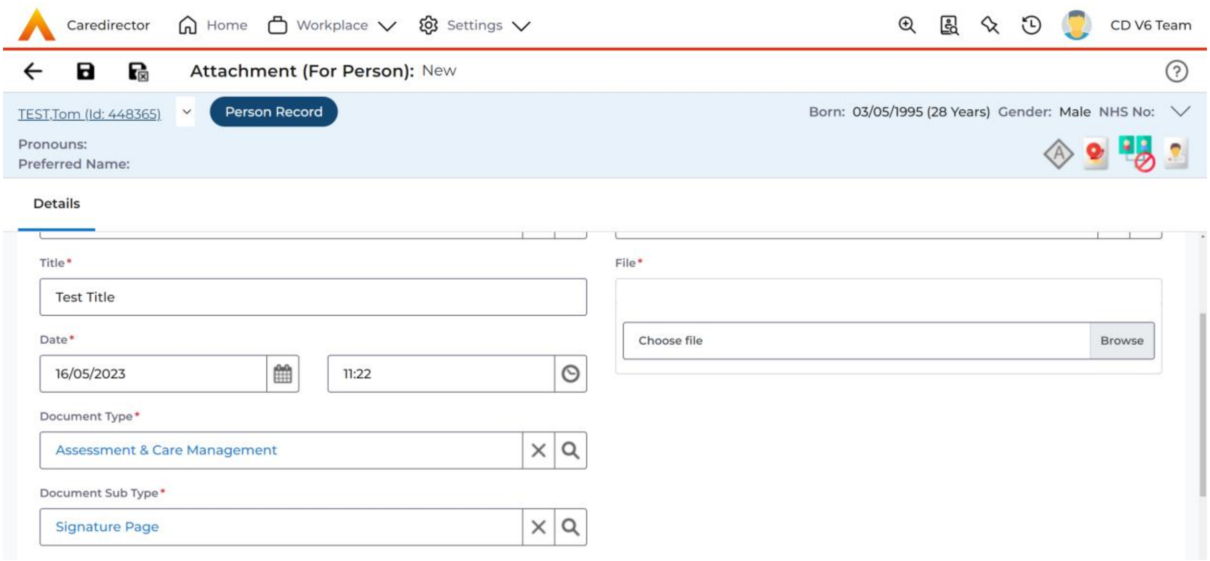
1. Attachments go onto the **Person Record**. Attachments can be a lot of different material, just understand you can either upload one or multiple files to a single person (not multiple) at one time.
2. To find attachments:
   Person Record > Menu > Related Items > Attachments > Create New Record



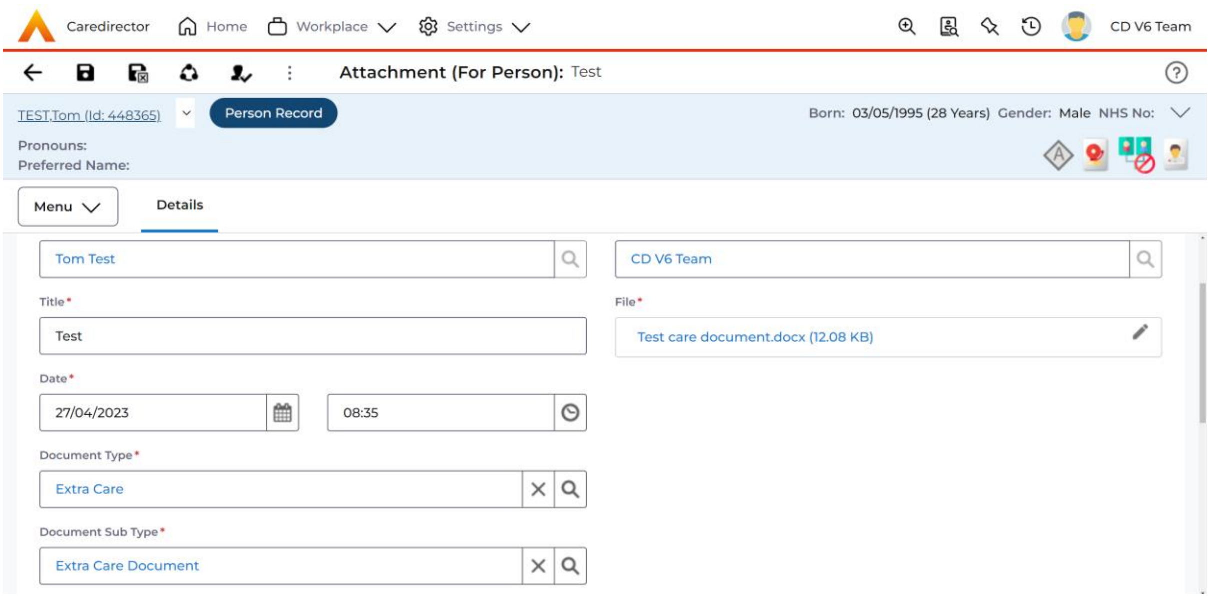
3. To upload one attachment:
   Create New Record



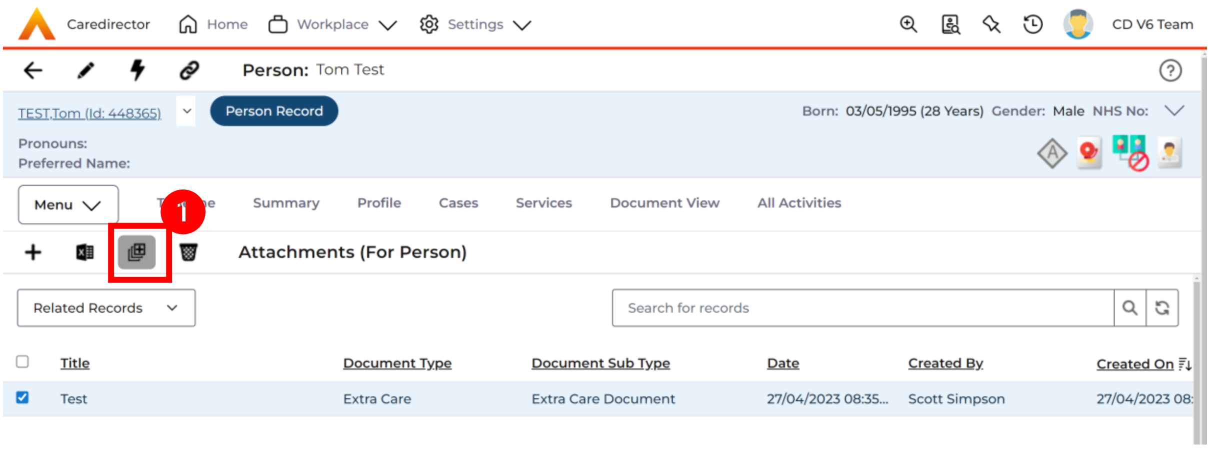
a. This will open the creation screen, add a suitable **Title, Date** and categorise it correctly using the **Document Type/ Sub Type**. Any issues what to class it under please refer to this: **Attachment Naming Convention**



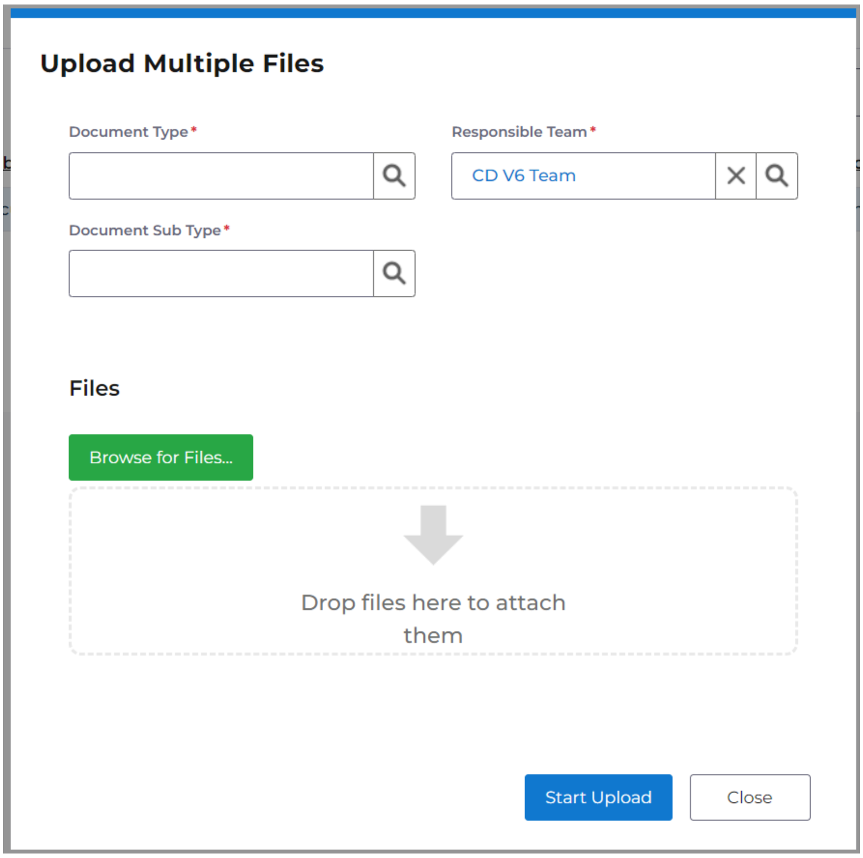
b. Next, select **Browse** to find the attachment uploaded onto your computer. Once found, select it and it will appear. Then select **Save**.



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)
Bayfields Referral	Sensory Impairment	Sensory Impairment Document	Bayfields 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 etc)	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 etc	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 etc (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)

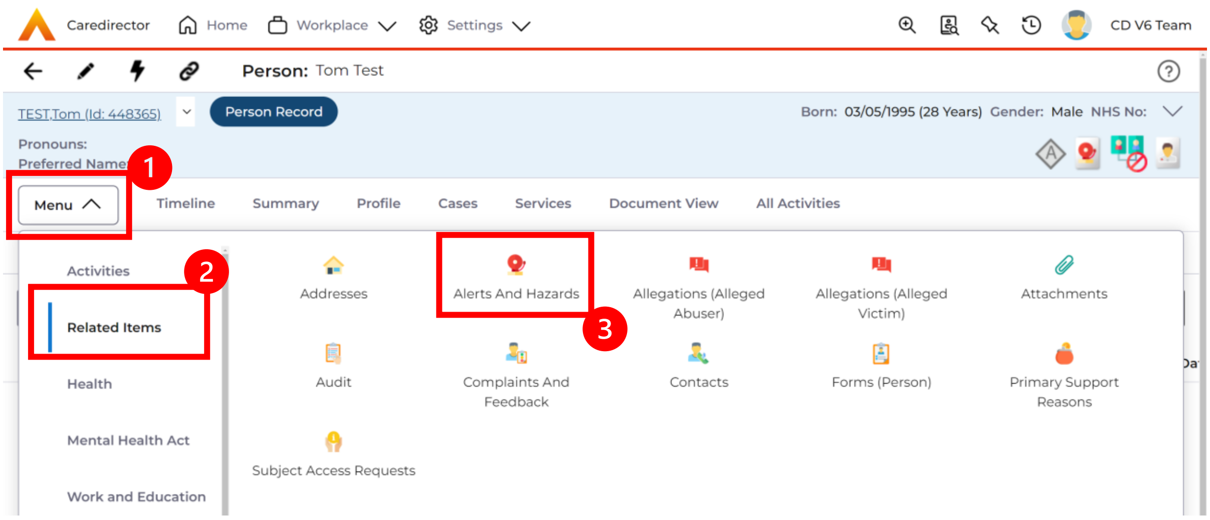
NHS Continuing Healthcare Checklist	Continuing Healthcare	Continuing Healthcare Document	NHS CHC Checklist (date of signing)
NHS CHC Panel Outcome	Continuing Healthcare	Continuing Healthcare Document	NHS CHC Panel Outcome (date of letter)
NHS DST Review	Continuing Healthcare	Continuing Healthcare Document	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 etc (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 request 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)

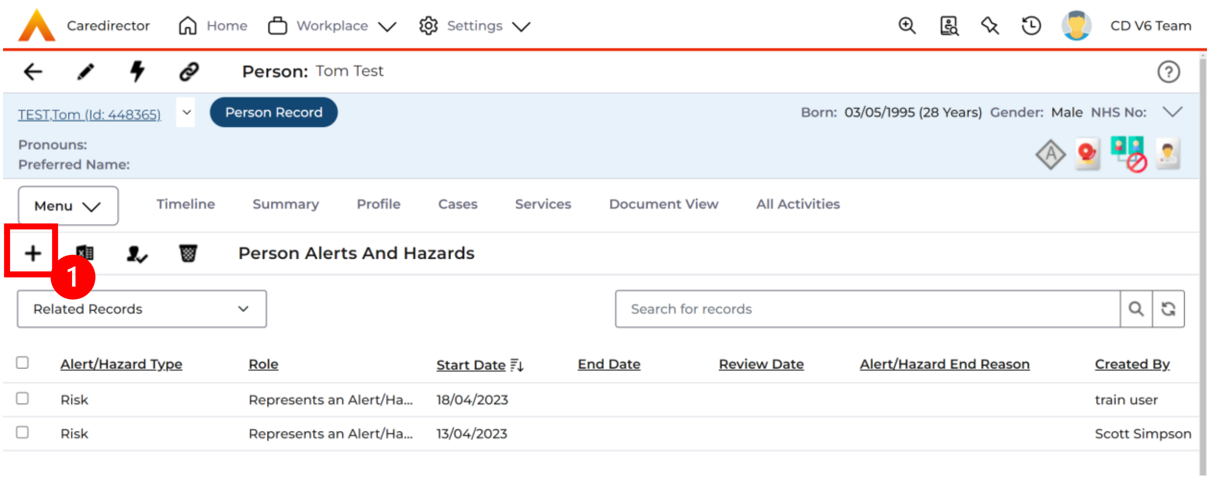
Deaf Registration Referral Form	Sensory Impairment	Sensory Impairment Document	Deaf Registration Referral Form (date)
Key Safe Referrals	Assessment and Care Management	Other Document	Key Safe Referral (date)
West Yorkshire Fire Service Referral	Assessment and Care Management	Other Document	WYFRS Referral (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.

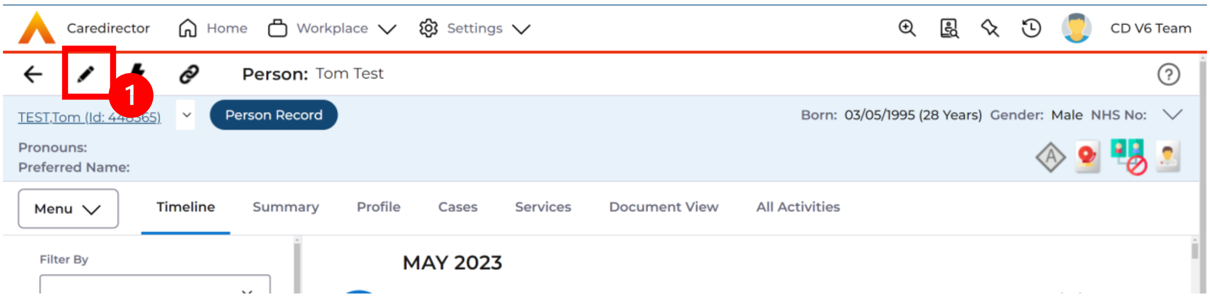


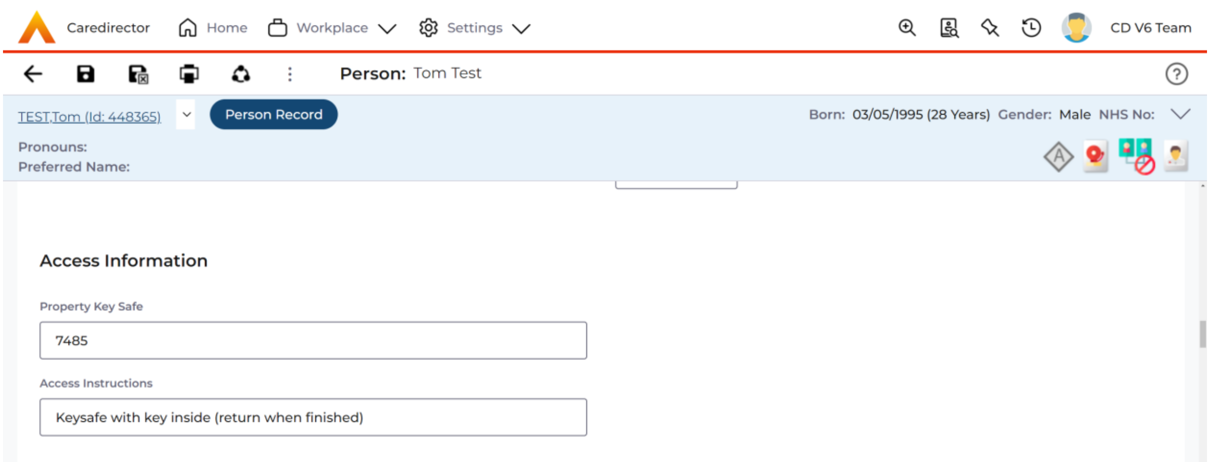
3. When creating a new risk, make sure to provide all the necessary details and clearly state that the individual or situation is exposed to a risk or represents a risk. Once you have finished, click on the "Save" button.

Key Safe

1. When creating a new person record, it is important to include as much information as possible. 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

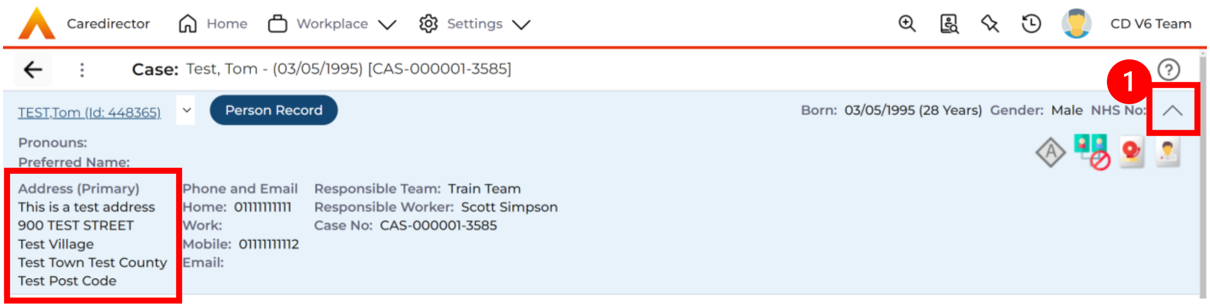




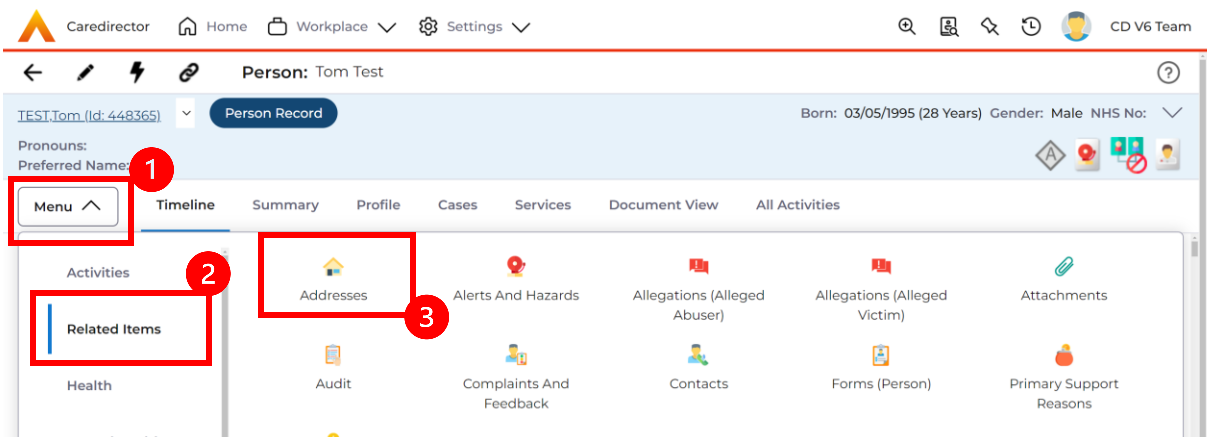
Address

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.

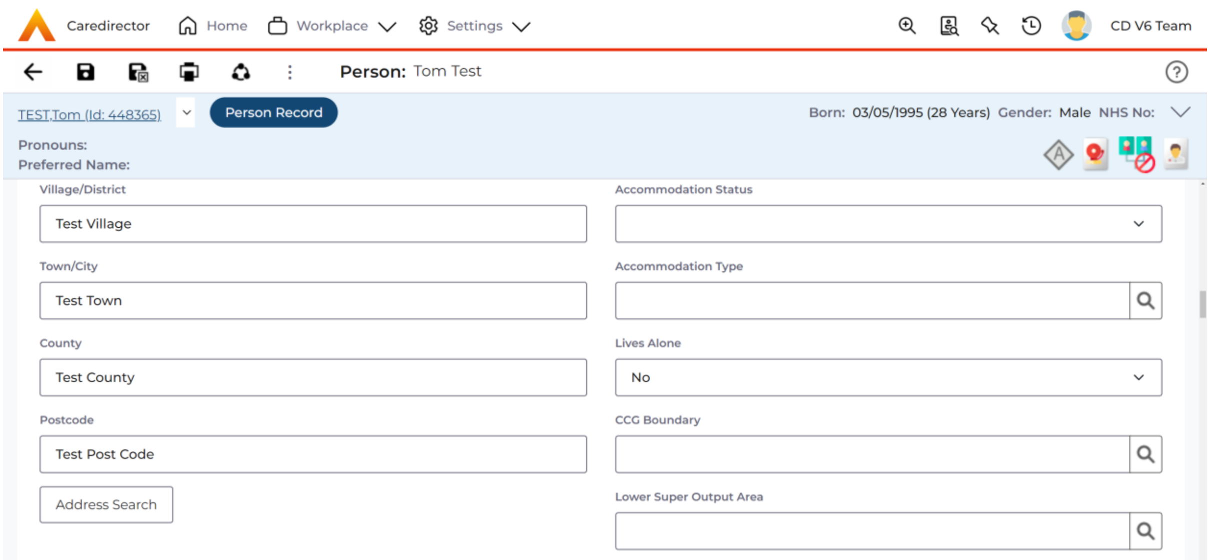


3. To create a new address, go to the:
   Person Record > Menu > Related Items > Address



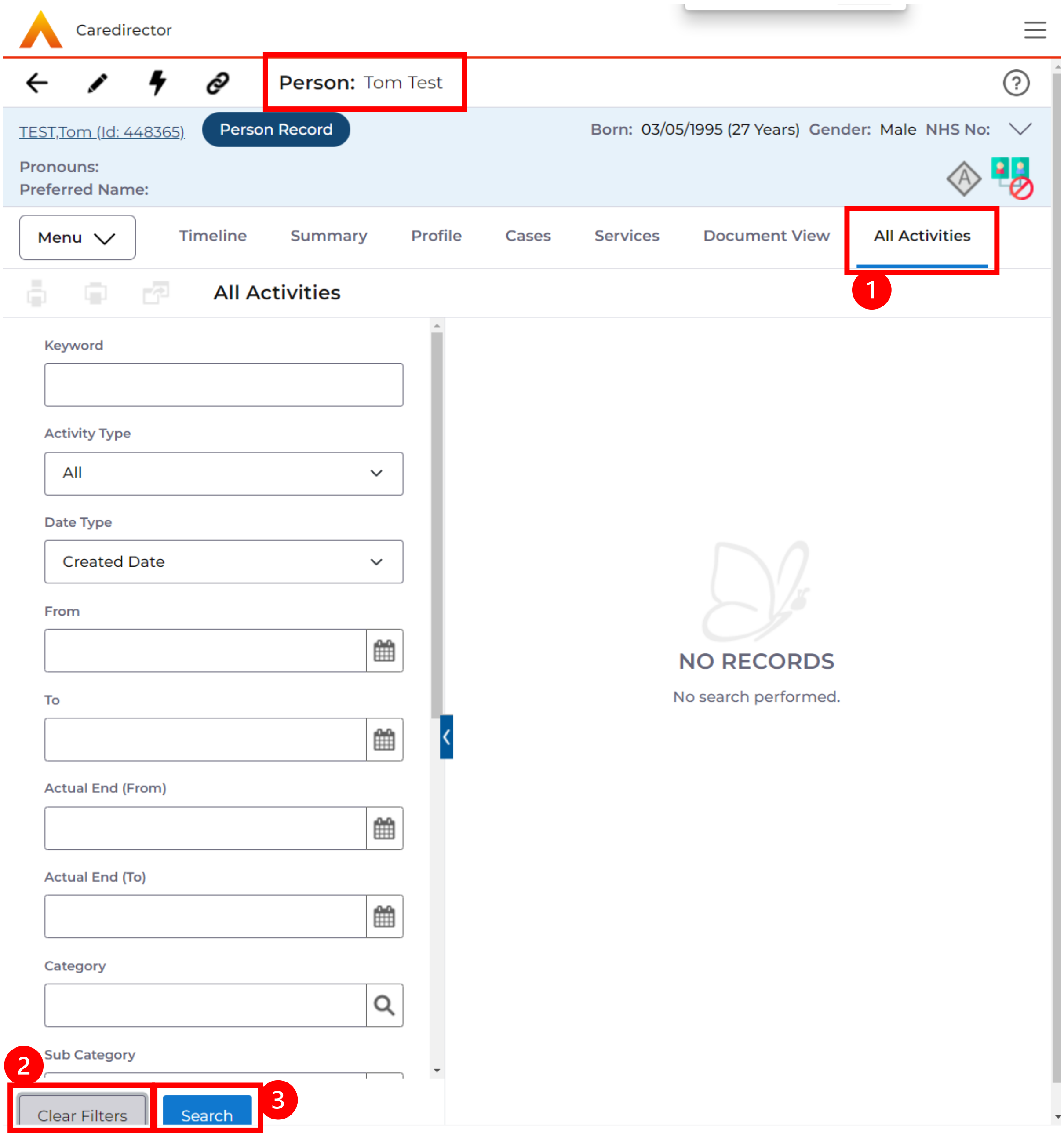
4. To create a new record for an old address that the person has lived at, follow these steps:
    a. Click on the "Create New Record" icon on the toolbar.
    b. Provide the correct information for the address in the gazetteer.
    c. Select "Save" to save the address details.
    d. Make sure to enter 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

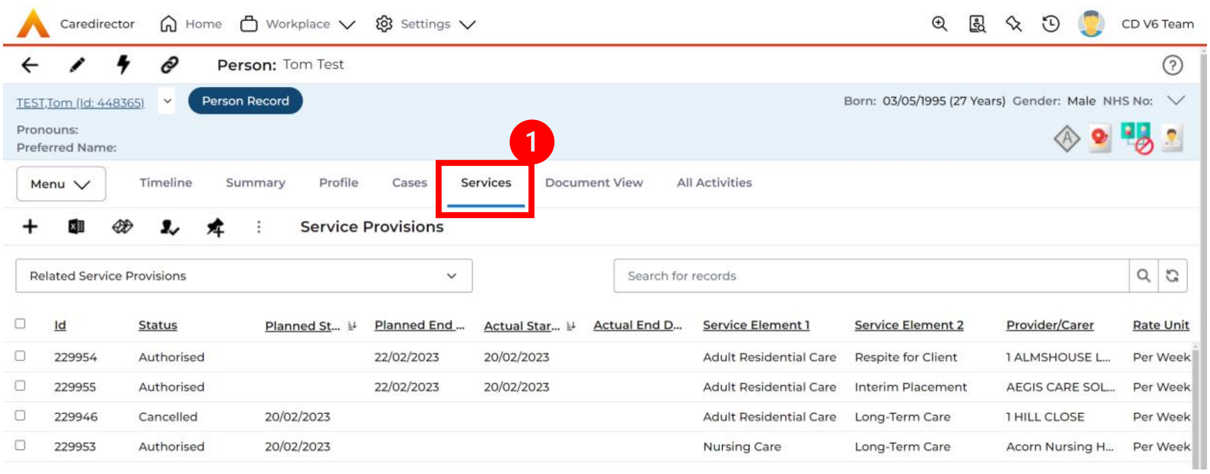
Service Provisions

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.

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/ CSO's** 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/CSO (Administrative/Client Service Officer) entails several responsibilities, including:

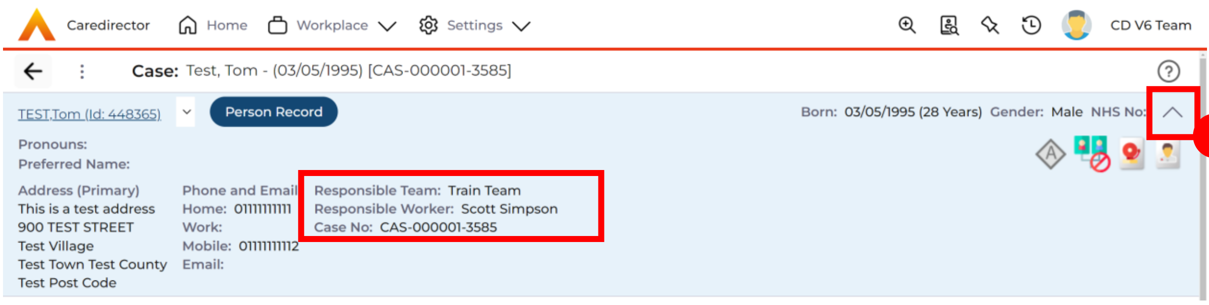
    a. Creating or Updating Activities: Admin/CSOs are responsible for creating new activities or updating existing ones within the case record. These activities serve to address specific events, tasks, or updates related to the person's care. By creating or updating activities, Admin/CSOs ensure that important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

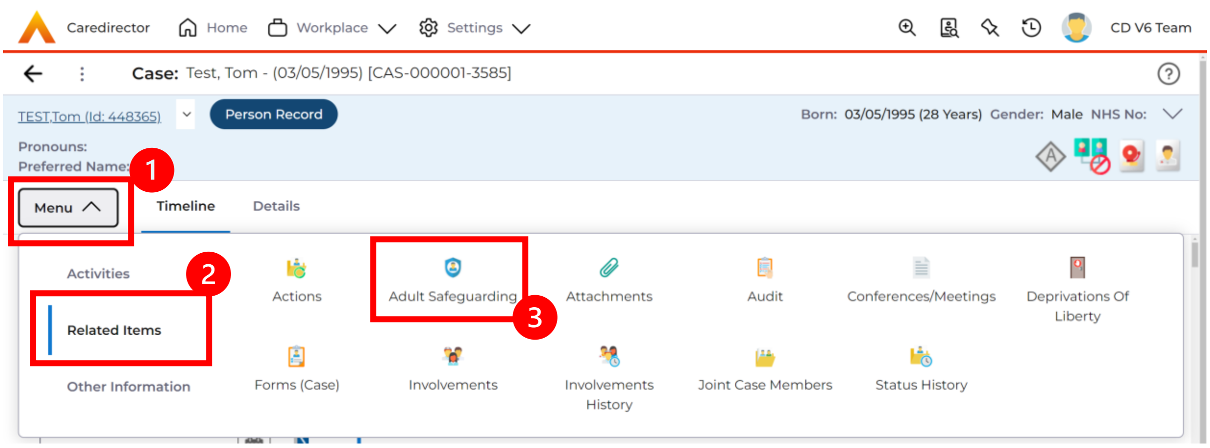
Who is the case allocated to?

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

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.

Activities

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

    a. **Appointments**: Fill out any appointments yourself or a professional has undergone or going to take.

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

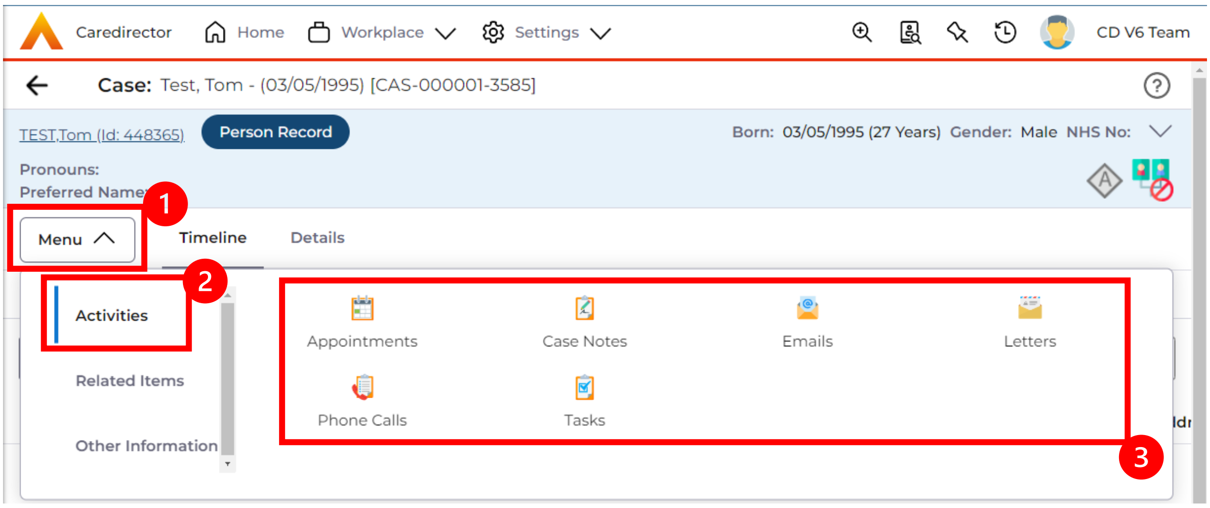
    c. **Emails**: Any emails that have been sent to you regarding this person and states advancement and relevance to be recorded.

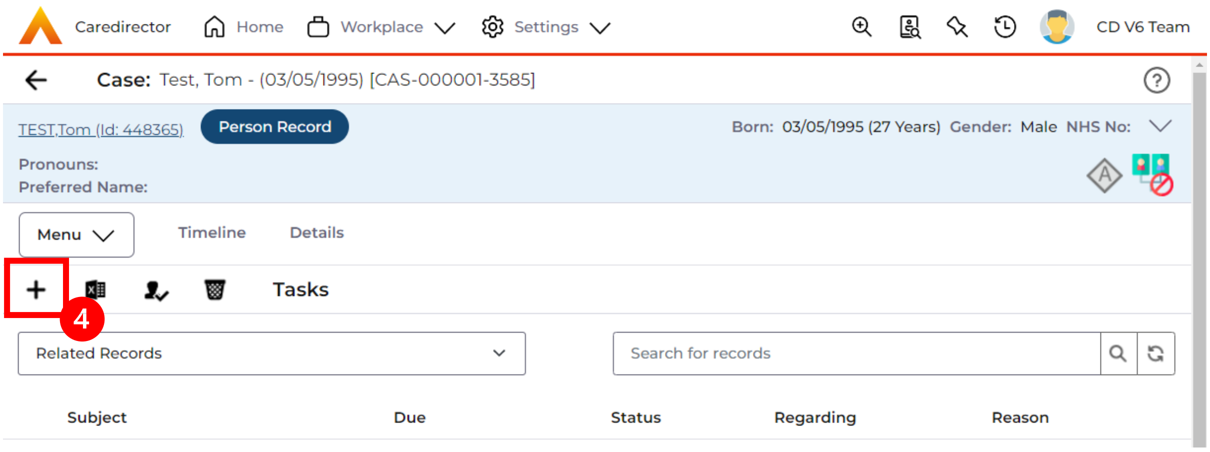
    d. **Letters**: Any letters that have been sent regarding the case and this can be uploaded and attached to this activity.

    e. **Phone Calls**: Any phone calls undertaken with this person or relevant people that can be transcribed onto Caredirector.

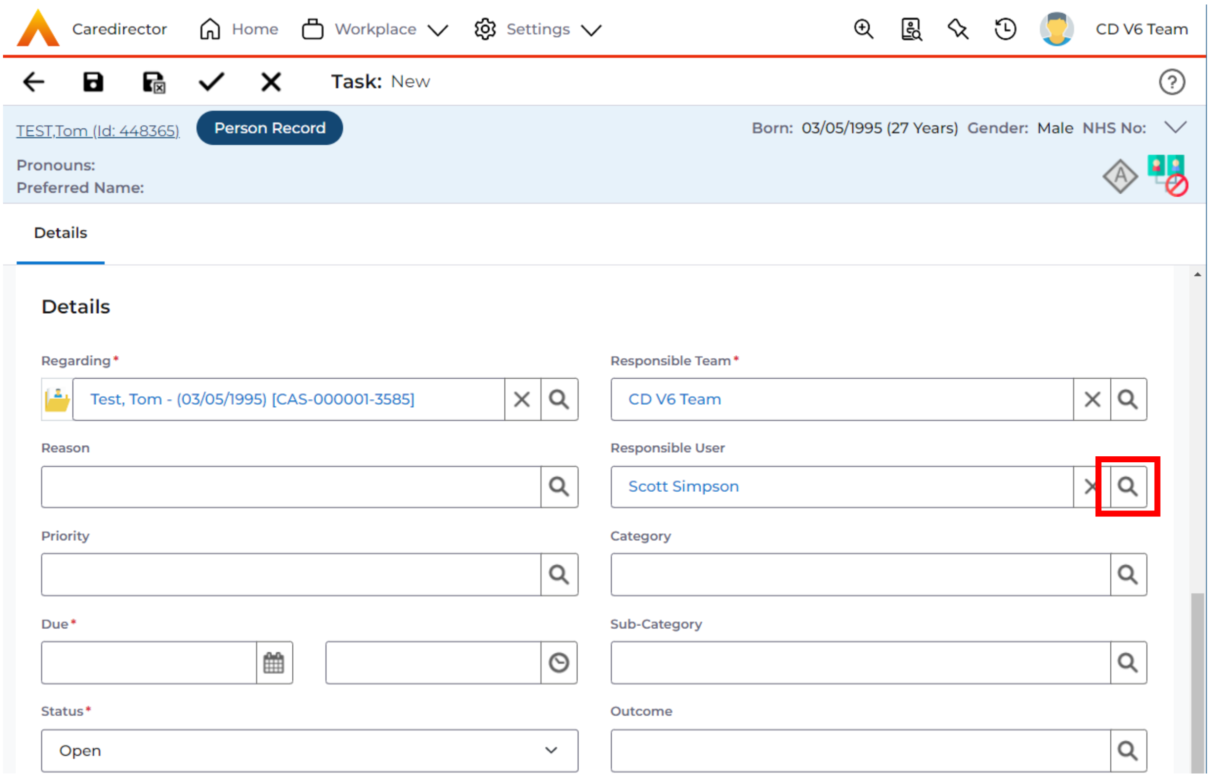
    f. **Tasks**: Anything that requires further actioning, this can be used to send activities to and from other system users on Caredirector.

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

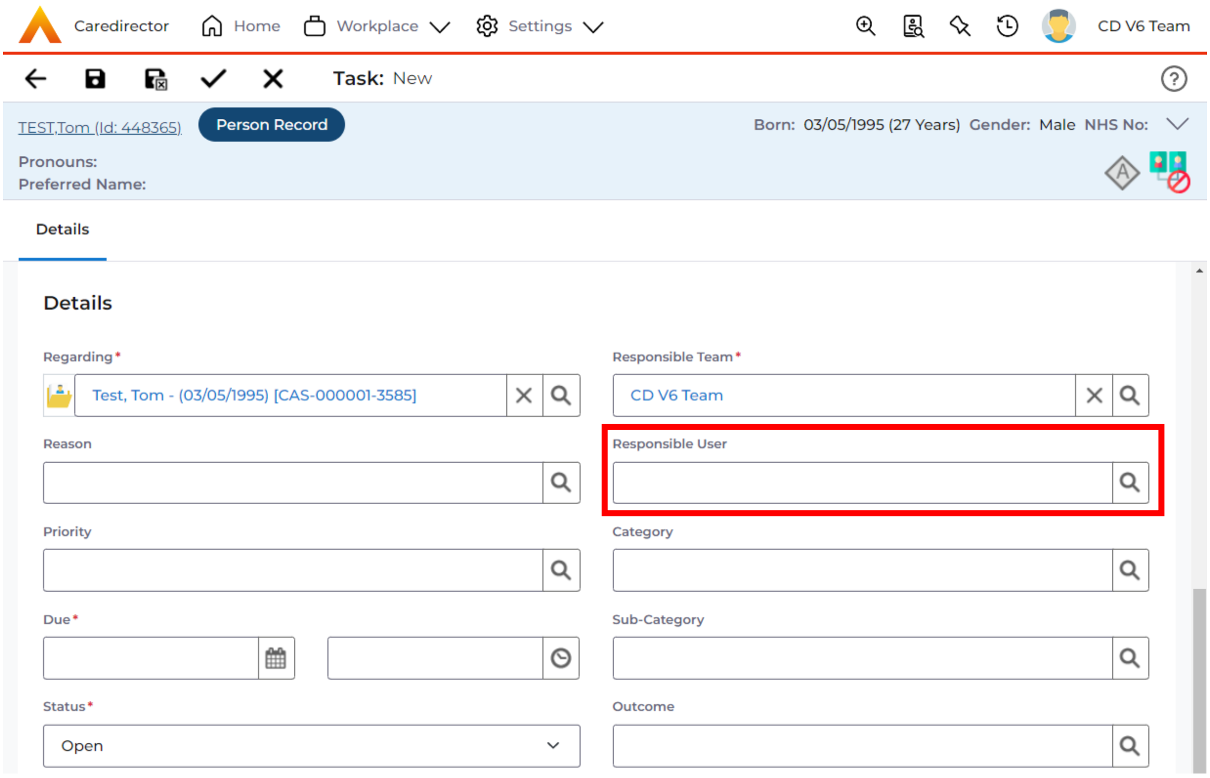




3. Allocating an activity to the appropriate person is crucial when there is a specific action required. By assigning it to the correct individual on Caredirector, it will be visible in their "My Activities" or "Team Activities" section for them to address. The initial step in this process is changing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

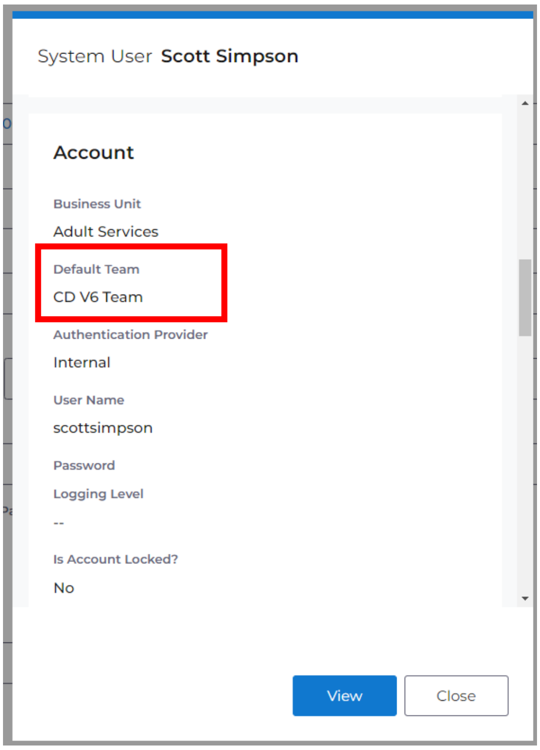


4. However, if that person is not known, select the **X** and leave blank and instead just focus on the **Responsible Team**.

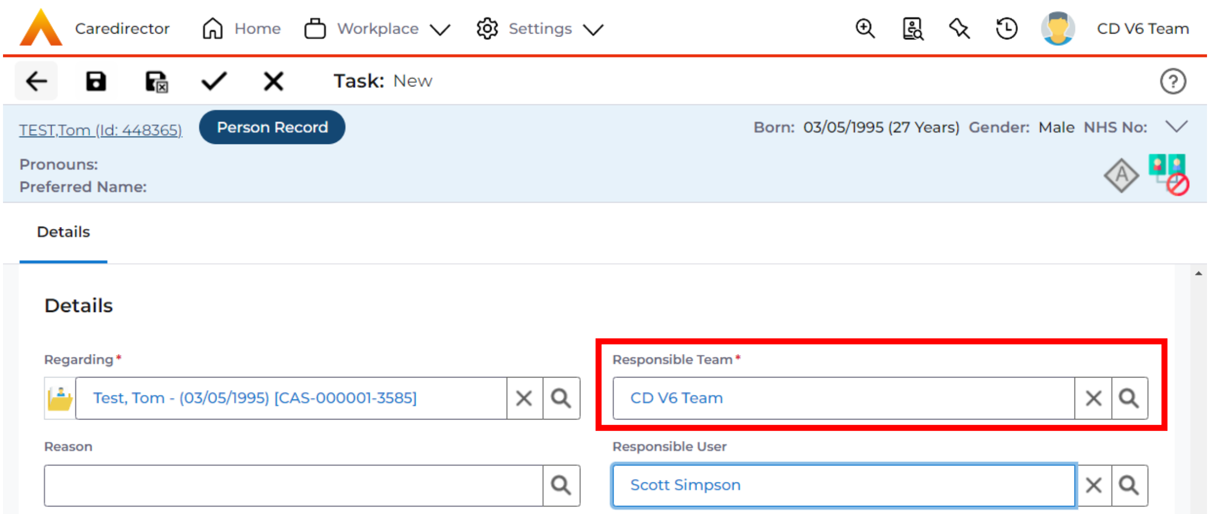


5. If you do know, who this is going to be sent to, but you do not know what team they are part of. A quick way of checking is to select their name (it should be in blue).

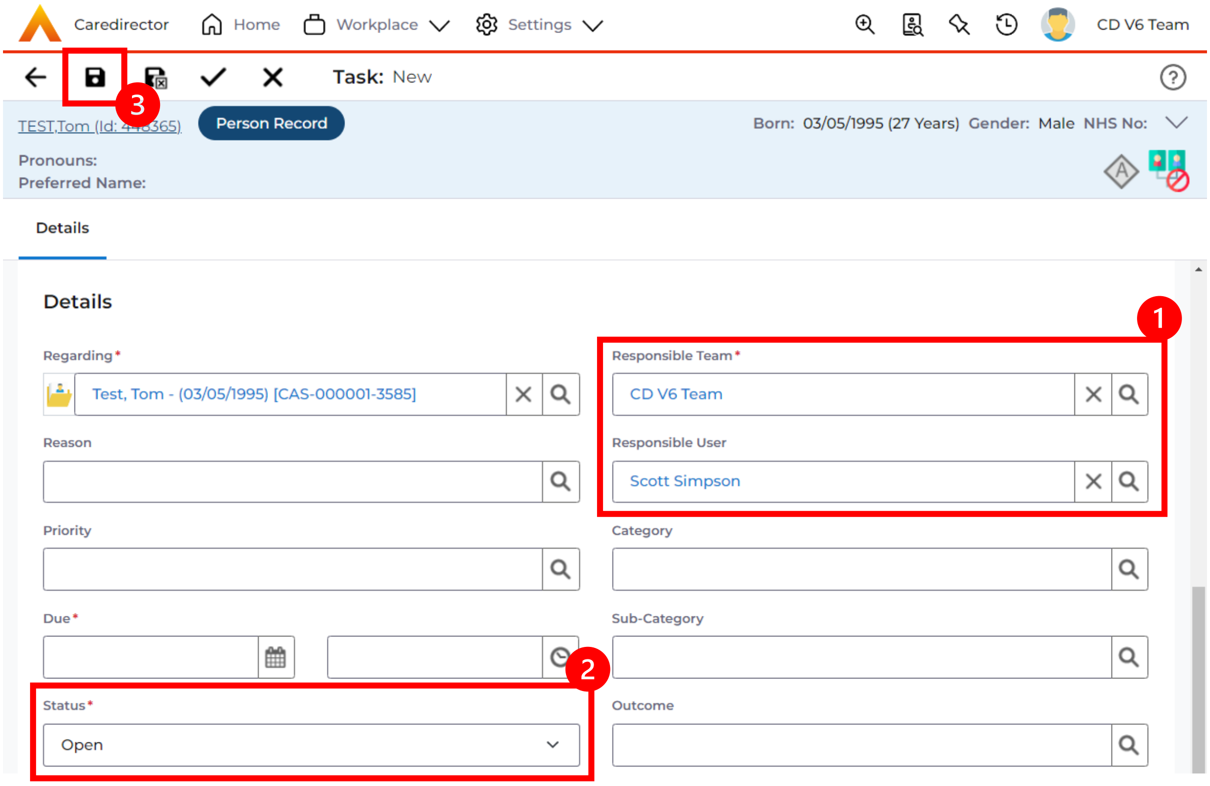
6. Once clicked, it will show their system user profile and most importantly, their default team.



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

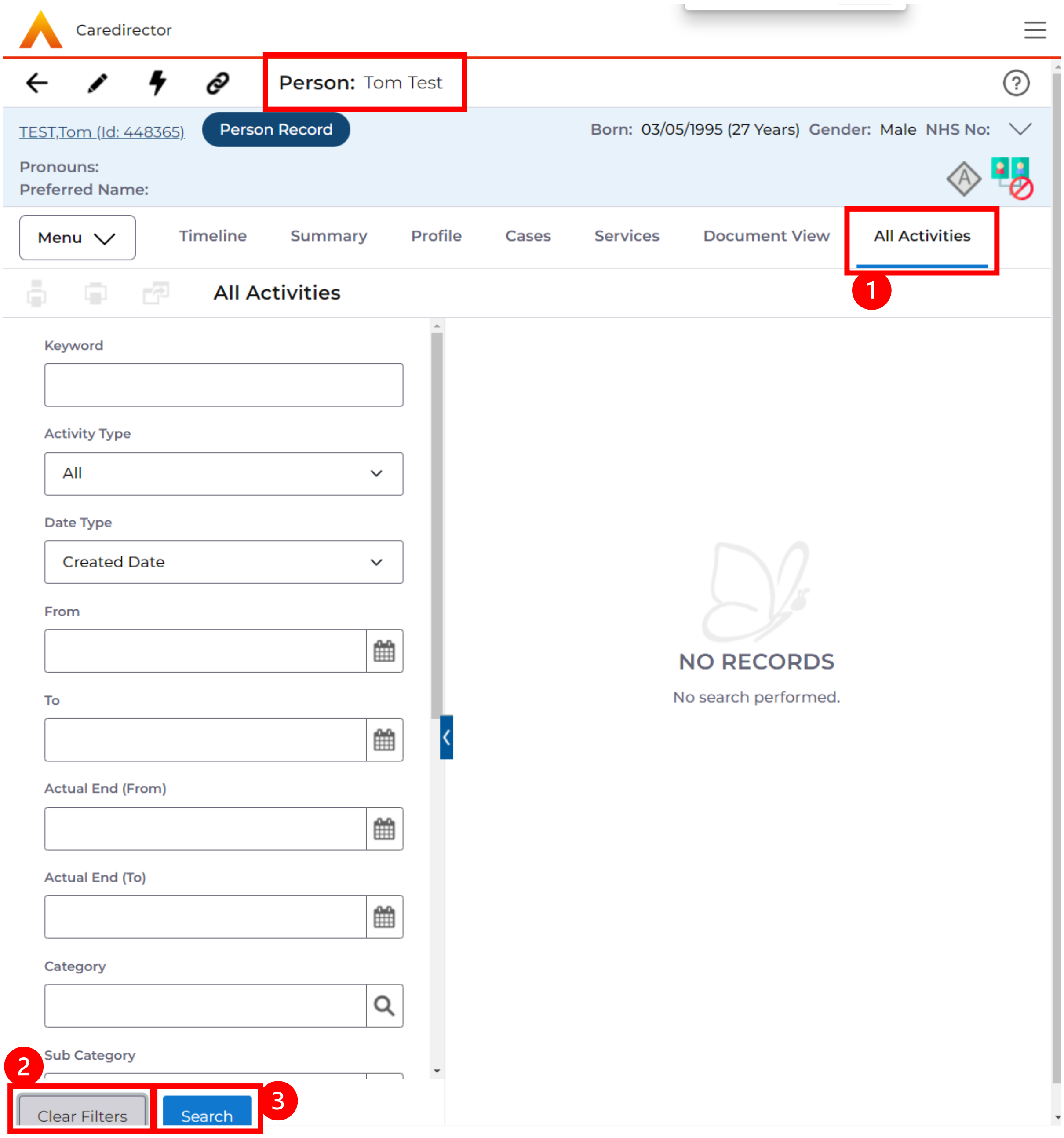


8. Once the system knows who and which team you want to send it to, leave the **Status** as **Open**. If it is set as **Completed** then it will just stay where you put it but will not show on the person/ teams dashboard. Then select **Save.**



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

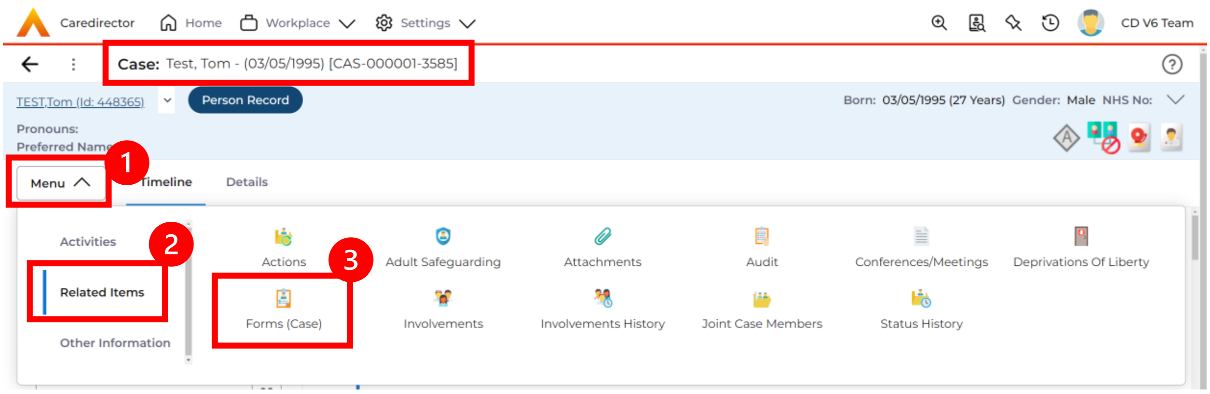
10. There may be times where you need to view all activities. This is useful if you want to see a clear picture of everything and that person's journey. To do this, go to **Person Record > All Activities > Clear Filters > Search**



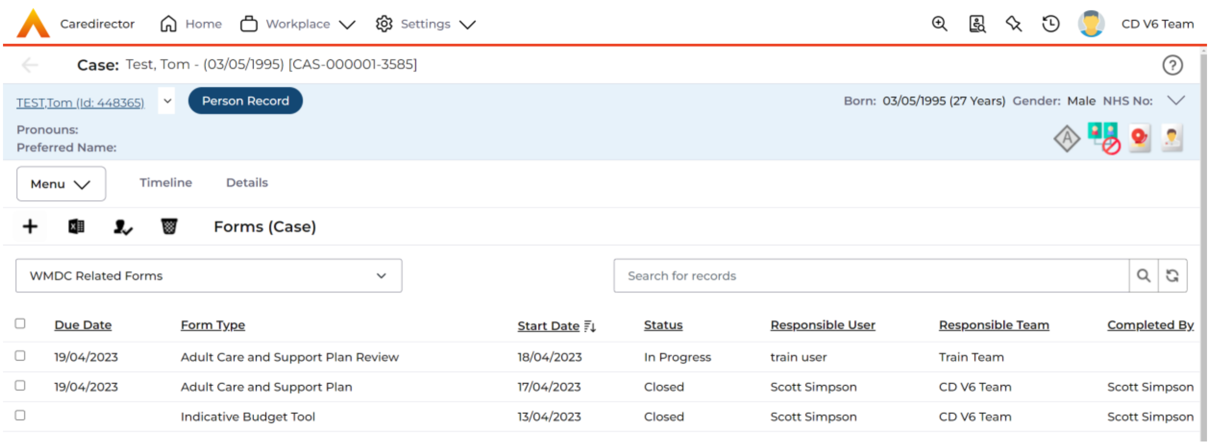
Forms (Case)

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)**

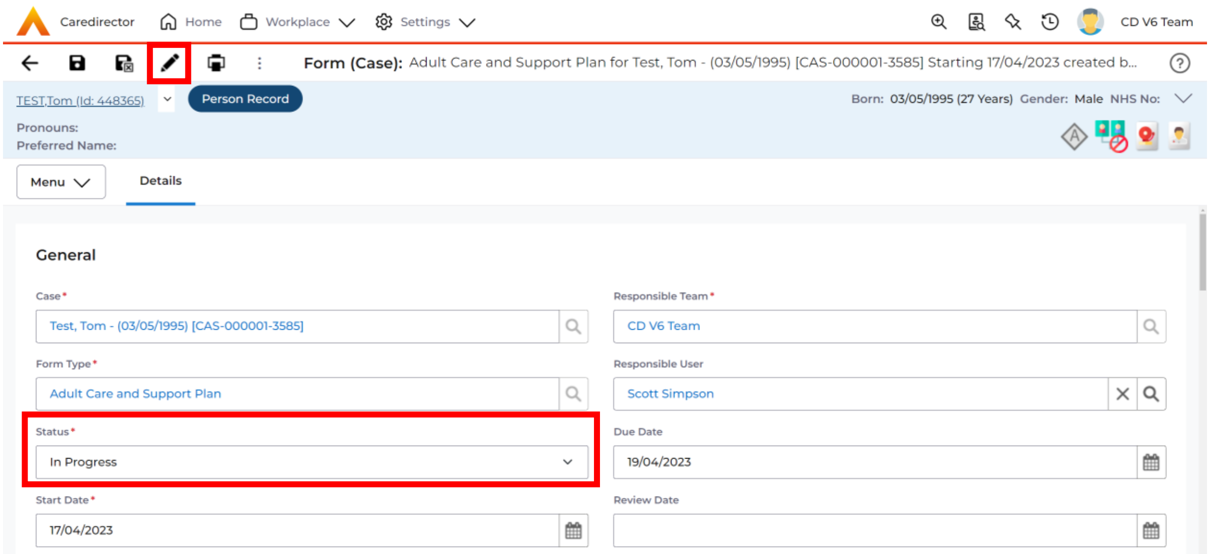


3. Once selected, it will give a list of current forms that have already been created on this case and the ability to create a new one.

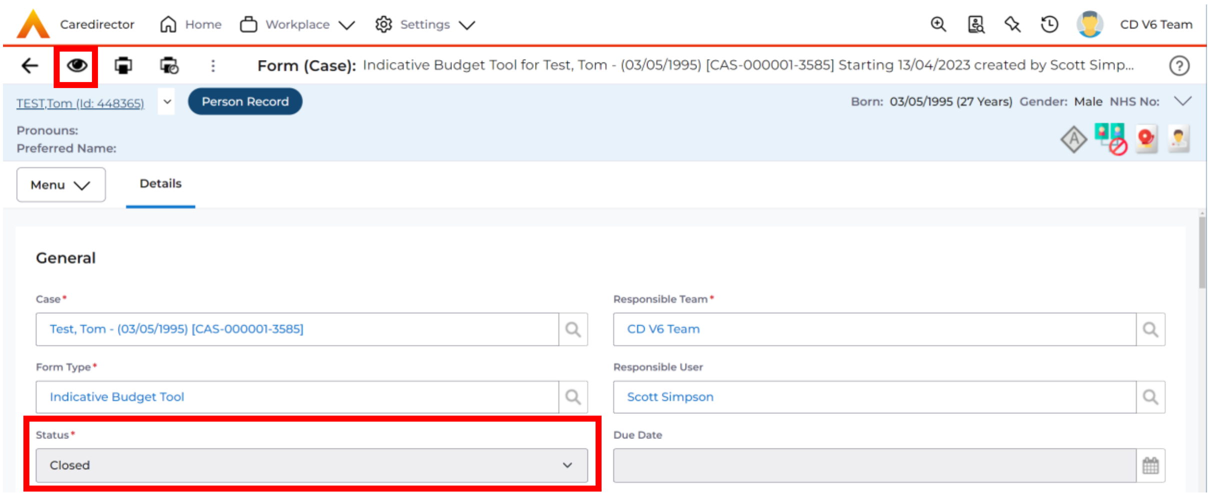


a. If a form has already been created, you can view and edit the form by selecting the **Pencil Icon (Edit)** which is available whilst the form is set as **In Progress** or to view the form use the **Eye Icon (View Only)** which is available whilst the form is set as **Closed**.

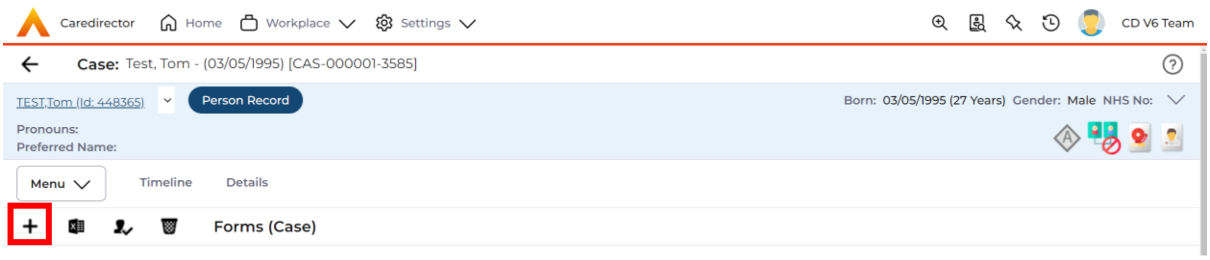
Pencil Icon (Edit)



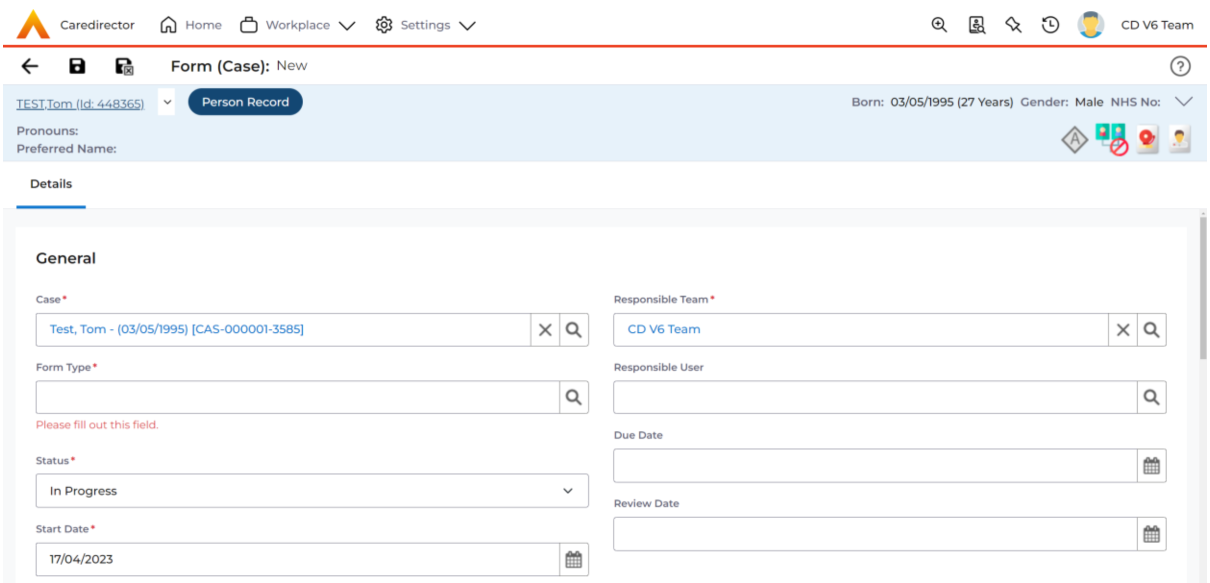
Eye Icon (View Only)



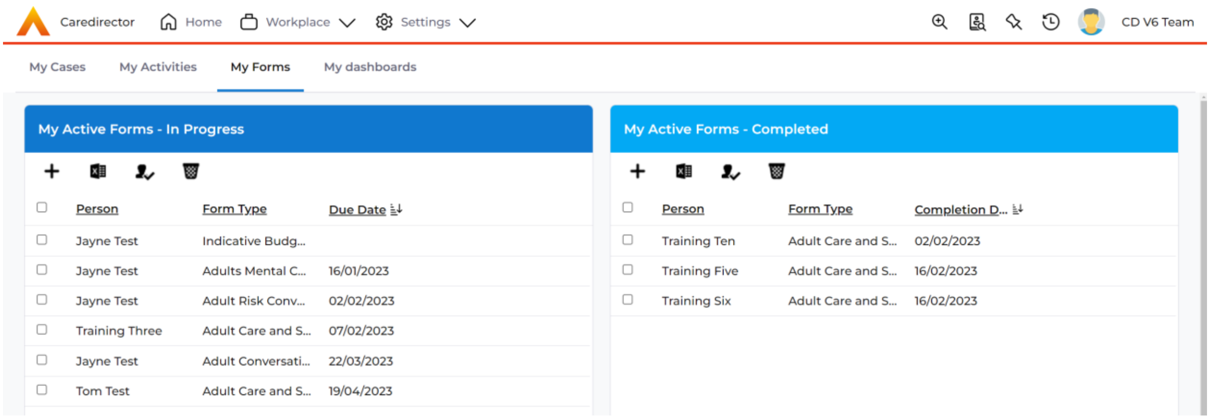
b. To create a new form, select **Create New Record** on the **toolbar.** Please note: For the majority of forms, you cannot create two of the same form whilst the **Status** is set as **In Progress** or **Complete,** they must be **Closed**.



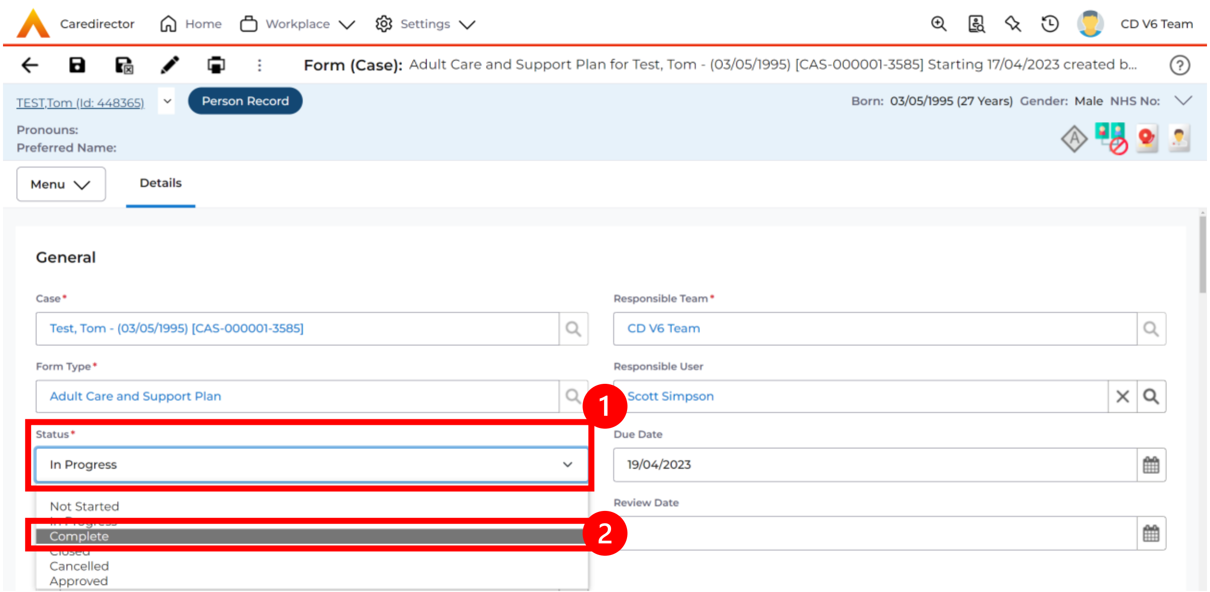
4. Once the form creation screen is open, we need to tell Caredirector what form is going to be created and who is responsible for it. Select the **Form Type** using the **Lookup Function** and the **Responsible User**. Select **Save** and you will notice the **Pencil Icon** will appear.



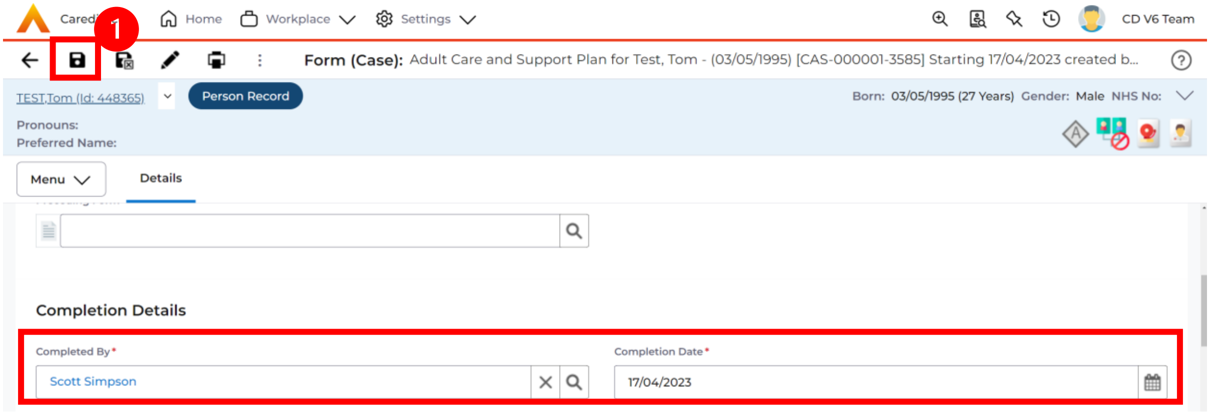
a. If the responsible user is a practitioner, then it will show under the **My Forms** dashboard on the **Home screen.**



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.


Home
Workplace
Settings
CD V6 Team
1
Form (Case): Adult Care and Support Plan for Test, Tom - (03/05/1995) [CAS-000001-3585] Starting 17/04/2023 created b...
TEST,Tom (Id: 448365)
Person Record
Born: 03/05/1995 (27 Years) Gender: Male NHS No:
Pronouns:
Preferred Name:
Menu
Details
Completion Details
Completed By
Scott Simpson
Completion Date
17/04/2023

Client Level Data

Purpose & Forms

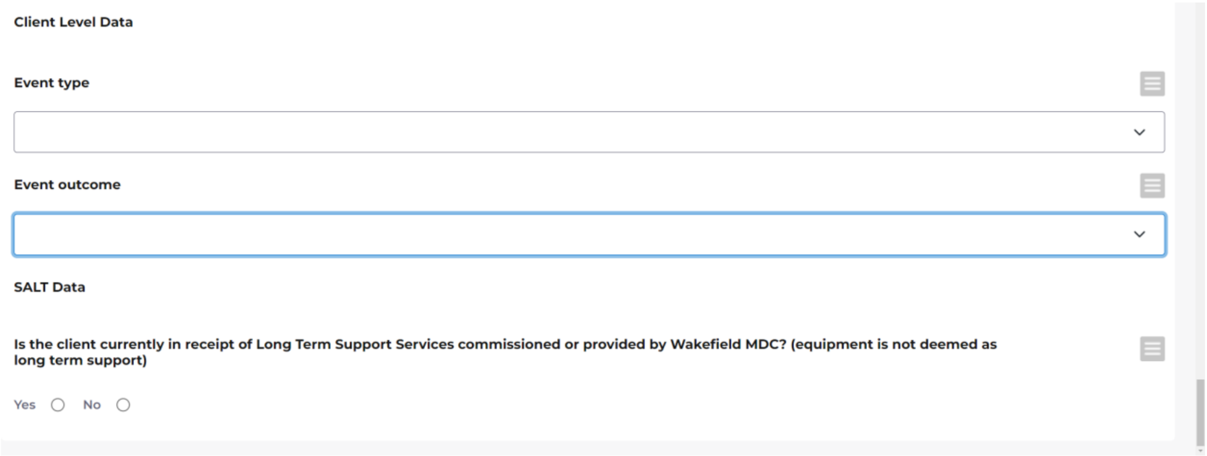
1. The new Client Level Dataset is a key project in the journey to transforming adult social care data. The new mandatory data collection will provide more timely, detailed data and will, for the first time, enable linked health and social care data, plugging the gaps in our knowledge of how people move 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

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



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 various 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	SS	25/01/2023