



Client Level Data Set V1.0

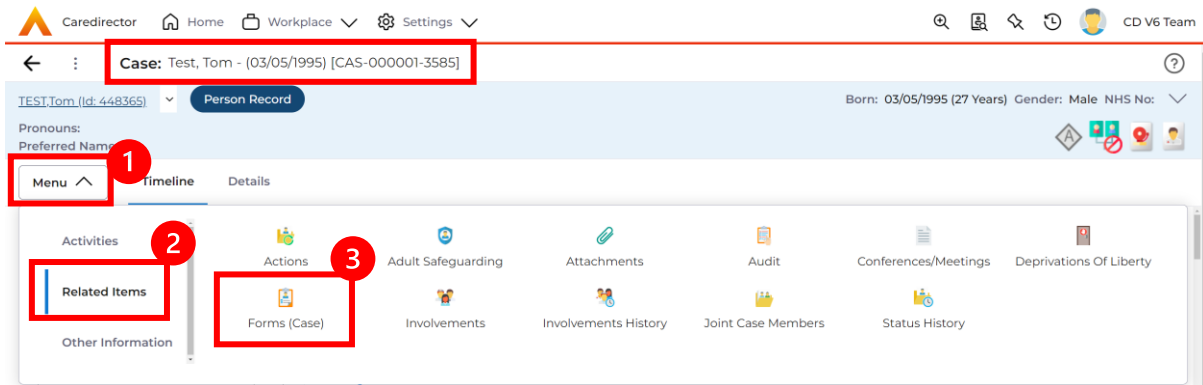
Document	Client Level Data Set
Purpose	Explaining the purpose and process of Client Level Data Set used in Forms
Version	V1.0
Owner	ICT Business Transformation Team
Last Updated	09/05/2023

Contents

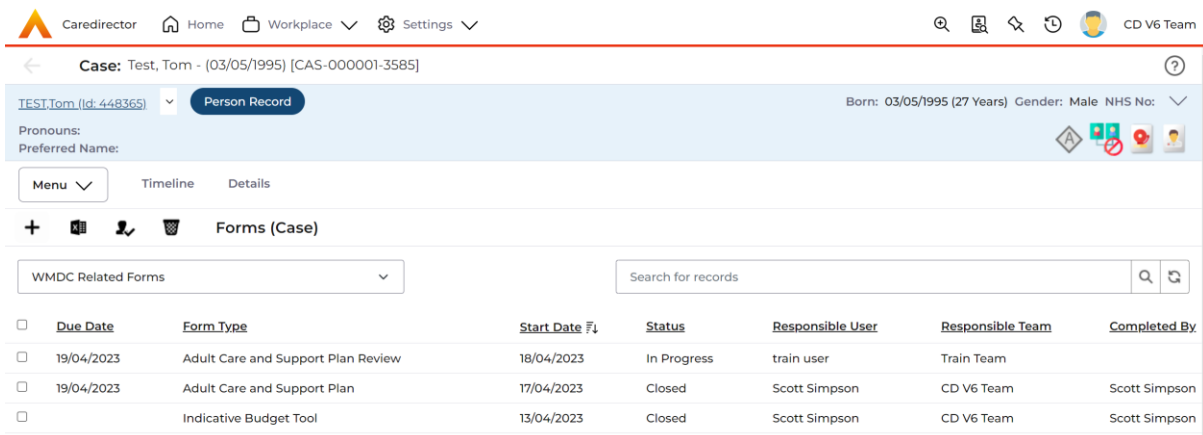
Forms (Case)	3
Client Level Data	11
Purpose & Forms	11
Event Type	13
Assessment	13
Request	17
Review	20
Total Voluntary Caring Hours per week	24
Version Control	25

Forms (Case)

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



- 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**.

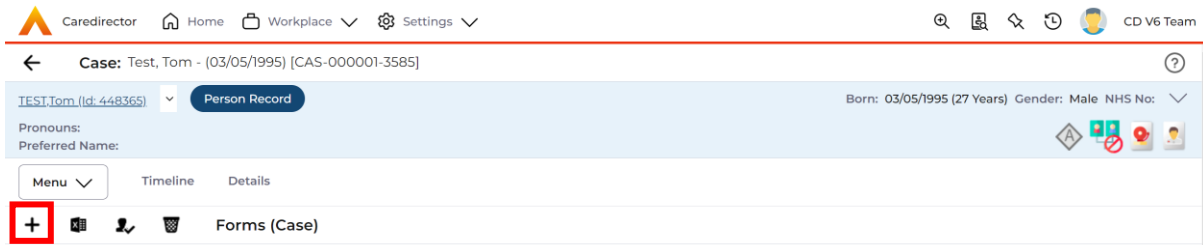
Pencil Icon (Edit)

The screenshot shows the Caredirector interface for a form titled "Form (Case): Adult Care and Support Plan for Test, Tom - (03/05/1995) [CAS-000001-3585]". The form is currently in the "In Progress" status. The "Pencil Icon" in the top navigation bar is highlighted with a red box. The "Status" dropdown menu is also highlighted with a red box and shows "In Progress".

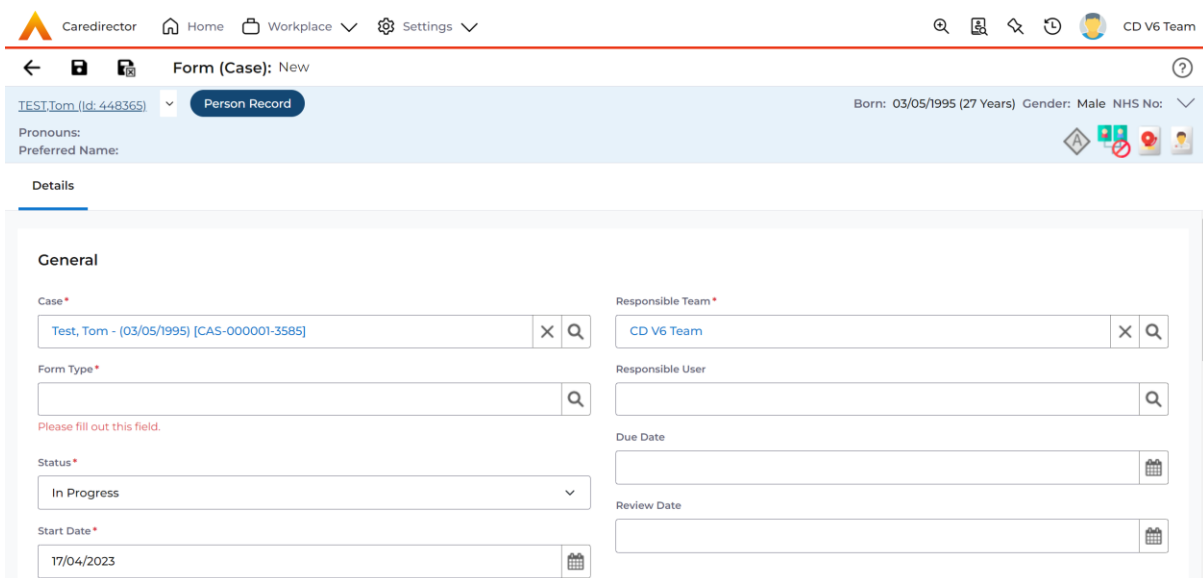
Eye Icon (View Only)

The screenshot shows the Caredirector interface for a form titled "Form (Case): Indicative Budget Tool for Test, Tom - (03/05/1995) [CAS-000001-3585]". The form is currently in the "Closed" status. The "Eye Icon" in the top navigation bar is highlighted with a red box. The "Status" dropdown menu is also highlighted with a red box and shows "Closed".

- 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**.



- 3. 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.

- 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.

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

Caredirect Home Workplace Settings

Form (Case): Adult Care and Support Plan for Test, Tom - (03/05/1995) [CAS-000001-3585] Starting 17/04/2023 created b...

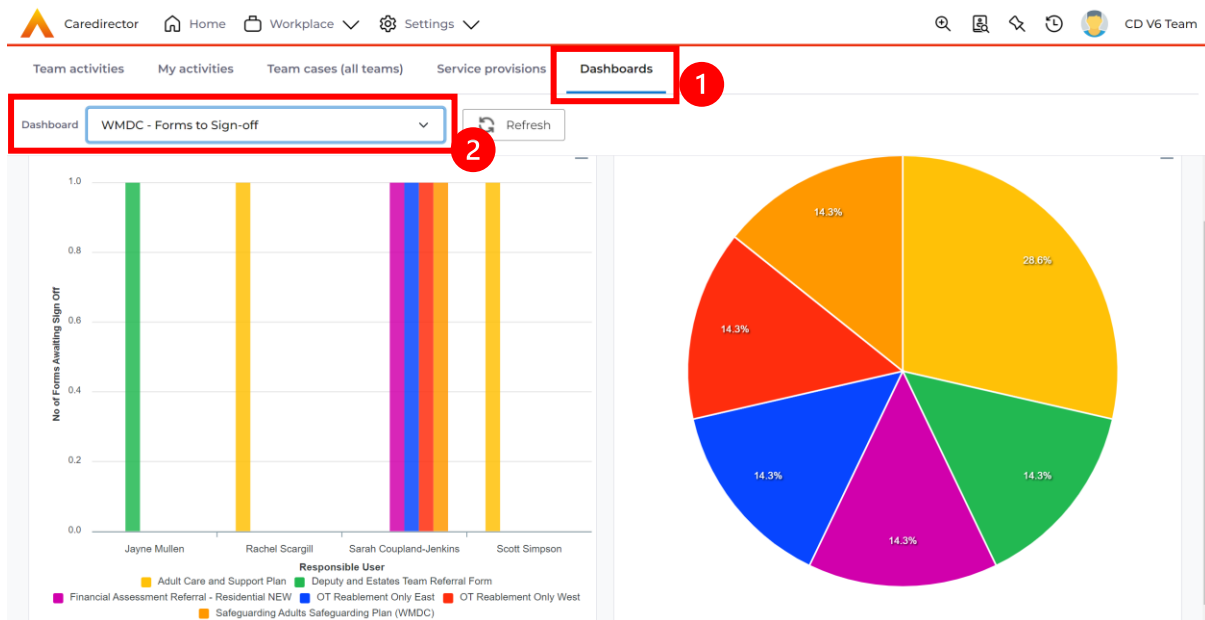
TEST, Tom (id: 448365) Person Record Born: 03/05/1995 (27 Years) Gender: Male NHS No: [redacted]

Menu Details

Completion Details

Completed By *	Completion Date *
Scott Simpson	17/04/2023

- a. As a manager, it is your job to now **Close this Form**. You can do this via your **Home Screen** dashboard
Dashboards > WMDC – Forms to Sign-Off



- b. Select one from the **Bar Chart** and it will open that into a list view. Select the appropriate one.

Title	Created By	Created On	Modified By	Modified On
Adult Care and Support Plan for Test, ...	Scott Simpson	17/04/2023 09:44...	Scott Simpson	17/04/2023 10:12...

- c. Open the form using the **Pencil Icon (Edit button)** and look through to ensure all areas have been fulfilled before closing.

Form (Case): Adult Care and Support Plan for Test, Tom - (03/05/1995) [CAS-000001-3585] Starting 17/04/2023 created b...

Person Record | Born: 03/05/1995 (27 Years) Gender: Male NHS No: [redacted]

General

Case * [Test, Tom - (03/05/1995) [CAS-000001-3585]]

Responsible Team * [CD V6 Team]

Form Type * [Adult Care and Support Plan]

Responsible User [Scott Simpson]

Status * [Complete]

Due Date [19/04/2023]

- d. Once happy, change the **Status** to **Closed**. This will automatically create another field underneath that requires you enter the date and your name.

Completion Details

Completed By*	Completion Date*
Scott Simpson	17/04/2023
Signed Off By*	Signed Off Date*

- e. Once done, select **Save** and this will close the form and allow **Cloning** and creation of another one with the same **Form Type**.

6. To clone a **Form**, which is useful in a few situations, ensure the **Form** is **Closed** and open it. Once opened, go to the three dots, and select **Clone**.

The screenshot shows the Caredirector interface for a form titled "Form (Case): Adult Care and Support Plan for Test, Tom - (03/05/1995) [CAS-000001-3585] Starting 17/04/2023 created by Scott...". The form is in the "Details" view. A dropdown menu is open, showing options: Share, Assign, Clone, Restrict Access, Activate, Delete, Run Workflow, and Copy Record Link. The "Clone" option is highlighted with a red box and a "2" in a red circle. The "Status" field is set to "Closed" and is also highlighted with a red box. A "1" in a red circle highlights the three-dot menu icon.

7. To print a **Form**, you go to:
Case Record > Forms (Case) > Open required form > Print

The screenshot shows the CareDirector interface. At the top, there is a navigation bar with icons for Home, Workplace, and Settings. A red box highlights the 'Print' icon (a printer symbol) in the top navigation bar, with a red circle containing the number '1' next to it. Below the navigation bar, the page title is 'Form (Case): Adult Care and Support Plan Review for Test, Tom - (03/05/1995) [CAS-000001-3585] Starting 18/04/2023 cr...'. The user profile 'TEST, Tom (id: 448365)' is visible, along with a 'Person Record' button. The main content area shows the 'General' section with fields for Case, Responsible Team, Form Type, and Responsible User.

8. This will open a separate screen asking which sections you want to include in your Microsoft word document.
Remember to deselect **For Office Use Only** if sending to client.

The screenshot shows the 'Print Assessment' dialog box. The title is 'Print Assessment'. Below the title, there is a 'Template*' dropdown menu with the selected option 'Adult Care and Support Plan Review - Print Templ'. There are three checkboxes: 'Print blank document?' (unchecked), 'Print only selected values?' (checked), and 'Save Document in Print History?' (unchecked). Below these, there is a 'Sections to Include:' section with a 'Check/Uncheck All' checkbox and several checked options: 'Client Details', 'Helping You Understand and express your views', 'Involvement', 'The conversation', 'Summary and Next Steps', 'People who are involved with your support', and 'Agreement'. The 'Office use only' checkbox is highlighted with a red box and a red circle containing the number '1'. At the bottom, there are 'Print' and 'Close' buttons.

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.

CARE DIRECTOR FORMS

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)



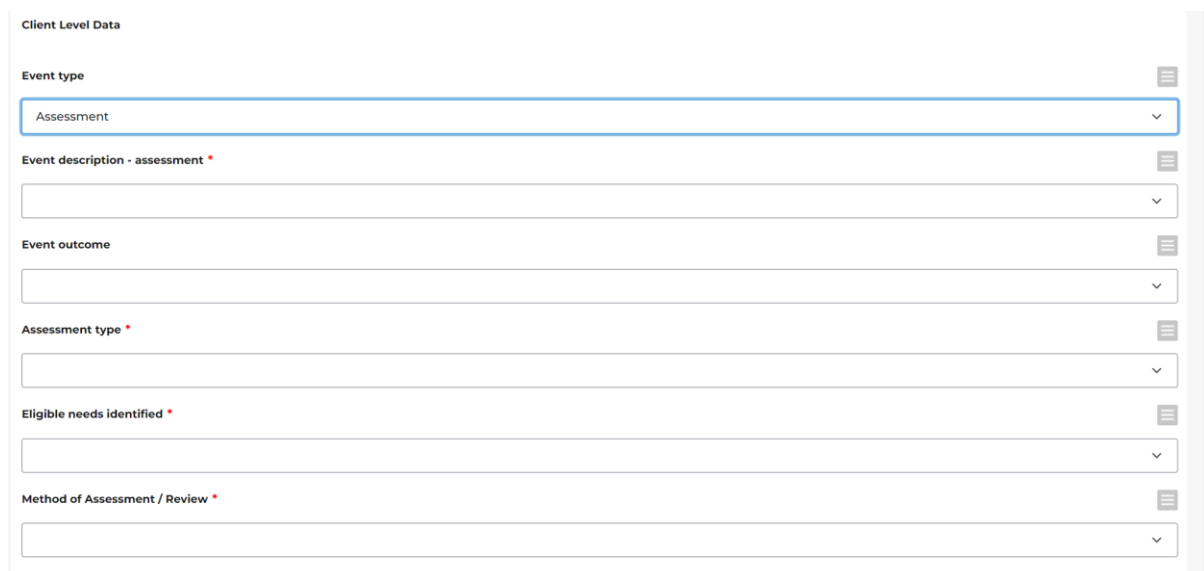
Yes No

Event Type

1. The **Event Type** works on skip logic, once one of the three choices are selected it will bring up different fields underneath that are relevant to it. All introduced forms will have **Event Type** available. The three choices are:
 - a. **Assessment** – that involve an assessment of need for care or support under the Care Act 2014, not restricted to those that involve an assessment of eligibility for services. Local authorities should provide records for a range of types and methods of assessment, including occupational therapy assessments for equipment or adaptations and financial assessments of people’s eligibility for financial support.
 - b. **Request** - covering all requests for support in relation to the provision of adult social care services, including contacts from clients or their representatives, or someone acting on their behalf. The only exception is casual contacts where no client details are captured. In a change from SALT, local authorities should submit requests from existing as well as new clients.
 - c. **Review** - of care and support plans for service users and carers. This covers people receiving long-term support, those receiving short-term services and people receiving support as a carer.

Assessment

1. When **Assessment** is selected these are the fields that it will create.



The screenshot shows a form titled "Client Level Data" with the following fields:

- Event type**: A dropdown menu with "Assessment" selected.
- Event description - assessment ***: A text input field.
- Event outcome**: A text input field.
- Assessment type ***: A text input field.
- Eligible needs identified ***: A text input field.
- Method of Assessment / Review ***: A text input field.

2. **Event Description – Assessment** will bring back three choices. These are determined by which form has been selected and what kind of assessment it is.

Event description - assessment ☰

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- Care Act Eligibility
- Contact Screening
- Initial Conversation

3. **Event Outcome** is not mandatory however it is advised to fill it in. As it is the intended action once an event is completed and what the next steps are.

Some key terminology points:

- a. **'NFA'** – No further Action and is when the Wakefield does not plan any further actions in relation to the adult's needs for care or support, with the expectation that there would be no subsequent events recorded in client level data.
- b. **'NFA - Self-funded client (inc. 12wk disregard)'** - should be used as the Event Outcome for a terminated permanent residential or nursing care service following a 12-week property disregard after which the service user became a self-funder.
- c. **'Provision of Service'** – relates to open and ongoing services to indicate that the service was continuing at the end of the reporting period.
- d. **'Progress to Support Planning/ Services'** – is for **Reviews** when there is a change in package, if there is no change in package the **Event Outcome** should be **'No Change in Package'**.
- e. When multiple **Event Outcomes** apply, a single outcome should be selected from the list. Choosing the first which applies according to the order in which they appear, from top to bottom.

Event outcome ☰

▼

- Admitted to Hospital
- NFA - 100% NHS funded care
- NFA - Deceased
- NFA - Information and advice / signposting only
- NFA - Moved to other LA
- NFA - Other
- NFA - Self-funded client (inc 12 week disregard)
- NFA - Support declined
- NFA - Support ended - other reason
- No change in package
- Progress to Assessment
- Progress to End of Life Care
- Progress to financial assessment
- Progress to Reablement / ST Max
- Progress to Reassessment / Unplanned Review
- Progress to Support Planning / Services
- Provision of service
- Service ended as planned

4. **Assessment Type** field provides a categorisation for assessment events.
 - a. **Long Term** – If the determination of eligibility for services is made as part of the assessment, as set out under the Care Act, it should be recorded as Long Term. This covers assessments of adults who may need care or support and carers
 - b. **Short Term** – Other types of care assessment, including occupational therapy assessments of equipment, reablement, and proportional assessments (Staged, conversation) that do not involve an assessment of eligibility for services, should be recorded as a Short Term Assessment.
 - c. **Financial Assessment** – A financial assessment determines the client's ability to pay for care services. The three that should be included in client level data: new client financial assessments; planned financial annual reviews (statutory requirement); and ad-hoc financial re-assessments (when circumstances change i.e. client moves from Community to Residential).

Assessment type *



▼

Financial Assessment

Long term

Short Term

5. **Eligible needs identified** allows you to state if there is a need that has been identified for the person.
 - a. **Non-Eligible need identified** - is stating those identified needs but those that are not eligible for support under the Care Act 2014.

Eligible needs identified *



▼

Eligible needs identified

No needs identified

Non-Eligible needs identified

6. **Method of Assessment / Review** describes who was actively involved in the assessment. To be actively involved, the person's views must have been considered as part of the assessment. The Care Act 2014 requires assessment of adults' needs for care and support and the carers' needs for support. When you carry out an adult's assessment with their carer involved, or a carer's assessment with the cared-for person involved, the method of assessment should be '**Service user and carer**'.

Method of Assessment / Review *



Dropdown menu with options:

- Service user only
- Service user and carer
- Carer only

Request

1. These are the fields that populate when **Event Type** is set as **Request**. This field records requests for support (contacts from people or their representatives, or someone acting on their behalf) being made in relation to the provision of adult social care services, expecting 'casual contacts' where no client details are captured. Where the first contact is also an initial conversation in a multi-stage assessment approach, this should be recorded as a request.

Client Level Data

Event type



Request



Event description - request *



Event outcome



Route of access *



2. **Event description – request** describes the type of contact made.

Event description - request *

- Adult Contact: new case
- Children's referral to ASC
- Hospital Contact
- Initial conversation

3. **Event Outcome** is not mandatory however it is advised to fill it in. As it is the intended action once an event is completed and what the next steps are.

Some key terminology points:

- a. **'NFA'** – No further Action and is when the Wakefield does not plan any further actions in relation to the adult's needs for care or support, with the expectation that there would be no subsequent events recorded in client level data.
- b. **'NFA - Self-funded client (inc. 12wk disregard)'** - should be used as the Event Outcome for a terminated permanent residential or nursing care service following a 12-week property disregard after which the service user became a self-funder.
- c. **'Provision of Service'** – relates to open and ongoing services to indicate that the service was continuing at the end of the reporting period.
- d. **'Progress to Support Planning/ Services'** – is for **Reviews** when there is a change in package, if there is no change in package the **Event Outcome** should be **'No Change in Package'**.
- e. When multiple **Event Outcomes** apply, a single outcome should be selected from the list. Choosing the first which applies according to the order in which they appear, from top to bottom.

Event outcome

- Admitted to Hospital
- NFA - 100% NHS funded care
- NFA - Deceased
- NFA - Information and advice / signposting only
- NFA - Moved to other LA
- NFA - Other
- NFA - Self-funded client (inc 12 week disregard)
- NFA - Support declined
- NFA - Support ended - other reason
- No change in package
- Progress to Assessment
- Progress to End of Life Care
- Progress to financial assessment
- Progress to Reablement / ST Max
- Progress to Reassessment / Unplanned Review
- Progress to Support Planning / Services
- Provision of service
- Service ended as planned

4. **Route of Access** is required for all requests for support whether this is for a new or existing client. Where did this request come from, some key points:
- a. **Discharge from Reablement** – is an option provided for the rare situation in which a client makes a new request for support following their discharge from reablement. Where a client has an assessment and/or further services following reablement.
 - b. **Planned Entry (Transition)** – Is when a child transitions to adult social care.

Route of access *



Prison

Self-Funder

Discharge from Reablement

Transfer from other LA

Planned Entry (Transition)

Discharge from Hospital

Diversion from Hospital services

Community / Other route

commissioned or provided by Wakefield MDC? (equipment is

Review

1. These are the fields that populate when you enter the **Event Type Review**. This should be an examination of an existing care and support plan. Where a review and re-assessment is recorded on Caredirector as a single combined event, this should be submitted as a review.

The screenshot shows a form with the following fields:

- Event type**: A dropdown menu with "Review" selected.
- Event description - review ***: An empty text input field.
- Event outcome**: An empty text input field.
- Method of Assessment / Review ***: An empty text input field.
- Review Reason ***: An empty text input field.
- Review outcomes achieved ***: An empty text input field.

2. **Event description – review** is based around an annual review, whether it is a scheduled or unscheduled review. Choose the relevant option based on the assessment.

The screenshot shows the "Event description - review *" dropdown menu with the following options:

- Annual Review
- Scheduled Review
- Unscheduled Review

3. **Event Outcome** is not mandatory however it is advised to fill it in. As it is the intended action once an event is completed and what the next steps are.

Some key terminology points:

- f. **'NFA'** – No further Action and is when the Wakefield does not plan any further actions in relation to the adult's needs for care or support, with the expectation that there would be no subsequent events recorded in client level data.
- g. **'NFA - Self-funded client (inc. 12wk disregard)'** - should be used as the Event Outcome for a terminated permanent residential or nursing care service following a 12-week property disregard after which the service user became a self-funder.
- h. **'Provision of Service'** – relates to open and ongoing services to indicate that the service was continuing at the end of the reporting period.
- i. **'Progress to Support Planning/ Services'** – is for **Reviews** when there is a change in package, if there is no change in package the **Event Outcome** should be **'No Change in Package'**.
- j. When multiple **Event Outcomes** apply, a single outcome should be selected from the list. Choosing the first which applies according to the order in which they appear, from top to bottom.

Event outcome ☰

- Admitted to Hospital
- NFA - 100% NHS funded care
- NFA - Deceased
- NFA - Information and advice / signposting only
- NFA - Moved to other LA
- NFA - Other
- NFA - Self-funded client (inc 12 week disregard)
- NFA - Support declined
- NFA - Support ended - other reason
- No change in package
- Progress to Assessment
- Progress to End of Life Care
- Progress to financial assessment
- Progress to Reablement / ST Max
- Progress to Reassessment / Unplanned Review
- Progress to Support Planning / Services
- Provision of service
- Service ended as planned

4. **Method of Assessment / Review** describes who was actively involved in the assessment. To be actively involved, the person's views must have been considered as part of the assessment. The Care Act 2014 requires assessment of adults' needs for care and support and the carers' needs for support. When you carry out an adult's assessment with their carer involved, or a carer's assessment with the cared-for person involved, the method of assessment should be '**Service user and carer**'.

Method of Assessment / Review *



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Service user only

Service user and carer

Carer only

5. **Review Reason** was known as **Significant event** in SALT. As with **Route of Access**, please choose the most appropriate review reason if known, with the default to '**planned**' for all carer reviews. This option is not available on the following **Forms** (this option will not appear):
- a. **Carers' Conversation Record**

Review Reason *



▼

Planned

Unplanned - Carer Related

Unplanned - Change in Commissioning Arrangements

Unplanned - Hospital (planned and unplanned episode)

Unplanned - Other Reason

Unplanned - Provider Failure

Unplanned - Safeguarding Concern

6. **Review Outcomes Achieved** is to highlight whether the review outcomes that have been discussed has been fully met, not met or partially met. Choose appropriately. This option is not available on the following **Forms** (this option will not appear):
- a. **Carers' Conversation Record**

Review outcomes achieved *



Fully met

Not met

Partially met

Total Voluntary Caring Hours per week

1. This is only available on the following **Forms**:
 - a. **Carers Support Plan Review**
 - b. **Carers Conversation Record**

2. This is not a mandatory field, but it is encouraged to complete as values are taken from the census to incorporate a measure of the extent of the caring role.

Client Level Data

Event type



Event outcome



Total voluntary caring hours per week



3. How many hours per week, does the carer provide service.

1-7 hours

8-14 hours

15-21 hours

22-28 hours

29-35 hours

36-42 hours

43-49 hours

50+ hours

▼

Version Control

Version	Change	Author	Date
V1	Creation of Document - Focus on Client Level Data & form creation/ edit/ clone/ close. - Change of purpose/ completion of some forms does not require manager sign off.	SS	18/04/2023