Client Level Data Set
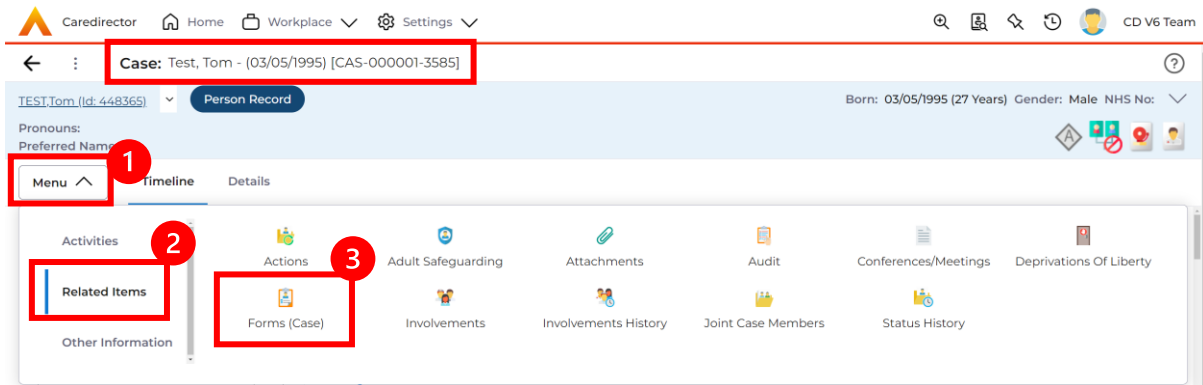# V1.0

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)

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

2. 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.
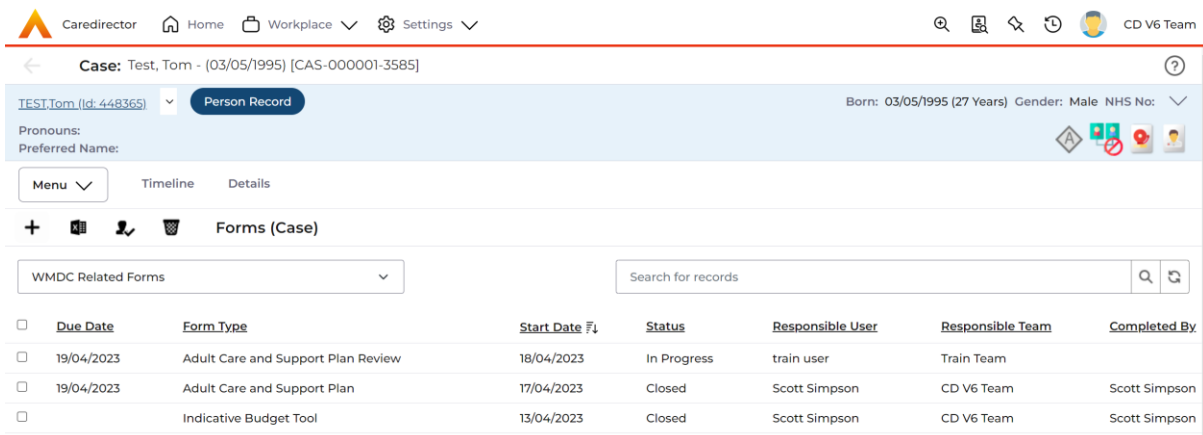
a. If a form has already been created, you can view and edit the form byselecting the **Pencil Icon (Edit)** which is available whilst the form is set as **In Progress** or to view the form use the **Eye Icon (View Only)** which is available whilst the form is set as **Closed**.
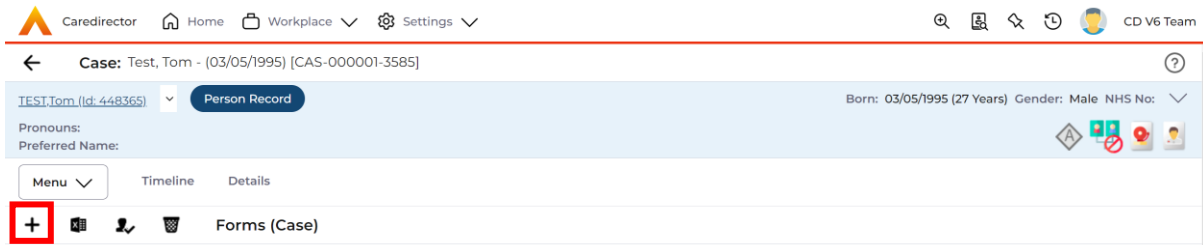
Pencil Icon (Edit)

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**.

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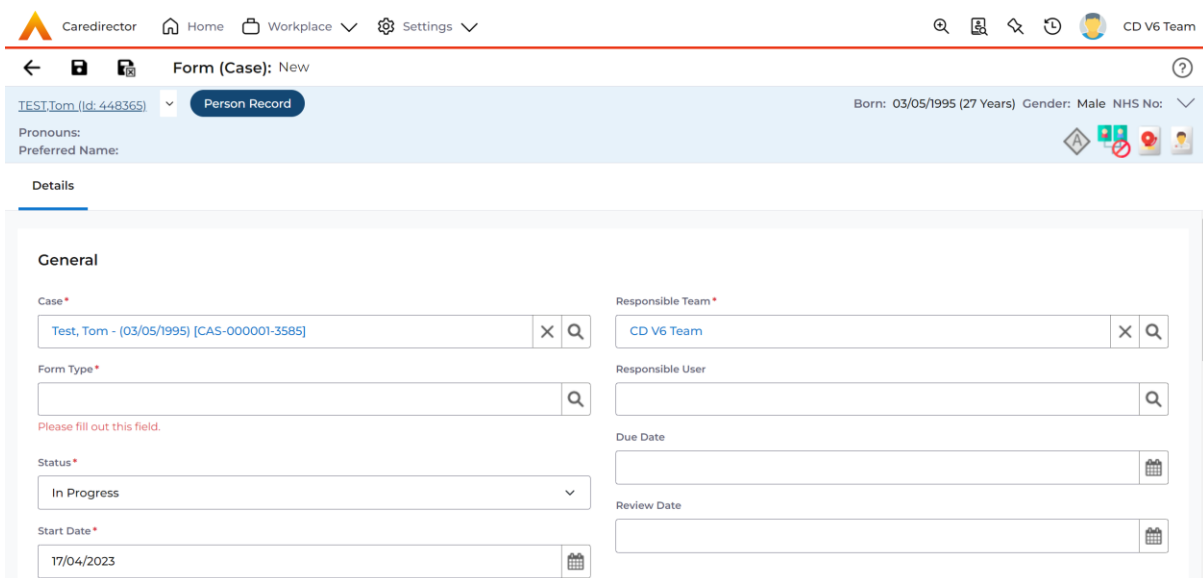
a. If the responsible user is a practitioner, then it will show under the **My Forms** dashboard on the **Home screen.**

4. 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.

5. 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.

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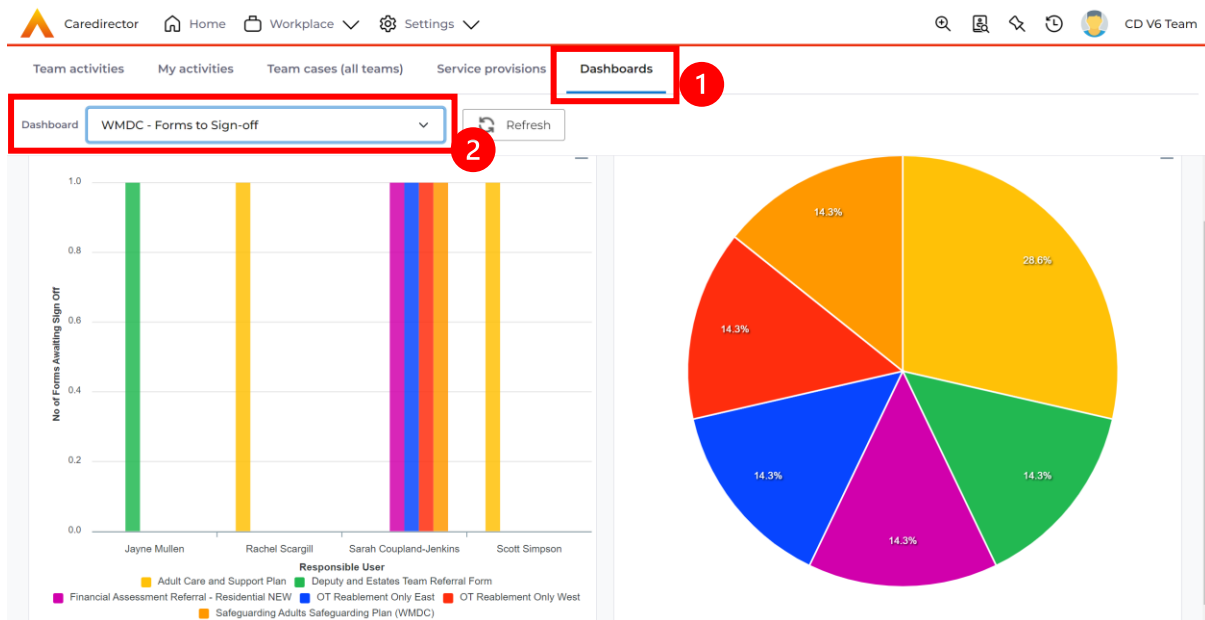
b. Select one from the **Bar Chart** and it will open that into a list view. Select the appropriate one.

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

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

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**.

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

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.

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.

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)
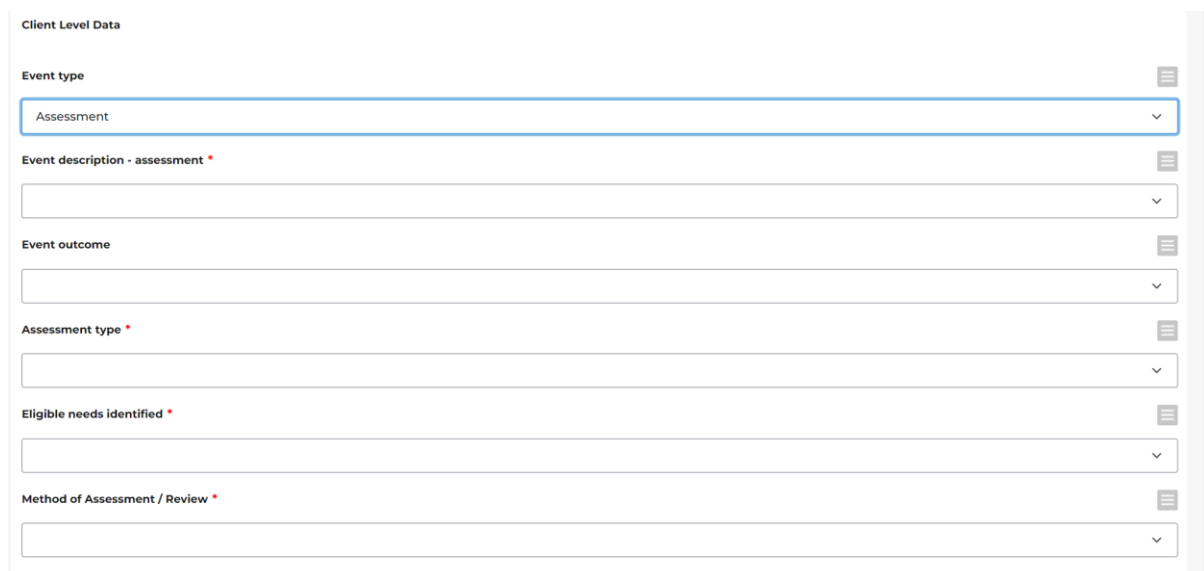
Yes ○   No ○

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.

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 *

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 tot 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 ne 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 an 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 *

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 tot the order in which they appear, from top to bottom.

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Progress to Assessment
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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.

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.

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 tot the order in which they appear, from top to bottom.

Event outcome

Admitted to Hospital
NFA - 100% NHS funded care
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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 *

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