

Information and Guidance on the Referrals, Assessments and Packages of Care collection (RAP)

For the collection period
April 1st 2007 to March 31st 2008

Issued: November 2007

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Section 1: Introduction

Background to RAP

Work began in 1996 to develop a coherent set of national statistics relating to adult community care, partly as new information and partly to supplement or replace existing data collection (mostly the 'September week'). Several trials and dress rehearsal stages were conducted.

Data from the fifth year of full rollout was collected in 2004 and published in December 2005 with detailed results published in February 2006. The report of the findings from the 2004-05 RAP collection can be found at:
<http://www.ic.nhs.uk/pubs/commcare05adultengrepcssr>

The project is supervised by Annabelle McGuire on behalf of the Information Centre for health and social care (IC) and reports to the joint Department of Health and Strategic Information Group for Adult Social Care (SIGASC) on information issues.

The intention of RAP is to establish a stable framework for annual returns. In doing this it has sought to follow a number of guidelines agreed with the original Reference Group

- Processes should be consultative. As well as the direct involvement of pilot CSSRs and Reference Group members, there continue to be regular newsletters sent to all RAP contacts.
- The only returns to be collected should be those where a business case has been made, ideally with interest in the data at both national and local level. DH, CSCI and Audit Commission information requirements should be co-ordinated.
- Every effort should be made to collect data that are comparable across CSSRs. With this in mind attention has been paid to the careful definition of labels used for data items.
- The time needed by CSSRs to adjust their information to fit the requested returns should be recognised by ensuring that all planned major changes are marked up at least six months before full implementation and tested prior to this. An aim is that stability should be obtained in the format of information requested by of The Information Centre.

Uses of information collected

The length of time spent on the preparation of RAP is an indication of the determination of all participants to develop more accurate and useful information about adult community care. The returns should offer scope for genuine comparability between CSSRs, and reliable aggregation to provide national and regional overviews.

The information is required for:

- The monitoring of community care and care management, for example, examining the number of initial contacts and examining the procedures for screening and assessment;

- Monitoring of targets laid out in the NHS Plan and those announced by the Secretary of State in July 2002 on waiting times to assessment and provision of services;
- Monitoring of specific legislation, such as the Carers Act, and Fair Access to Care Services;
- Monitoring the uptake of direct payments;
- Contributing to performance measures, such as the 'Best Value' initiative and indicators in the Social Services Performance Assessment Framework (PAF);
- Informing discussions to plan resources and to help to develop policies on resource allocation;
- Contributing to several Performance indicators for the Learning Disability strategy;
- Contribute to the NSF for older people and on mental health;
- Helping in the preparation of Audit Commission indicators;
- Supporting CSCI inspection and monitoring activity, for example through CSSR profiles;
- Enabling CSSRs to monitor their own provision, develop local performance indicators and make comparisons with their own choice of other CSSRs.;
- Answering Parliamentary Questions and ministerial briefing;
- Answering a range of requests from external customers.

The next couple of pages include a detailed breakdown of the uses of data collected in each proforma.

RAP Proforma	Uses of information
<p>R1 Contacts from new clients that resulted in further assessment of need of commissioning of ongoing service.</p>	<ul style="list-style-type: none"> • Data collected on R1 is used to indicate the level of demand placed on CSSRs for assessments. • Used in policy evaluation in relation to care management and staffing at national level. • Information on referrals is also required for the Atkinson review of government output measurement to be updated each year.
<p>R2 Contacts from new clients attended to solely at or near the point of contact.</p>	<ul style="list-style-type: none"> • Data collected on R2 is used to indicate the level of demand placed on CSSRs for screening assessments. • Used in policy evaluation in relation to care management and staffing at national level. • Information on referrals is also required for the Atkinson review of government output measurement to be updated each year. • Additionally, information on R2 can be used to show the extent to which a CSSRs initial screening process is able to deal with simple requests.
<p>R3 Source of referral for R1 & R2 contacts.</p>	<ul style="list-style-type: none"> • Used by CSSRs, partner agencies and central government to give insight into the source of referral for new contacts coming to the CSSR for assessment. • Information on the number of referrals from primary and secondary health sources can reflect work at the important interface between social and health care.

RAP Proforma	Uses of information
<p>A1 New clients with completed first assessment & existing clients with completed reviews</p>	<ul style="list-style-type: none"> • Purpose of this return is to enable policy monitoring and resource planning and to build a profile of CSSR activity under the Community Care Act. • Data can be also be used to compare assessment and review activity across CSSRs for different user types. • Information from A1 is required for the Atkinson review of government output measurement to be updated each year. • Used to monitor FACS policies. • The total number of existing clients receiving a review reported on A1 page 2 is used as the numerator for PAF indicator AO/D40. • Also provides data used in the PAF indicators AO/E82. • Data has also previously been used for EOR Age discrimination tool.
<p>A5 Sequel to assessment</p>	<ul style="list-style-type: none"> • Provides information on turnover, disposal and drop out of clients assessed and is used for policy monitoring and development. • Data on client type gives an insight into the help that key user groups are offered and/ or receive following assessment. • Used to monitor FACS policies. • Used in the PAF indicator AO/E82 on the provision of service following assessment. • Data has also previously been used for EOR Age discrimination tool.
<p>A6 Ethnicity of clients with completed assessment</p>	<ul style="list-style-type: none"> • Provides information on turnover, disposal and drop out of clients assessed and is used for policy monitoring and development. • Data on client type gives an insight into the help that key user groups are offered and/ or receive following assessment. • Is used as data source for the PAF indicators AO/E47 and AO/E48 on ethnicity of older people receiving assessment and services. • Information from A6 is also required for analysis related to equality and to monitor FACS policies. • Used for a Key Threshold indicator on ethnicity
<p>A7 Time from first contact to completed assessment for new clients</p>	<ul style="list-style-type: none"> • The main use of the information from this form is to help monitor the ministerial targets on waiting times. The data is used to feed into the PAF PI AO/D55 on acceptable waiting times for assessments for older clients. • Is also used to monitor and assess differences in waiting times across primary client groups. • Data has also previously been used for EOR Age discrimination tool.
<p>A8 Time from completed assessment to receipt of all services for new clients aged 65 and over</p>	<ul style="list-style-type: none"> • The main use of the information from this form is to help monitor the ministerial targets on waiting times. The data is used to feed into the PAF PI AO/D56 on acceptable waiting times for care packages for older clients. • Is also used to monitor and assess differences in waiting times across primary client groups.
<p>A9 Time from first contact to first contact with client for new clients</p>	<ul style="list-style-type: none"> • The main use of the information from this form is to help monitor the ministerial targets on waiting times. The data is used to feed into the PAF PI AO/D55 on acceptable waiting times for assessments for older clients. • Is also used to monitor and assess differences in waiting times across primary client groups.

<p>P1 Clients receiving services during the period</p>	<ul style="list-style-type: none"> • Provides essential information for the commissioning and planning of services. • The total number of clients receiving services reported on P1 is used as the denominator for PAF indicator AO/D40. • Data from P1 is also used in answering PQs and ministerial briefing.
<p>P2f Clients receiving community-based services during the period</p>	<ul style="list-style-type: none"> • Provides essential information for the commissioning and planning of services. • The total number of clients receiving community based services reported on P2f is used as the denominator for the indicator on carers services (AO/C62). • Provides useful information on the uptake of direct payments. • Information on community-based services is required for the Atkinson review of government output measurement to be updated each year. • Data from P2f is also used in answering PQs and ministerial briefing.
<p>P2s Clients on the books to receive community-based services on 31 March</p>	<ul style="list-style-type: none"> • Provides essential information for the commissioning and planning of services. • Data on the total number of clients on the books to receive services by client type is used to feed into the 'helped to live at home' indicators AO/C29-32. • Data is also used in monitoring the uptake of direct payments via indicator AO/C51. • Information on community-based services is required for the Atkinson review of government output measurement to be updated each year. • Data from P2s is used in answering PQs and ministerial briefing. • Data has also previously been used for EOR Age discrimination tool.
<p>P4 Ethnicity of clients receiving services</p>	<ul style="list-style-type: none"> • Data required for analysis related to equality and to monitor FACS policies. • Used for a Key Threshold indicator on ethnicity
<p>C1 Carers with completed assessment or review</p>	<ul style="list-style-type: none"> • Provides information needed for the commissioning and planning of carer assessments. • Data enables monitoring of Carer's Act legislation. • Support the introduction of new Carer's services PI. • Information is required for the Atkinson review of government output measurement to be updated each year.
<p>C2 Carers services</p>	<ul style="list-style-type: none"> • Provides information needed for the commissioning and planning of carer services. • Data enables monitoring of Carer's Act legislation. • Information on the number of carers receiving services following an assessment or review is used in the numerator of the new PI on carers services (AO/C62).

Collection period 2007-08

This collection period is the eighth year of the roll-out of RAP. It was recognised that considerable challenges have been posed to CSSR staff, operational as well as information, in preparing to provide the data requested. However, it is now expected that each CSSRs will provide a full return. Preferably this should be based on a full population count for the period, though sampling will continue to be an option. **If a CSSR carries out sampling the data should be grossed up before it is submitted to the IC.**

The period covered by this collection is the financial year from **1st April 2007 to 31st March 2008. The deadline for returns is NO LATER THAN 31ST MAY 2008.** If returns are made by this date the IC is committed to circulating a report by 30th December 2008. However, in the event that an insufficient number of returns are received by 31st May 2008, the IC cannot guarantee meeting the deadline for the final report.

A set of return proformas will be available for completion using the Internet Data Collection facility, which can be found at **<http://www.icweb.nhs.uk/websecurity/default.asp>**

This documentation, including the Return Proformas, Frequently Asked Questions and the Validation Checks for RAP 2007-08 Internet Data Collection documents will be available electronically on the Information Centre for health and social care's (IC) website at: <http://www.ic.nhs.uk/pss/returns/2008>

Changes to RAP in 2007-08

- (i) **Form R2**
New table introduced to R2 is entitled: **Number of contacts for new clients receiving services covered by definitions relating to RAP P forms at the point of contact outside a formal assessment.** This table will collect data by CSSRs on a voluntary basis for the period 1st October 2007 – 31st March 2008.
- (ii) **Forms A1**
Revised guidance on double counting of clients on pages 1, 2 and 3 of the A1 proforma.
- (iii) **P Forms**
Revised definitions of 'respite care' and 'Short term residential - not respite'.
- (iv) The removal of 'overnight – respite care' from 'P' forms. This will now be a service provided to carers on the 'C' forms
- (v) Revised definitions on recording of equipment on P2s – one-off pieces of equipment.
- (vi) Revised definition of the subset 'Dementia' -
- (vii) Guidance for CSSRs on how to record 'Telecare'
- (viii) Revised guidance on carer assessments carried out by other organisations, For implementation wherever possible from 2007/08
- (ix) New guidance for CSSRs on recording clients receiving services via "In Control" projects (for implementation in 2007/08).
- (x) Due to new legislation, note that Section 31 arrangements (of the Health Act 1999) are now referred to as Section 75 arrangements (of the NHS Act 2006). http://www.opsi.gov.uk/acts/acts2006/ukpga_20060041_en_6#pt3-l1g75

Copies of the revised 2007-08 forms are available on the IC website at:

<http://www.ic.nhs.uk/pss/returns/2008>

These changes match those communicated to CSSRs in the LA letter sent via email on 28/09/07 and available at the web address above.

Contacts

Any CSSR staff who require advice regarding RAP or who have questions on issues relating to the content and coverage of these returns are invited to contact the RAP Helpdesk at The Information Centre **RAP@ic.nhs.uk**. Further information on the RAP project is also available via the IC's website at: <http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/collections-2008>

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Section 2: Guidelines to making the returns

The general approach

The IC appreciates the amount of effort involved in the production of the RAP return for CSSRs. While acknowledging this, the request is for you to make every effort to provide a full and accurate set of returns. The data provided by CSSRs will be fully utilised at CSSR and national level for the purposes outlined earlier, and will be made available to CSSRs for their own use. It may be helpful to bear in mind:

- An overall aim of the returns is to enable a statistical presentation based on **numbers of people (clients) rather than episodes (events)**. Referral returns are a count of episodes / events, but assessment and package returns are a count of people, and the overall intention is to retain volume measures, but at the same time to complete people-based profile.
- Once fully implemented the returns are likely to be used centrally to build up a picture of the work of CSSRs, and *inter alia* to inform decisions on resource allocation from central government and enable cross-agency comparisons. Hence it is important to **present the work of your CSSR as fully and accurately** as you can. If you have any concerns about the quality of information that you are providing, please highlight these in the notes sections of the proformas.
- Any tendency to overstate performance volume arises mainly from double counting. The specific brief for each return seeks to define terms so that either double-counting is eliminated, or it is identified and consistently handled across CSSRs.
- It is important not to understate volume measures. The pilot studies indicated the extent of this risk, often because of the inconvenience of achieving comprehensiveness, or a tendency for some staff to lack diligence in ensuring that activity is recorded. The returns make allowance for you to describe activity which you cannot fit into the requested figures.

Making the returns

With this documentation you will find:

- This introduction plus a set of the return protocols for each return and a glossary of terms and definitions. You are asked to read and follow the protocols carefully because they guide you as to exactly what should be included and excluded from each return. They also identify the definitions you should consult in the glossary. A set of the return proformas. These should be completed and returned via the Internet Data Collection (IDC) facility.
- A 'Frequently Asked Questions' (FAQs) document with further guidance and specific examples of how to complete the RAP return.
- Waiting times summary and guidance for CSSRs to sample data for the waiting times indicators

All documentation can be found at: <http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/collections-2008>

Return proformas and protocols

You are asked to provide returns in 15 areas (as listed in Section 3), plus an 'End Sheet' to capture anything not covered elsewhere. The returns follow a logical sequence from initial contact with a potential client through assessment to the provision of services. These are followed by two returns relating to carers. Each return is labelled 'R' (for referral), 'A' (for assessment), 'P' (for package), or 'C' (for carer).

The list of returns in Section 3 also pinpoints the PAF and Best Value indicators to be derived from the RAP data.

Linked to each return is a 'protocol' setting out the reason for seeking this particular area of information (that is, the business case), and clarifying what is to be included and excluded from the return. Each return also has a 'Proforma'; a layout of the format in which you are asked to make the return. There is a 'Notes' section added to each proforma, and you are asked to record here how you handled any components of the return which you felt unsure of, whether because of their accuracy, or because of doubts over what should or should not go in. Sometimes the 'Notes' section asks you to comment on a specific topic, in an effort to obtain contextual material relevant to understanding the full import of the figures.

Basis of returns

For every return you are asked to provide a full population count in the specific category. If this is not possible then you are asked to provide information based on a sample of records. Data should be grossed up to the size of the relevant local population before submitting to the IC. You should describe the sampling method in the free text field, including details of the sample size and the method used to gross up the data.

In December 2003 a document providing guidance on sampling for proforma A8 was issued. This information can be found in the separate sampling 'waiting times' guidance document on our website <http://www.ic.nhs.uk/pss/returns/2008>. In addition to this guidance, in April 2004, DH prepared a grossing up tool to help CSSRs apply weights to their data. This tool is available for download (in Excel format) from the web site above. The general sampling guidance from the Audit Commission for Best Value performance indicators is available at <http://www.audit-commission.gov.uk/products/guidance/497C9886-FC5B-4E37-AFD3-FD468CEE4DF3/piguid4.pdf#search=%22sampling%20guidance%20audit%20commisio n%22>

If you intend to provide data for A8 based on a sample for 2007-08, some key areas to note are;

- a) A "random" sample must be taken of clients from across the whole period 1 April 2007 to 31 March 2008. The Audit Commission does **not** allow samples based on some months of the year and uprated to the whole year, for example the last 3 months multiplied by 4.
- b) As a minimum the sample sizes for 2007-08 should meet the requirements set out in table A of appendix A of the sampling guidance. **Any data based on a smaller sample size will not be accepted for RAP or the performance indicators.**

c) Sample data should be updated to the whole population before it is submitted on the RAP return.

Out of area clients

In order to ensure that everyone takes the same route, the rule is to count what your CSSR pays for. If you assess clients from another area, at your expense, then count them in your figures. If the other area pays you to do the assessments then that area counts them in their return and you do not. Similarly, you may count clients from your patch that have been assessed by another CSSR only if you pay for the assessment. The same principle applies to services.

Jointly assessed clients

If the CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006 (formerly section 31 of the Health Act 1999) they should include assessments carried out and social services provided by the health partner in RAP. Legally, joint teams can only operate (in terms of assessing needs for social services) within section 75 where they have delegated authority from social services to do so. Where this is the case ALL the **social care related assessments** carried out by the team should be counted for RAP purposes whether made by a social services member of staff or not.

We expect all the **social** services that are provided by joint teams operating under section 75 to be included in RAP, including those provided by health service staff. The CSSR can choose to provide both the assessment itself and the provision of services following the assessment through mixed teams under Section 75 integrated provision arrangements. The CSSR could choose to delegate the commissioning of such services to an NHS organisation if it wanted to, again under Section 75. The key point is that the statutory responsibility for those services remains with the CSSR, so, however it chooses to organise these responsibilities in partnership, they should still be covered on the RAP return. These services should be specified in the client's care plan, and the client's package of care should be managed by the social services department. Further definitions can be found in the glossary and proforma descriptions.

(i) Assessments carried out by joint teams prior to agreeing a section 75 flexibility

CSSRs are reminded that they may not delegate their statutory duty of assessment except within the context of section 75 of the NHS Act 2006. However prior to agreeing a section 75 flexibility, where joint health and social services teams are sharing assessment work in the best interests of actual or potential service users, then assessments completed by authorised social care workers or health staff should be included **providing** the assessment may lead to a person being provided with community care services because of social care needs. If the assessment is purely for health services then it should be excluded from the A proformas.

(ii) Assessments carried out by other organisations

As CSSRs have a statutory duty of assessment, they need to ensure and assure themselves that all assessments that include a social care element are carried out in the appropriate way. However CSSRs can delegate or contract out the process of carrying out an assessment to other organisations, for example to voluntary organisations, **only** if they fund them and have some means of checking the process and outcomes of the assessment. The checking should be done for each individual assessment rather than a sample that the other organisation carries out. Where CSSRs contract the assessment process out to other organisations, they must ensure that the checking procedures are met. CSSRs need to ensure that the assessment is valid and fair, and evaluates all the individual's presenting needs. If the CSSR does not check each individual assessment carried out by another organisation, then these assessments must be excluded from RAP.

Inclusions and exclusions to RAP

Preserved rights (PR). Clients formerly in receipt of preserved rights refers to those clients that were in receipt of a preserved rights income up to 8th April 2002 but were not supported by the CSSR before that date. From 2006-07 these clients should be **included** on all RAP forms.

Sheltered accommodation: If a client, living in sheltered accommodation, is fitted with an alarm with access to a warden as a basic service provided by social services, this would be included on the R2 RAP form as there is no ongoing commitment. However, if this was the outcome of a community care assessment, there are two scenarios;

- a) If it is the only service in the care plan, once the alarm is fitted, it is the end of the service and should be included under equipment on RAP form P2f (possibly P2s too).
- b) If it is one of the services in the care plan, the alarm is recorded under equipment on P2f (possibly P2s too) but the client stays on the books due to the other services.

There is no ongoing commitment due to the warden service as this is maintained/funded by the housing department, not by the CSSR.

Supported Housing Service: If the supported housing service is provided by the housing department or other agencies, it should be excluded from RAP.

Supported people. A Supporting People assessment does *not* count as a Community Care assessment (under the NHS and Community Care Act 1990). Clients who have received a Supporting People assessment *only* and no other assessment of their eligibility to receive services from the CSSR should not be included in the RAP assessment forms nor in the RAP services (P) forms.

Services funded by the Supporting People initiative can therefore only be included in RAP if the clients receiving these services have received a Community Care assessment (under the NHS and Community Care Act 1990) *and* the relevant expenditure from the Supporting People grant is being classified as social services expenditure rather than housing expenditure. The services being provided must be part of a package of care that is managed by the CSSR and is subject to review by the CSSR.

- **The Single Assessment Process (SAP) and RAP**

Background - CSSRs have been required to assess older people using the single assessment process since April 2004. One of the implications of the approach is that some information will be recorded just once by one professional and where necessary this will be shared with others.

- **Recording assessments in RAP**

An example of how a client may be assessed under the single assessment process is that they are first seen by a community nurse who carries out an initial assessment. If there appeared to be a social care need the client would be referred to social services and seen by a care manager. This process should be counted as one assessment and since it includes a social care element, i.e. a Community Care assessment (carried out under section 47 of the NHS and Community Care Act 1990), it should be included in RAP.

The underlying principle is that if a Community Care assessment is conducted (under section 47) it should be included in RAP. This applies to the single assessment process in that if an assessment is carried out under SAP and it contains a social care element it should be counted in RAP. This is the case regardless of who carries out the assessment. For example if through joint working arrangements (under a section 75 agreement) a health worker carries out a Community Care assessment (under section 47) this should be counted in RAP.

If a nurse carries out a SAP assessment in which a care worker is not involved and does not include a social care element (i.e. it is not carried out under section 47) this assessment should not be counted in RAP.

- **Recording reviews in RAP**

If someone has had a SAP assessment and is in receipt of services, then in the same way as is currently the case their needs will be reviewed, or if their circumstances change they may require an unscheduled review. Both these cases should be recorded in RAP as a review if it includes a social care element (i.e. it is a Community Care assessment carried out under section 47).

- **Recording services in RAP**

Services which are part of a care plan and are delivered by social services or on behalf of social services as a result of a SAP assessment should be included in RAP. Other services should not be included.

Related Publications

The latest information on Referrals, Assessments and Packages of Care for adults (RAP) can be found on the IC website at:

<http://www.ic.nhs.uk/statistics-and-data-collections/social-care>

- ***“Community Care Statistics 2005/06. Referrals, Assessments and Packages of Care, for Adults – Report of findings from the 2005-06 RAP collection” – report published in February 2007.***

Further information on Referrals, Assessments and Packages of Care for adults (RAP), including the following reports of findings from the First and Second Rollout and Dress Rehearsal periods, is available from the DH website at:

http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalDevelopment/ReferralsAssessmentsPackagesCare/ReferralsAssessmentsPackagesCareArticle/fs/en?CONTENT_ID=4016281&chk=rqjxRS

- *“Community Care Statistics 2004/05. Referrals, Assessments and Packages of Care- Report of findings from the 2004/05 RAP collection” - report published in February 2006.*
- *“Community Care Statistics 2003/04. Referrals, Assessments and Packages of Care- Report of findings from the 2003/04 RAP collection” - report published in February 2005.*
- *“Community Care Statistics 2002/03. Referrals, Assessments and Packages of Care- Report of findings from the 2002/03 RAP collection” - report published in February 2004.*
- *“Community Care Statistics 2001/02. Referrals, Assessments and Packages of Care- Report of findings from the second year of the rollout of RAP” - report published in January 2003.*
- *“Community Care Statistics 2000/01. Referrals, Assessments and Packages of Care- Report of findings from the first year of the Rollout of RAP”- report published in December 2001.*
- *“Community Care Statistics 1999/00. Referrals, Assessments and Packages of Care- Report of the findings from the Second Dress rehearsal”- report published in November 2000.*
- *“Referrals, Assessments and Packages of Care – First Report of findings from the First Dress Rehearsal” – report published in September, 1999.*

Similar information on referrals and assessments for children is available at:

<http://www.dfes.gov.uk/rsgateway/DB/VOL/v000444/index.shtml>

Other information on non-residential community care for adults is dealt with in the publication "*Community Care Statistics 2005: Home help and care services for Adults, England*". This publication is available via the IC website at:
<http://www.ic.nhs.uk/pubs/commcare2005homehelpadulteng>

Information on adult residential and nursing care is provided in the statistical bulletins "*Community Care Statistics 2001: Residential Personal Services for adults England*" (<http://www.publications.doh.gov.uk/public/sb0129.htm>) and "*Community Care Statistics 2001: Private nursing homes, hospitals and clinics, England 2001*" (<http://www.publications.doh.gov.uk/public/sb0209.htm>).

Section 3: List of Returns for 2007/08 and linkage to Audit Commission, PAF and Best Value Indicators

The returns are concerned with adults, defined as those aged 18 or over, and relate to adult services. Children's services are not covered in these returns, and nor are services provided to adults on behalf of children (e.g. Section 17 payments). Some CSSRs are known to continue with children's services for a few clients aged 18 or over. Where possible these should be included with the adult returns. Two returns relate to carers of adults and seek information on the carers themselves, some of whom may be under 18.

The first three return areas (R prefix) are concerned with new clients who make contact with the CSSR, and receive information and advice, a one-off basic service (e.g. a blue badge), or are passed on for further assessment. They cover activity prior to the formal assessment stage and are a count of episodes/events.

R1 - Number of contacts for new clients during the period that resulted in further assessment of need or commissioning of ongoing service.

R2 - Number of contacts for new clients during the period concerning services from the CSSR whose needs were attended to solely at or near the point of contact. [Please note that for 2007-08 an additional table has been added to R2 to capture services received by clients at the point of contact, outside of a formal assessment.](#)

R3 - Source of referral for all contact events covered in R1 and R2.

The next six return areas (A prefix) cover the assessment phase, and concern only those initial contacts who are passed through for assessment.

AI - page 1 Number of new clients for whom the first assessment was completed during the period by primary client type and age group.

AO/E82

AI - page 2 Number of existing clients for whom a review was completed during the period by primary client type and age group.

AO/D40

AI - page 3 Number of clients for whom the assessment or review process was terminated during the period by age group.

A5 - Number of clients for whom assessments were completed in the period by primary client type cross-tabulated with known or anticipated sequel to assessment and extended age group.

AO/E82

A6 - Number of clients for whom assessments were completed in the period by ethnicity cross-tabulated with known or anticipated sequel to assessment and age group.

AO/E47, AO/E48

A7 - Length of time from first contact to completed assessment for new clients whose assessments were completed during the period, in time bands, by referral category, age group and primary client type.

AO/D55 (BVPI 195)

A8 - Length of time from completed assessment to receipt of all services for new clients aged 65 and over for whom all services were put in place during the period, in time bands, by primary client type.

AO/D56 (BVPI 196)

A9 - Length of time from first contact to first contact with client following referral. This is for new clients who were contacted following referral during the period in time bands by age group and primary client type.

AO/D55 (BVPI 195)

The next four returns (P prefix) cover clients receiving services during the reporting period or, in the case of P2(s), clients on the books to receive services on the last day of the period.

P1 - Number of clients receiving services during the period provided or commissioned by the CSSR, by primary client type, service type, and age group.

AO/D40

P2(f) - Number of clients receiving community-based services during the period, provided or commissioned by the CSSR, by components of service, primary client type and age group.

AO/C62

P2(s) - Number of clients on the books to receive community-based services on the last day of the period provided or commissioned by the CSSR, by selected components of service, primary client type and age group. [Please note that the table on page 7 of P2s to capture information for Individual Budgets, should only be completed by those CSSRs who are piloting Individual Budgets.](#)

AO/C29, AO/C30, AO/C31, AO/C32 (BVPI 54), AO/C51 (BVPI 201)

P4 - Number of clients receiving services during the period provided or commissioned by the CSSR, by ethnicity, service type, primary client type and age group,

The last two returns (C prefix) relate to carers and cover the period **1st April 2007 to 31st March 2008**.

C1 - page 1 Number of carers for whom assessments or reviews were completed during the period, by age group of carer .

C1 - page 2 Number of carers for whom assessments or reviews were completed during the period, by client group and age group of the person cared for by the carer.

C2- page 1 Number of carers receiving different types of services provided as an outcome of an assessment or review, by age group of carer.

C2- page 2 Number of carers receiving different types of services provided as an outcome of an assessment or review, by client group and age group of the person cared for by the carer.

AO/C62

End sheet State any cost-bearing activity undertaken by your Social Services Department in relation to meeting the needs of adults that you have not been able to include within the preceding returns. If possible, both describe and quantify.

The 'Keystats' page on your IDC RAP return shows calculations for your PAF indicators, based on the data you have completed.

Indicator	AO/C29 Adults with physical disabilities helped to live at home
Definition	Adults with physical disabilities helped to live at home per 1,000 population aged 18-64.
The numerator	Adults aged 18-64 with physical disabilities helped to live at home at 31 March. <i>Source: RAP proforma P2s Page 1 line 1 (physical disability, frailty and sensory impairment) column 1.</i>
The denominator	Population aged 18-64. <i>Source: ONS Mid-year estimate for 30 June.</i>

Indicator	AO/C30 Adults with learning disabilities helped to live at home
Definition	Adults with learning disabilities helped to live at home per 1,000 population aged 18-64.
The numerator	Adults aged 18-64 with learning disabilities helped to live at home at 31 March. <i>Source: RAP proforma P2s, Page 1, line 9 (learning disability), column 1.</i>
The denominator	Population aged 18-64. <i>Source: ONS Mid-year estimate for 30 June.</i>

Indicator	AO/C31 Adults with mental health problems helped to live at home
Definition	Adults with mental health problems helped to live at home per 1,000 population aged 18-64.
The numerator	Adults aged 18-64 with mental health problems helped to live at home at 31 March. <i>Source: RAP proforma P2s, Page 1, line 6 (mental health), column 1.</i>
The denominator	Population aged 18-64. <i>Source: ONS Mid-year estimate for 30 June.</i>

Indicator	AO/C32 Older people helped to live at home (BVPI 54)
Definition	Older people helped to live at home per 1,000 population aged 65 or over.
The numerator	Older people aged 65 or over helped to live at home at 31 March. <i>Source: RAP proforma P2s, Pages (3+5), line 11 (Total of above), column 1</i>
The denominator	Population aged 65 or over. <i>Source: ONS Mid-year estimate for 30 June.</i>

Indicator	AO/C51 Direct payments (BVPI 201) (KT)
Definition	Adults and older people receiving direct payments at 31 March per 100,000 population aged 18 or over (age standardised). This is a weighted average of four indicators which are calculated separately. The weight for each indicator is the percentage of the population of England aged 18 and over that falls into the relevant age group (this achieves the age standardisation).
The numerators	Adults and older people receiving direct payments at 31 March (1) aged 18-64 (2) aged 65-74 (3) aged 75 –84 (4) aged 85 or over <i>Source : RAP proforma P2s, Page 2, line 11 (Total of above), column 1, Page 4, line 11 (Total of above), column 1, Page 7 box 1 and box 2.</i>
The denominator	Population aged (1) 18-64 (2) 65-74 (3) 75 –84 (4) 85 and over <i>Source: ONS Mid-year estimate for 30 June.</i>
<i>Please see CSCI website for worked example of the calculation of this PI http://www.csci.org.uk</i>	

Indicator	AO/C62 Services for Carers
Definition	The number of carers receiving a 'carer's break' or a 'specific carer's service' as a percentage of clients receiving community based services.
The numerator	The number of carers receiving a 'carer's break' or 'specific carer's service' during the year following an assessment or review. <i>Source: RAP proforma C2, page 1, column 1, line 5.</i>
The denominator	The number of clients receiving a community based service during the year. <i>Source: RAP proforma P2f, pages (1+3), line 11 (Total of above), column 1.</i>

Indicator	AO/D40 Clients receiving a review
Definition	Adult and older clients receiving a review as a percentage of those receiving a service.
The numerator	The number of existing clients receiving a review during the year (either by SSD or non-SSD staff). <i>Source: RAP proforma A1, Page 2 first box.</i>
The denominator	The total number of clients (adults and older people) receiving services during the year. <i>Source: RAP proforma P1, Page 1 first box.</i>

Indicator	AO/D55 Acceptable waiting times for assessments (BVPI 195) (KT)
Definition	For new older clients, the average of (i) the percentage where the time from first contact to contact with the client is less than or equal to 48 hours (that is, 2 calendar days), and (ii) the percentage where the time from first contact to completion of assessment is less than or equal to four weeks (that is, 28 calendar days).
The average of:	
(i)	
The numerator	Of new older clients for whom contact was made with the client, the number for whom length of time from first contact to contact with the client was less than or equal to 48 hours (that is, 2 calendar days). (This time includes weekends and bank holidays). <i>Source: RAP proforma A9, Page 1, All new clients 65+, line 1.</i> For clients in hospital, first contact is defined as when the hospital informs Social Services formally that the person will imminently be medically fit for discharge i.e. 'section 5 notice'.
The denominator	The total number of new clients aged 65 or over for whom contact was made with the client in the year regardless of which year the first contact was made. <i>Source: RAP proforma A9, Page 1, All new clients 65+, lines (1 to 4).</i>
and	
(ii)	
The numerator	Of new older clients in the denominator, the number for whom length of time from first contact to completion of assessment was less than or equal to 4 weeks (that is, 28 calendar days). <i>Source: RAP proforma A7, Page 1, All new clients 65+, lines (1 to 3).</i>
The denominator	The total number of new clients aged 65 or over whose assessments were completed in the year regardless of which year the first contact was made. <i>Source: RAP proforma A7, Page 1, All new clients 65+, lines (1 to 5).</i>
<p>NB Additional guidance is available in the December 2004 RAP newsletter which is available at http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalDevelopment/ReferralsAssessmentsPackagesCare/fs/en. The definition of part i. was clarified for 2005-06. See RAP Newsletter September 2004 http://www.dh.gov.uk/assetRoot/04/09/35/24/04093524.pdf Fuller details and scenarios relating to this guidance are in annex H at: http://www.dh.gov.uk/assetRoot/04/09/91/84/04099184.pdf</p>	

Indicator	AO/D56 Acceptable waiting times for care packages (BVPI 196) (KT)
Definition	For new older clients, the percentage for whom the time from completion of assessment to provision of all services in the care package is less than or equal to 4 weeks.
The numerator	Of new older clients in the denominator, the number for whom length of time from completion of assessment to provision of all services in a care package is less than or equal to four weeks (that is 28 calendar days). <i>Source: RAP proforma A8, Page 1, lines (1+2).</i>
The denominator	The total number of new clients aged 65 or over whose assessment was completed and went on to receive all services during the reporting year. <i>Source: RAP proforma A8, Page 1, lines (1 to 4).</i>
NB Additional guidance is available on the following website http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4099184.pdf	

Indicator	AO/E47 Ethnicity of older people receiving assessment
Definition	The percentage of older service users receiving an assessment that are from minority ethnic groups, divided by the percentage of older people in the local population that are from minority ethnic groups.
The numerator	The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group as a percentage of all such clients of these or White ethnic origin. <i>Source: RAP proforma A6, Page 2, lines (4 to 16) columns (1 to 4) as a percentage of RAP proforma A6, Page 2, lines (1 to 16) columns (1 to 4).</i>
The denominator	The estimated percentage of older people (aged 65 and over) living in the CSSR area who are classified as other than "white". <i>Source: 2001 Census.</i>

Indicator	AO/E48 Ethnicity of older people receiving services following an assessment
Definition	The percentage of older service users receiving services following an assessment that are from a minority ethnic group, divided by the percentage of older service users assessed that are from a minority ethnic group.
The numerator	Of the clients in the denominator, the number whose known or anticipated sequel to assessment was 'Some or all (new) services intended or already started (incl. those started and finished)' or '(New) service(s) offered but declined' and whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group as a percentage of all such clients of these or White ethnic origin. <i>Source: RAP proforma A6, Page 2, lines (4 to 16) columns (1+3) as a percentage of RAP proforma A6, Page 2, lines (1 to 16) columns (1+3) .</i>
The denominator	The number of older clients with completed assessments during the year whose ethnic origin is Mixed, Asian or Asian British, Black or Black British, or Chinese or other ethnic group as a percentage of all such clients of these or White ethnic origin. <i>Source: RAP proforma A6 Page 2, lines (4 to 16), columns (1 to 4) as a percentage of RAP proforma A6 Page 2, lines (1 to 16), columns (1 to 4).</i>

Indicator	AO/E82 Assessments of adults and older people leading to provision of service
Definition	The percentage of assessments which lead to service being provided.
The numerator	Of the clients included in the denominator, the number whose anticipated sequel to assessment was 'Some or all (new) services intended or already started (incl. those started and finished)' or '(New) service(s) offered but declined'. <i>Source: RAP proforma A5, Pages (1,2 and 3), line 11 (Total of above), columns (1 and 3).</i>
The denominator	The number of adult and older clients with completed assessments during the year. <i>Source: RAP proforma A1, Page 1 first box.</i>

The following pages include all the proformas related to performance indicators with the relevant cells highlighted. These cells are also highlighted in red on your RAP IDC return.

Key threshold indicators on ethnicity

There are two Key Threshold Indicators taken from the 'not stated' rows in RAP A6 and P4:

- Ethnicity information for adult users assessed or reviewed in the year (RAP Table A6)
- Ethnicity information for adults provided with a service/s in the year following assessment (RAP able P4)

These cells are also highlighted in blue on your RAP IDC return.

Return Ref: A1 <i>Page 1 – Completed Assessments for new clients</i> Period 01/04/07 to 31/03/08	Return Title: Number of new clients for whom the first assessment was completed during the period, by primary client type and age group.			
Enter overall total of new clients with completed assessments (Sum of 'Column totals' below)		<table border="1"> <tr> <td style="padding: 5px;">AO/E82</td> </tr> </table>		AO/E82
AO/E82				
Primary client type:	Clients with completed assessments for new clients:			
	18 - 64	65-74	75 and over	
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable people (total)				
Learning disability (total)				
Substance misuse (total)				
Column Totals				

Return Ref: A1 <i>Page 2 – Reviews completed for existing clients</i> Period 01/04/07 to 31/03/08	Return Title: Number of existing clients for whom a review was completed during the period, by primary client type and age group.		
Enter overall total of existing clients with completed reviews (Sum of 'Column totals' below)		AO/D40	
Primary client type:	Clients with completed reviews for existing clients:		
	18 - 64	65 – 74	75 and over
Physical disability ,frailty and sensory impairment (total)			
Of which: Physical disability, frailty and/or temporary illness			
Hearing impairment			
Visual impairment			
Dual sensory loss			
Mental Health (total)			
Of which: Dementia			
Vulnerable people (total)			
Learning disability (total)			
Substance misuse (total)			
Column Totals			
Total Review Events			

Return Ref: A5 <i>Page 1 - for the 18 – 64 age group only</i> Period 01/04/07 to 31/03/08	Return Title: Number of new clients for whom assessments were completed in the period by primary client type cross-tabulated with known or anticipated sequel to assessment and age group.			
Status of new clients returned as assessment completed in A1 – 18 to 64 age group only				
Primary client type:	Some or all (new) services intended or already started (incl. those started and finished)	No (new) services offered or intended to be provided	(New) service(s) offered but declined	Other sequel to assessment
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable People (total)				
Learning Disability (total)				
Substance Misuse (total)				
Total of above	AO/E82		AO/E82	

Return Ref: A5 Page 2 - for the 65-74 age group only Period 01/04/07 to 31/03/08		Return Title: Number of new clients for whom assessments were completed in the period by primary client type cross-tabulated with known or anticipated sequel to assessment and age group.		
Status of new clients returned as assessment completed in A1 65 to 74 age group only				
Primary client type:	Some or all (new) services intended or already started (incl. those started and finished)	No (new) services offered or intended to be provided	(New) service(s) offered but declined	Other sequel to assessment
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable People (total)				
Learning Disability (total)				
Substance Misuse (total)				
Total of above	AO/E82		AO/E82	

Return Ref: A5 Page 3 - for the 75+ age group only Period 01/04/07 to 31/03/08		Return Title: Number of new clients for whom assessments were completed in the period by primary client type cross- tabulated with known or anticipated sequel to assessment and age group.			
<i>Status of new clients returned as assessment completed in A1 – 75 and over age group only</i>					
Primary client type:	Some or all (new) services intended or already started (incl. those started and finished)	No (new) services offered or intended to be provided	(New) service(s) offered but declined	Other sequel to assessment	
Physical disability, frailty and sensory impairment (total)					
Of which: Physical disability, frailty and/or temporary illness					
Hearing impairment					
Visual impairment					
Dual sensory loss					
Mental Health (total)					
Of which: Dementia					
Vulnerable People (total)					
Learning Disability (total)					
Substance Misuse (total)					
Total of above	AO/E82		AO/E82		

Return Ref: A6 Page 2- for the 65 and over age group only		Return Title: Number of new clients for whom assessments were completed in the period by ethnicity cross-tabulated with the known or anticipated sequel to assessment and age group. <i>This page is for the 65 and over age group only</i>			
Period 01/04/07 to 31/03/08					
Ethnicity:		Some or all (new) services intended or already started (incl. those started and finished)	No (new) services offered or intended to be provided	(New) service(s) offered but declined	Other sequel to assessment
White	British	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Irish	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Any other White background	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
Mixed	White and Black Caribbean	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	White and Black African	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	White and Asian	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Any other mixed background	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
Asian or Asian British	Indian	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Pakistani	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Bangladeshi	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Any other Asian background	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
Black or Black British	Caribbean	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	African	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Any other Black background	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
Chinese or other ethnic group	Chinese	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
	Any other ethnic group	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48	AO/E47 AO/E48
Not stated					

Return ref: A7 Page 2 – Time band Period 01/04/07 to 31/03/08	Return Title: Length of time from first contact to completed assessment for new clients whose assessments were completed during the period, in time bands, referral category, age group and primary client type.
Time from first contact to completion of assessment. Enter the number for new clients aged 65 and over, in each box:	
Time bands	All new clients 65 and over
Less than or equal to 2 days	AO/D55
More than 2 days and less than or equal to 2 weeks	AO/D55
More than 2 weeks and less than or equal to 4 weeks	AO/D55
More than 4 weeks and less than or equal to 3 months	AO/D55
More than 3 months	AO/D55

Return Ref: A8 <i>Page 1 – Time band</i> Period 01/04/07 to 31/03/08	Return Title: Length of time from completed assessment to receipt of all services for new clients aged 65 and over for whom all services were put in place during the period in time bands and primary client type.
Time from completion of assessment to receipt of all services. Enter the number for new clients aged 65 and over in each box:	
<i>Time bands</i>	All new clients 65 and over
Less than or equal to 2 weeks	AO/D56
More than 2 weeks and less than or equal to 4 weeks	AO/D56
More than 4 weeks and less than or equal to 6 weeks	AO/D56
More than 6 weeks	AO/D56

Return Ref: A9 <i>Page 1 – Time band</i> Period 01/04/07 to 31/03/08	Return Title: Length of time from first contact to first contact with new client following referral. This is for new clients who were contacted following referral during the period in time bands by age group and primary client type.
Time from first contact to first contact with client following referral. Enter the number for new clients aged 65 and over in each box:	
<i>Time bands</i>	All new clients 65 and over
Less than or equal to 2 days	AO/D55
More than 2 days and less than or equal to a week	AO/D55
More than a week and less than or equal to 2 weeks	AO/D55
More than 2 weeks	AO/D55

Return Ref: P1 <i>Page 1 – Overall total and 18 – 64 group only</i> Period 01/04/07 to 31/03/08	Return Title: Number of clients receiving services during the period, provided or commissioned by the CSSR, by primary client type, service type and age group.
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The total number of adult clients of all age groups receiving services during the period is AO/ D40 (also enter this figure on ages 1 & 2 of P4)

Service type - 18 to 64 age group only

Primary client type:	Total of clients	Community-based services in own home	CSSR Residential care	Independent sector residential care	Nursing care
Physical disability, frailty and sensory impairment (total)					
Of which: Physical disability, frailty and/or temporary illness					
Hearing impairment					
Visual impairment					
Dual sensory loss					
Mental Health (total)					
Of which: Dementia					
Vulnerable people (total)					
Learning disability (total)					
Substance misuse (total)					
Total of above					

Return Ref: P2f <i>Page 1 - for the 18 – 64 age group only</i> Period 01/04/07 to 31/03/08		Return Title: Number of clients receiving community-based services during the period, provided or commissioned by the CSSR, by components of service, primary client type and age group.		
Components of service – 18 to 64 age group only				
Primary client type:	Total of clients	Home Care	Day Care	Meals
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable people (total)				
Learning disability (total)				
Substance misuse (total)				
Total of above	AO/C62			

Return Ref: P2f <i>Page 3 - for the 65 and over age group only</i> Period 01/04/07 to 31/03/08	Return Title: Number of clients receiving community-based services during the period, provided or commissioned by the CSSR, by components of service, primary client type and age group.			
Components of service – 65 and over age group only				
Primary client type:	Total of clients	Home Care	Day care	Meals
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable People (total)				
Learning Disability (total)				
Substance Misuse (total)				
Total of above	AO/C62			

Return Ref: P2s <i>Page 1 - for the 18 – 64 age group only</i> Period 31/03/08	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and age group.				
Selected components of service – 18 to 64 age group only					
Primary client type:	Total of clients	Home care	Day care	Meals	Short term residential not respite
Physical disability, frailty and sensory impairment (total)	AO/C29				
Of which: Physical disability, frailty and/or temporary illness					
Hearing impairment					
Visual impairment					
Dual sensory loss					
Mental Health (total)	AO/C31				
Of which: Dementia					
Vulnerable People (total)					
Learning Disability (total)	AO/C30				
Substance Misuse (total)					
Total of above					

Return Ref: P2s <i>Page 2 - for the 18 – 64 age group only</i> Period 31/03/08	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and extended age group.			
<i>Selected components of service – 18 to 64 age group only</i>				
Primary client type:	Direct Payments	Professional support	Equipment & adaptations	Other
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable People (total)				
Learning Disability (total)				
Substance Misuse (total)				
Total of above	AO/C51			

Return Ref: P2s <i>Page 3 - for the 65 -74 age group only</i> Period 31/03/08	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and age group.				
Selected components of service – 65 to 74 age group only					
Primary client type:	Total of clients	Home care	Day care	Meals	Short term residential not respite
Physical disability, frailty and sensory impairment (total)					
Of which: Physical disability, frailty and/or temporary illness					
Hearing impairment					
Visual impairment					
Dual sensory loss					
Mental Health (total)					
Of which: Dementia					
Vulnerable People (total)					
Learning Disability (total)					
Substance Misuse (total)					
Total of above	AO/C32				

Return Ref: P2s <i>Page 4 - for the 65-74 age group only</i> Period 31/03/08	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and age group.			
Selected components of service – 65 to 74 age group only				
Primary client type:	Direct Payments	Professional support	Equipment & adaptations	Other
Physical disability, frailty and sensory impairment (total)				
Of which: Physical disability, frailty and/or temporary illness				
Hearing impairment				
Visual impairment				
Dual sensory loss				
Mental Health (total)				
Of which: Dementia				
Vulnerable People (total)				
Learning Disability (total)				
Substance Misuse (total)				
Total of above	AO/C51			

Return Ref: P2s <i>Page 5 - for the 75 and over age group only</i> Period 31/03/08	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and age group.				
Selected components of service –75 and over age group only					
Primary client type:	Total of clients	Home care	Day care	Meals	Short term residential not respite
Physical disability, frailty and sensory impairment (total)					
Of which: Physical disability, frailty and/or temporary illness					
Hearing impairment					
Visual impairment					
Dual sensory loss					
Mental Health (total)					
Of which: Dementia					
Vulnerable People (total)					
Learning Disability (total)					
Substance Misuse (total)					
Total of above	AO/C32				

Return Ref: P2s <i>Page 7– all ages</i>	Return Title: Number of clients on the books to receive community-based services on the last day of the period, provided or commissioned by the CSSR, by selected components of service, primary client type and age group.	
Period 31/03/08		
Total number of clients receiving Direct payments :		
Aged 75-84	<input type="text" value="AO/C51"/>	
Aged 85 and over	<input type="text" value="AO/C51"/>	
The following section should only be completed by Councils who are piloting Individual Budgets		
Number of clients planned to receive services by or on behalf of social services via an Individual Budget at 31 March 2007		
<i>Client group</i>	<i>Total number of clients planned to receive services via an Individual Budget</i>	<i>Number of clients planned to receive a direct payment as part of an Individual budget</i>
Aged 18-64		
Physical disability, frailty and sensory impairment		
Learning Disability		
Mental Health		
Substance misuse		
Other vulnerable people		
Total 18-64		
Aged 65 and over		
65-74		
75-84		
85 and over		
Total 65 and over		

Return Ref: C2 <i>Page 1</i> Period 01/04/07 to 31/03/08	Return Title: Number of carers receiving different types of services provided as an outcome of an assessment or review, by age group of carer	
Age of carer	Services including respite for the carer and /or other carers' specific services	Information and advice only
Under 18		
18-64		
65-74		
75 and over		
All ages	AO/ C62	
Basis of return: <input type="checkbox"/> Whole population count <input type="checkbox"/> Sample		
<i>Please describe the basis of your sample:</i> 		
<i>Notes:</i> 		

Section 4: Guidance for the proformas

R1

Number of contacts for new clients during the period that resulted in further assessment of need or commissioning of ongoing service.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return aims to measure the number of contacts for new clients made with the CSSR, which are screened and as a result it is decided that there is need for further assessment or the provision/commissioning of a package of care.

Business case

R1 is intended to indicate the level of demand placed on CSSRs, in this instance for assessments, and to be useful in policy evaluation in relation to care management and staffing at national level. Demand can relate to a number of factors, including needs within the population and the extent to which CSSRs have informed the public about social care services.

Inclusions and exclusions

- The return is for adults aged 18 and over only.
- The R returns are concerned with **contacts** (episodes, events), not **clients**.
- Casual contacts should be excluded from the returns.
- The R1 figure should exclude contacts made by existing clients regarding referral for a review.

Contact on referral (R) forms:

All the referral (R) forms are defined to only include contacts from **new clients**, that is clients not on the books of the CSSR at the time the contact was made. A person who has previously received services, which have ceased before the time of contact (i.e. the client is "off the books" when the contact is made) should be included. A client may be on the books of the CSSR but not actually receiving a service. This would **not** count as a new contact for RAP purposes.

For the R forms all contacts made by **new clients** in the year should be included, whether or not they received an assessment or any service in the year. For example a contact on 30 March 2008 who did not receive an assessment until 2 April 2008 would be included in RAP 2007-08 as a contact only. The waiting time for such an individual would be counted in RAP 2008-09.

It is assumed that the figures given may exceed the number of clients because some clients may make more than one contact in the period.

- **Distinguishing between R1 and R2**

A contact should appear in only one of R1 or R2.

If the decision in relation to the contact is for further assessment then it should be included in R1. If the initial screening of a contact is seen as sufficient to warrant commissioning / providing a service then it should also be included in R1, unless it is a 'basic service', in which case it should be in R2. The key distinction between 'service' and 'basic service' is that the former (which in many CSSRs will be called a package of care / care package) has the intention of an ongoing resource commitment, while the latter is seen as 'one-off' with an initial but no intended further resource commitment.

If a contact meets the criteria for inclusion in R2 **and** is passed on for further assessment, then it should be included in R1 only. That is, there should be no double counting of contact episodes / events between R1 and R2.

Experience suggests that there are two areas of complexity about the use of 'ongoing' and 'one-off' to describe the distinction between 'service' and 'basic service'. These relate to the role of interim or emergency services put in place while further assessment is undertaken; and the provision of equipment. It is important to be aware of the glossary definitions 'Interim / emergency services' and 'Equipment / adaptations'.

- **Emergency Services**

For the purposes of inclusion in R1, interim and emergency services should be included under 'commissioning ongoing services'. Where there are emergency duty teams consisting of staff from several CSSRs, with a pooled budget, carrying out assessments, these assessments can be allocated to the CSSRs either in proportion to the CSSRs share of funding or based on which CSSRs member carried out the assessment.

- **Equipment / adaptations**

The provision or commissioning of equipment / adaptations does not conform to the general approach to distinguishing between 'service' and 'basic service'.

A small item of equipment provided at or near the point of contact, following initial screening but no further assessment, should be categorised as a basic service and entered in R2. In all other instances where equipment or adaptations may be under consideration and an assessment is undertaken, there should be an entry in R1.

There is an element of judgement as to what constitutes a 'small item', and it is not possible to be prescriptive. A ferrule, walking stick or bath rail (including fitting) would normally be seen as a basic service, unless provided as part of a wider care package. Any equipment given in the context of a wider package, or where there are ongoing needs for supervision or maintenance, should be recorded as a service (as in 'Components of service'), and arise from an entry in R1.

NB 'Service' as used here will include the categories of 'service type' (see glossary) as employed in P1 and 'components of service' (see glossary) as used in P2f/s. If you are in doubt on specific categories then please contact the RAP team for guidance (see *contacts* page for details of how to get in touch)

- **Telecare**

Telecare should be treated in the same way as equipment. A small item of telecare provided at or near the point of contact, following initial screening but no further assessment, should be categorised as a basic service and entered in R2. In all other instances where telecare may be provided as the result of an assessment, there should be an entry on R1. To be included in the RAP P forms, this service like other services must be provided as part of a care plan following a Community Care Assessment. If the telecare requires ongoing financial commitment, then the client must be recorded in P2s. If telecare is provided via a direct payment, then the client should be recorded under direct payments, not under equipment.

- **Defining a contact**

A contact for R1 purposes is one that leads to an assessment or to commissioning of ongoing services. The initial contact is entered into R1, but any later contacts in relation to the assessment process or to service provisions arising from the initial contact should not be included in R1. For an episode of assessment or provision of ongoing services there should be just one R1 entry (with one source of referral recorded in R3). For further discussion see the glossary entry for 'contacts'.

Contacts that are passed on for assessment by several different teams, e.g. multi-disciplinary assessments, should not have a separate R1 referral for each teams' involvement. The whole process should be recorded as one R1 contact.

- **Asylum seekers**

Assessments completed for asylum seekers under the National Assistance Act 1948 or the Asylum and Immigration Act 1996 should not be included. Only Community Care assessments for asylum seekers should be included.

Return:

The return is a figure of the number of screened contacts for new clients passed forward for further assessment or commissioning of ongoing service.

R2

Number of contacts for new clients during the period concerning services from the CSSR whose needs were attended to solely at or near the point of contact.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return aims to measure the number of contacts for new clients with the CSSR, either directly or through an intermediary, which are screened, and information and / or advice only given, with no further action beyond registration or a 'basic service'.

Business case.

As with R1, this return is intended to indicate the level of demand placed on CSSRs, and to be useful in policy evaluation in relation to care management and staffing at national level. Information from R2, when set alongside R1 information, can indicate the different CSSR responses arising from contacts. It can also show the extent to which CSSR care management arrangements at initial screening are able to deal with simple requests.

Inclusions and exclusions

- The return is for adults aged 18 and over only.
- R returns are concerned with **contacts** (episodes, events), **not clients**.
- Casual contacts should be excluded from the returns.

Contact on referral (R) forms:

All the referral (R) forms are defined to only include contacts from **new clients**, that is clients not on the books of the authority at the time the contact was made. A person who has previously received services, which have ceased before the time of contact (i.e. the client is "off the books" when the contact is made) should be included. A client may be on the books of the CSSR but not actually receiving a service. This would **not** count as a contact for RAP purposes.

For the R forms all contacts made by **new clients** in the year should be included, whether or not they received an assessment or any service in the year. For example a contact on 30 March 2008 who did not receive an assessment until 2 April 2008 would be included in RAP 2007-08 as a contact only. The waiting time for such an individual would be counted in RAP 2008-09.

It is assumed that the figures given may exceed the number of clients because some clients may make more than one contact in the period.

- The intention is to count all contacts for **new clients** relating to adult services, excepting:
 - Those passed on for further assessment or commissioning of service, as included in R1. (See the glossary for details on the distinction between 'service' and 'basic services'.)
 - Casual contacts who are not screened.

- **Clients receiving both R1 and R2 services**

If a contact is given information, advice or a basic service, but not passed on for further assessment or commissioning of service then it should be recorded on R2. However, if the contact is also passed for further assessment or commissioning of service then it should be included in R1, and not in R2.

- **Welfare benefits advice and equipment as basic services**

It is important to be aware of the circumstances in which some 'services' may be classified both as 'basic' (i.e. relevant for R2 inclusion), or as a community based service following assessment (i.e. relevant for R1 entry). For example, welfare benefits advice and help for asylum seekers may be a one-off basic service (i.e. R2 entry), or may involve a further community-care assessment and / or be ongoing (i.e. R1 entry). For further discussion see the glossary entry for 'welfare benefits'. Careful judgement is needed with regards to equipment; see the glossary entry for 'Equipment / adaptations' for further discussion.

- **Services provided by one-stop agencies such as Care Direct**

Care Direct is an organisation that older people and disabled people can approach with queries about matters such as social care, community health or housing. The Care Direct advisor will contact service providers as required and may refer clients on to social services for assessment; this referral would be dealt with on R1 as usual. However Care Direct is also able to provide basic services such as blue badges or issue items of equipment. Information on the provision of services should be obtained from these agencies and recorded on R2.

- **Blue badges for disabled clients (reported on R2)**

When a new client is issued with a blue badge for disabled parking this is a basic service and should be included on form R2. If a client contacts the CSSR to have their blue badge renewed they are not to be regarded as a new client. Therefore renewals of blue badges should **not** be included on R2.

Blue badges can only be included in the P forms (under "Other") if they are part of a care plan (**including other services**) following a Community Care Assessment.

- **Additional R2 table: Number of contacts for new clients receiving services covered by definitions relating to RAP P forms at the point of contact outside of a formal assessment**

An additional table has been included within the R2 proforma that will be collected by CSSRs on a voluntary basis for the period 1st October 2007 – 31st March 2008.

There is evidence that some CSSRs are providing services at the point of contact outside of assessment which were previously provided following a Community Care Assessment. The main type of service provided this way is equipment. The increasing use of providing services at the point of contact as opposed to through assessment will have an impact on the number of people receiving services in the RAP P tables, and

therefore, impact on PAF AO/C32 and the PSA target on older people. This table will help to capture the whole picture of services being provided by CSSRs.

Return:

The figure is the number of contacts for new clients with the CSSR, either directly or through an intermediary, which are screened, and information and / or advice only given, with no further action beyond registration or a 'basic service'.

R3

Source of referral for all contact events covered in R1 and R2.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return seeks to identify the source of referral for all contacts by new clients passed on for assessment (R1) and all dealt with at or near the point of contact (R2). Detail in the list of sources of referrals is intentionally slanted to focus more on referrals from health services.

Business case

It is important for CSSRs, partner agencies and central Government to have insight into the source of referral for all contacts coming for CSSR assessment. The numbers of self, family and other personal referrals can show the extent to which individuals are able to approach the CSSR for themselves, reflecting their knowledge of services and the information CSSRs make available. The number of referrals from primary and secondary health sources can reflect work at the important interface between social care and health care.

Inclusions and exclusions

- The return is for adults aged 18 and over only.
- R returns are concerned with **contacts** (episodes, events), **not clients**.
- Casual contacts should be excluded from the returns.

Contact on referral (R) forms

All the referral (R) forms are defined to only include contacts from **new clients**, that is clients not on the books of the authority at the time the contact was made. A person who has previously received services, which have ceased before the time of contact (i.e. the client is "off the books" when the contact is made) should be included. A client may be on the books of the authority but not actually receiving a service. This would **not** count as a contact for RAP purposes.

For the R forms all contacts made by **new clients** in the year should be included, whether or not they received an assessment or any service in the year. For example a contact on 30 March 2008 who did not receive an assessment until 2 April 2008 would be included in RAP 2007-08 as a contact only. The waiting time for such an individual would be counted in RAP 2008-09.

It is assumed that the figures given may exceed the number of clients because some clients may make more than one contact in the period.

- Only contacts given in the core figures for R1 and R2 are covered by R3.

- **Link to R1 and R2**

The total of the referral sources on R3 should be the same as the sum of the contacts figures given on R1 and R2 respectively.

- **Internal referrals**

The re-referral of an existing client (e.g. referral for a review) by a member of CSSR staff should be excluded.

- **Self-referrals**

Some CSSRs have automated referral processes for some basic services. Count these as self-referrals, and draw attention to this in the notes section.

- **Instances where there is more than one source of referral.**

In a small number of instances a referral may come from more than one source. Do not double count. Use the initial source -the source from which the referral is first received.

- **Referrals from One Stop agencies such as Care Direct**

If an R1 or R2 contact is referred from an agency such as Care Direct then the source of referral should be recorded as 'other'.

Return:

Number of contacts for new clients (sum of R1 and R2) by source of referral
Sources of referral are given by the following categories -

- Primary health / Community health (GP, community-based professions allied to medicine, etc)
- Secondary Health (A&E, hospital OT, ward, hospice, etc)
- Self-referral
- Family / friend / neighbour
- Internal (i.e. own CSSR)
- LA Housing Department or Housing Association
- Other departments of own LA or other LA
- Legal agency (police, court, probation, immigration)
- Other
- Not known

A1

Number of clients for whom the assessment or review process was completed or terminated during the period by primary client type and extended age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return aims to measure:

- a) The number of **new** adult clients whose needs were **assessed** in the period specified (page1).
- b) The number of **existing** adult clients whose needs were **reviewed** in the period specified (page 2).

The return is broken down by primary client type and extended age group.

A further measure is requested of clients who were passed forward or either assessment or review, but where, during the period, the assessment or review was terminated either before its start or while in progress (page 3).

Business case

The purpose of the return is to enable policy monitoring and resource planning, and to fill out the profile of CSSR activity under the Community Care Act. The breakdown of assessments and reviews into primary client types can indicate the extent to which key user groups are being identified at assessment and subsequently reviewed. The returns will give useful comparative data across authorities on assessment and review activity across the board and for user types.

Inclusions and exclusions

- The return is for adults aged 18 and over only.
- **Baseline population**

All new clients who appear as having a completed or terminated assessment would have been recorded in R1 either in this period or a previous collection period.

All existing clients who have received a review during the period.

- **Assessment**

An “assessment” is defined as the **first** assessment for a **new** client. All subsequent assessments which include a reassessment will be defined as a **review**.

- **Review**

A “review” is an examination of the client’s needs for an **existing** client and **must** include a (formal) reassessment, irrespective of whether it was a scheduled or unscheduled review.

- **Completed assessments and reviews**

A complete assessment or review for the purposes of inclusion in A1 means that the assessment or review of needs has been completed and a care plan agreed. It is not required that a financial assessment has been completed (see glossary definition for further detail).

- **Double counting**

A1 is mainly concerned with client figures. New clients should only be counted once in the first box and main table on A1 page one. If a client has had more than one assessment event during the reporting period then provide details in relation to the most recently completed assessment event (i.e. no double counting). Similarly, if an existing client has had more than one review event in the period then provide details in relation to the most recently completed review process. There should be no double counting of clients in the first box and main table on A1 page 2. However, it is possible for a client to be counted in both pages 1 and 2 of A1 if they were a new client and received a review during the reporting period.

It is also possible for a client to be recorded on all 3 pages of A1. As the criteria for inclusion refer to completed assessments and reviews, clients who have had a completed assessment and a completed review within the year, and then have a subsequent review terminated in the same time period (e.g. due to death) in these cases the 3 events should be recorded on pages 1, 2 and 3 of A1.

- **Multi-disciplinary assessments and assessments under the Single Assessment Process**

The whole assessment process should be recorded as a single event. Activity in a single assessment event by different teams (e.g. a multi-disciplinary assessment) should **not** be recorded separately. This also applies to assessments under the Single Assessment Process (SAP). If a client receives more than one of the four types of assessment referred to by the SAP- Contact, Overview, Comprehensive or Specialist, then this should be dealt with in the same way as a multi-disciplinary assessment. For further discussion of SAP please see the glossary definition 'Single Assessment Process'.

- **Mental health assessments**

Mental health assessments should be included in RAP if they include a social care element. If you have joint health and social services teams, then assessments completed by social workers or health staff could be included, providing the outcome of the assessment could be health or social care services. If the assessment is purely for health services then it should be excluded from the 'A' returns. If the outcome of the assessment is the provision of health services then the sequel to assessment for A5 would be "no (new) services offered or intended to be provided".

- **Asylum seekers**

Assessments completed for asylum seekers under the National Assistance Act 1948 or the Asylum and Immigration Act 1996 should not be included. Only Community Care assessments for asylum seekers should be included.

- **Age Group**

Client age is calculated as at the last day of the period. If a client dies, the age should be recorded as their age at death. If only the year of birth is known, as opposed to the month, then age should be calculated by assuming that their birthday falls between March and December. For example if a client was born in 1960, then for the collection period 2007-2008, they would be recorded as being 46 years of age.

- **Defining Clients**

See the glossary definition of 'client'. Please state in the notes whether your agency practice is that one client equals one person, or whether a 'client' can be a composite of more than one person. If you take the latter position please quantify how many such 'clients' are included in your total.

- **Carers**

This return is concerned with social services clients and should **not** include persons who are carers. Carers assessment information should be included in forms C1 and C2. A person who is a carer should only be included in A1 if they have been assessed as a client in their own right, and **not** as a carer.

Other persons involved in service provision (e.g. persons assessed as potential foster parents) should also not be included in A1. See glossary entry for 'End sheet' for how to handle these.

- **Use of primary client types**

It is important to follow the definition / categories for primary client type given in the glossary. The intention is that the primary client type categorisation shall be a professional decision, established as an outcome of assessment and updated as relevant, not a decision of administrative convenience (e.g. for convenient allocation to a specialist team). In some CSSRs each client has an overarching client classification, but may receive a different classification for a specific assessment, in these circumstances use the overarching client type for the return.

- **Double counting of primary client types**

A client may appear in only one primary client type, so there should be no double counting.

- **Use of client type subsets**

We encourage you to complete as much information on subsets as possible. The subsets are not designed to be exhaustive and as such will not include all possibilities. The information required has specifically been requested due to an interest by policy. There is a particular interest in the subset Dual Sensory impairment. In 2001 DH issued new statutory guidance under section 7 of the Local Authority Social Services Act 1970 on the monitoring of details on people who are deafblind. Part of this guidance relates to the recording of assessments for dual sensory impaired clients and any information provided on these clients is extremely beneficial.

- **Double counting and client type subsets.**

It is possible for a client to appear in none or more than one subset of a primary client type and hence the total of entries in subsets is not expected to equate to the total number of clients within each primary client type. However, double counting within the subsets is restricted to within the same primary client type. Therefore a person classified in the primary client type 'physical disability, frailty and sensory impairment' could appear in the subsets 'physical disability' and 'hearing impairment' but they could not appear in the subset 'dementia' (*see glossary definition*) as this would be double counting across primary client types.

- **Older people classification**

There is not a primary client type for older people. Clients who may have previously been classified as 'elderly' or 'older person' should be reassigned to one of the primary client types. Information regarding older people is picked up via the age breakdown details.

- **Terminated assessments and reviews**

A1 page 3 seeks a global figure for clients passed through for assessment or review, but where, during the period, it was terminated, either with or without the assessment process having got under way. The criteria for inclusion is that the client must have appeared as a contact in R1 for this or a previous period, and a decision must have been taken not to undertake or continue with the assessment or review, i.e. bring to an end before completion. Clients should not be included if the assessment process is still in progress, but is not as yet completed.

- **Joint assessments or reviews**

Joint assessments or activity by joint teams should be included in the RAP returns if an element of social services budget has gone into the assessment.

If the CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006 they should include assessments carried out and social services provided by the health partner in RAP. Legally, joint teams can only operate (in terms of assessing needs for social services) within section 75 where they have delegated authority from social services to do so. Where this is the case ALL the social care related assessments carried out by the team should be counted for RAP purposes whether made by a social services member of staff or not.

(i) Assessments carried out by joint teams prior to agreeing a section 75 flexibility
 CSSRs are reminded that they may not delegate their statutory duty of assessment except within the context of section 75 of the NHS Act 2006. However prior to agreeing a section 75 flexibility, where joint health and social services teams are sharing assessment work in the best interests of actual or potential service users, then assessments completed by authorised social care workers or health staff should be included **providing** the assessment may lead to a person being provided with community care services because of social care needs. If the assessment is purely for health services then it should be excluded from the A proformas.

(ii) Assessments carried out by other organisations

As CSSRs have a statutory duty of assessment, they need to ensure and assure themselves that all assessments that include a social care element are carried out in the appropriate way. However CSSRs can delegate or contract out the process of carrying out an assessment to other organisations, for example to voluntary organisations, **only** if they fund them and have some means of checking the process and outcomes of the assessment. The checking should be done for each individual assessment rather than a sample that the other organisation carries out. Where CSSRs contract the assessment process out to other organisations, they must ensure that the checking procedures are met. CSSRs need to ensure that the assessment is valid and fair, and evaluates all the individual's presenting needs. If the CSSR does not check each individual assessment carried out by another organisation, then these assessments must be excluded from RAP.

- **Out of area clients**

In order to ensure that everyone takes the same route, the rule is to count what your CSSR pays for. If you assess clients from another area, at your expense, then count them in your figures. If the other area pays you to do the assessments then that area counts them in their return and you do not. Similarly you may count clients from your patch that have been assessed by another CSSR only if you pay for the assessment.

Return:

Overall number of new clients receiving a completed first assessment, during the period by extended age group and primary client type.

Overall number of existing clients receiving a review, during the period by extended age group and primary client type.

Extended age groups are 18 to 64, 65 to 74, 75 and over (75+).

Primary client types are -

- Physical disability, frailty and sensory impairment
- Mental health
- Vulnerable people (including special services)
- Learning disability
- Substance misuse

Subsets -

- Physical disability, frailty and/or temporary illness
- Hearing impairment
- Visual impairment
- Dual sensory loss

All as subsets of 'physical and sensory disability / frailty'

- Dementia as a subset of 'Mental health'

Return of the total number of review events carried out during the period.

Return of the number of clients for whom the assessment or review process was terminated during the period, by extended age group.

Include in the notes your approach to defining 'client' (see protocol).

A5

Number of clients for whom assessments were completed in the period by primary client type cross-tabulated with known or anticipated sequel to assessment and extended age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return aims to monitor assessed clients according to the sequel to their assessment, taken as what is known or decided or intended at the time the assessment is completed. This is cross-referenced with primary client type and extended age group.

Business case.

The purpose of this return is to build up a picture of what is expected to happen to people who have been assessed, in relation to turnover, disposal and drop-out. The data on client type will give CSSRs and DH valuable insights into the help which different users are offered and/ or receive as a result of assessment.

Inclusions and exclusions

- Figures refer only to adults aged 18 and over.
- **Baseline population**

The baseline population for A5 is the total of unique clients for whom the assessment process was completed in the period, which should be equal to the sum of completed assessments reported on A1 page 1. This includes those clients with a completed assessment and excludes those whose assessment has been terminated. Basically the return seeks to monitor the status of each client group once the assessment has been completed, and cross-reference this data with other variables.

- **Double counting**

There should be no double counting across sequel categories.

If a client has had more than one assessment process completed in the period then use the most recently completed. There should be **no** double counting of the same client.

Double counting across primary client types is not permitted - a client may appear in only one primary client type category. However, it is possible for a client to appear in none or more than one subset of a primary client type. Hence the total of entries in subsets is not expected to equate to the total number of clients within each primary client type. The double counting of subsets is restricted to within the same primary client type. Therefore a person classified in the primary client type 'physical disability, frailty and sensory impairment' could appear in the subsets 'physical disability' and 'hearing impairment' but they could not appear in the subset 'dementia' as this would be double counting across primary client types.

- **Assessment**

An “assessment” is defined as the **first** assessment for a **new** client. All subsequent assessments which include a reassessment will be defined as a **review**.

- **Sequel to assessment**

It is important to work carefully to the definition of ‘sequel to assessment’ given in the glossary.

- **(i) New Services**

At the time the assessment is completed some sequels are known (in the sense of established fact), with decisions already taken and implemented, whether for services or no further action. However, it is acknowledged that in other cases the sequel may only have reached the stage of being anticipated or intended, but not yet implemented. This return should include all of these sequels, and recognises that in some instances the actual sequel may eventually differ from the intended one.

- **Recording of outcome of assessment for clients who pay for their own services**

If following an assessment the decision is to provide services but the client is paying in full for these services then the outcome would be recorded as "No (new) services offered or intended to be provided".

The same principle applies if another agency, such as health pays for the services. A client is defined as being ‘fully funded’ if there is no financial input from the CSSR. If a client is paying for services, but the CSSR pays for the care management, the client can be recorded in the P returns under the services they are in receipt of. See glossary definition for ‘Fully funded client’.

Return:

Status of the clients returned in A1 at completion of assessment (excluding assessments terminated prior to completion) in the following groups -

- Some or all (new) services intended or already started (including those started and finished).
- No (new) services offered or intended to be provided.
- (New) service(s) offered but declined.
- Other sequel to assessment

These ‘sequel to assessment’ categories are cross-referenced with -

- Extended age group (see A1 protocol for detail)
- Primary Client type (see A1 protocol for detail)

A6

Number of clients for whom assessments were completed in the period by ethnicity, cross-tabulated with the known or anticipated sequel to assessment and age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return aims to monitor assessed clients according to their ethnicity. Ethnic categories are a subset of those used in the 2001 Census. This is cross-referenced with age group and known or anticipated sequel to assessment. It is appreciated that some authorities may not be able to provide information on ethnic group for all clients (but just new clients) that had a completed assessment during the period.

Business case.

The purpose of this return is to build up a picture of what is expected to happen to people who have been assessed in relation to turnover, disposal and drop-out. The data on ethnicity will give CSSRs and DH an indication of the effectiveness of referral processes in identifying those from ethnic minorities who have needs, and will permit analysis related to equality. In particular, it will be used to monitor 'Fair Access to Care' policies.

Inclusions and exclusions

- Figures refer only to adults aged 18 and over.
- The return refers only to clients with an assessment completed during the period.

- **Baseline population**

The baseline population for A6 is the total of unique clients for whom the assessment process was completed in the period, and should equal the sum of completed assessments recorded in A1 page 1

- **Double counting**

There should be no double counting across ethnicity or sequel categories.

If a client has had more than one assessment process completed in the period then use the most recently completed. There should be **no** double counting of the same client.

- **Assessment**

An "assessment" is defined as the **first** assessment for a **new** client. All subsequent assessments which include a reassessment will be defined as a **review**.

- **Sequel to assessment**

It is important to work carefully to the definition of 'sequel to assessment' given in the glossary.

(i) New services

At the time the assessment or review is completed some sequels are known (in the sense of established fact), with decisions already taken and implemented, whether for services or no further action. However, it is acknowledged that in other cases the sequel may only have reached the stage of being anticipated or intended, but not yet implemented. This return should include all of these sequels, and recognises that in some instances the actual sequel may eventually differ from the intended one.

- **Recording of outcome of assessment for clients who pay for their own services**

If following an assessment the decision is to provide services but the client is paying in full for these services then the outcome would be recorded as "No (new) services offered or intended to be provided".

The same principle applies if another agency, such as health pays for the services. A client is defined as being 'fully funded' if there is no financial input from the CSSR. If a client is paying for services, but the CSSR pays for the care management, the client can be recorded in the P returns under the services they are in receipt of. See glossary definition for 'Fully funded client'.

Return:

Status of the clients returned in A1 page 1 at completion of assessment (excluding assessments terminated prior to completion) in the following groups –

- Some or all (new) services already started (including those started and finished).
- No (new) services offered or intended to be provided.
- (New) service(s) offered but declined.
- Other sequel to assessment.

These 'sequel to assessment' categories are cross-referenced with –

- Age group (see A1 for detail).
- Ethnicity

The ethnic categories are:

- | | | |
|----|---------------------------|---|
| a) | White - | British
Irish
Any other White background |
| b) | Mixed - | White and Black Caribbean
White and Black African
White and Asian
Any other mixed background |
| c) | Asian or Asian British - | Indian
Pakistani
Bangladeshi
Any other Asian background |
| d) | Black or Black British - | Caribbean
African
Any other Black background |
| e) | Chinese or other ethnic - | Chinese
Any other ethnic group |
| f) | Not stated | |

A7

Length of time from first contact to completed assessment for new clients whose assessments were completed during the period, in time bands, referral category, age group and primary client type.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return aims to record how long it took, in calendar days, from the time a new client made contact with the CSSR up to the completion of the assessment of their needs. This material is cross-referenced with three variables used elsewhere in RAP – primary client type, age group and referral category. The length of time is recorded in time bands.

Business case

There is a ministerial target requiring all assessments for new clients to be completed within 4 weeks and 70% within 2 weeks of first contact with social services. The information from this and the next two returns (A8, A9) will be used to build up a picture of the speed of response each CSSR is able to make to presented need, including emergency needs.

Inclusions and exclusions

- Figures refer only to adults aged 18 and over.
- The return is concerned with waiting times for **new clients**, and **excludes** existing clients.
- Terminated assessments should be excluded.

- **Baseline population**

The baseline population for A7 is the total of new clients for whom the assessment process was completed in the period, and should be the same as on A1 (page 1). Basically the return seeks to monitor how long each client group waited for the assessment process to be completed, and cross-reference this data with other variables.

- **Double counting**

A client may appear in only one time band, primary client type and referral category. If a client has had more than one assessment event during the reporting period, then provide details relating to the most recent assessment event. There should be no double counting across categories.

- **Defining referral category**

The 'Primary/Community Health' and 'Secondary Health' columns are as defined for return R3. See glossary definition 'Source of referral'.

- **First Contact**

- All individuals excluding those who are inpatients in hospitals:* This is the date when first contact is received from or on behalf of the client in relation to the needs that require assessment. The contact may be by way of personal call, phone call, letter or other form. It may be direct or through an intermediary (such as a neighbour, relative or GP). The date of first contact is not necessarily the same as the date of screening, though in many CSSRs screening will take place on the same day as contact.
- Individuals who are inpatients in hospital:* This is the date when it is confirmed by an NHS hospital to a social services department by means of a 'section 5 notice' that the patient is medically fit and ready for discharge. The contact may be by way of phone call, letter or other form.

If a CSSR is informed that a patient's intended release is delayed for medical reasons, the time of the first contact should be reset to when the CSSR is re-notified by the hospital via a section 5 notice. If an assessment has already been carried out before the release date changed and no further assessment is required, the first contact with client must be the new date of discharge.

- **Measuring first contact for joint teams and SAP**

The waiting time from first contact should be measured from the time of first contact with social services or joint teams under section 75 arrangements. Three examples are given below:

- A member of the joint team starts an assessment looking at both the health and social care needs of the client on 1st June. For RAP proforma A7 and A9 the first contact is counted on RAP as 1st June.
- A member of the joint team starts an assessment looking at the social care needs of the client on 1st June. They then contact the health part of the team to assess the health needs on 5th June. The first contact is counted as 1st June.
- A member of the health team starts an assessment looking at the health needs of the client on 1st June. Then on the 3rd June they contact social services as it is decided that the social care needs of the client need to be assessed. The first contact is then counted as 3rd June.

- **Completed assessment**

For RAP purposes include all assessments which were completed in 2007-08 whether or not they started in 2007-08. Exclude any assessments that were not actually completed by 31 March 2008. This clarifies the current guidance on completed assessments as set out in the glossary.

- **Measuring completed assessments**

The waiting time to completed assessment should be measured as the time social services complete their last assessment event within the whole assessment process. Three examples are given below;

- a) A multi-disciplinary assessment is carried out within social services. This includes two assessment events, an overview assessment carried out by a social worker that was completed on 3 June and an OT assessment that was completed on 10 June. The date the assessment is counted on RAP as complete is 10 June.
- b) A SAP assessment is carried out to look at both the health and social care needs of the client. The social services element of the assessment is completed on 3 June and the assessment of the health needs is completed on 10 June. The date the SAP assessment is counted on RAP as complete is 3 June when the social services part is complete. This example is also applicable to joint teams under section 75 arrangements. [From the service user perspective this is not ideal but reflects the possible problem of not knowing when the health part of the assessment is complete.]
- c) A joint assessment is **coordinated by social services**. Social services have completed their part of the assessment by 3 June but the assessment of health needs is not completed until 10 June. The date the assessment is counted on RAP as complete is 10 June.

- **Recording of assessments in relation to FACS**

For assessments which stop because the users needs do not meet the Fairer Access to Care (FACS) eligibility criteria, treat these as completed assessments.

- **Measuring waiting times**

Waiting times are based on calendar days, not working days.

For the purpose of measuring calendar days to the completion of assessment, the preferred time point is when the statement of needs and how these are to be met (care plan) is logged.

- **Completing the assessment before receiving the section 5 notice**

Where CSSRs have completed the assessment for a client in hospital before receiving the section 5 notice, the time between first contact and completed assessment should be recorded in the lowest time band on RAP form A7, i.e. less than or equal to 2 days.

- **OT assessments**

Assessments completed by Occupational Therapists (OT) and Occupational Therapy Assistants (OTA) and paid for by social services should be included in RAP. If the OT/OTA contributes to a multi-disciplinary team assessment, then the OT assessment would be one assessment event within the whole assessment of the client's needs. In the Single Assessment Process OT assessments are captured under 'Specialist' assessment. If the OT assessment is the only assessment then it should still be recorded on RAP.

Any items of equipment which are issued at or near the point of contact as a basic service and are recorded in form R2 should be excluded from the waiting times forms.

Where social services refer the OT assessment to an outside agency, if social services have funded the assessment then it should be included in RAP; however, if social services have not paid for the assessment then it is excluded from RAP.

- **Dealing with waiting times for OT assessments**

CSSRs are known to take varying approaches to clients assessed as needing major adaptations. Some CSSRs keep the assessment open for a long period (possibly years) until the adaptation work is about to start; others close the assessment and then reassess when the start of work date is known. There may be still other approaches. Please use the notes to state how you handle such clients. This will help us evaluate the degree of variation in procedures locally.

Return:

- Length of time for new clients from first contact to completion of assessment, in time bands, by age group.
- Length of time for new clients from first contact to completion of assessment, in time bands, by primary client type, and age group.
- Length of time for new clients from first contact to completion of assessment, in time bands, by referral category, and age group.

A8

Length of time from completed assessment to receipt of all services for new clients aged 65 and over for whom all services were put in place during the period, in time bands and primary client type.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return aims to record how long it took, in calendar days, from the time the assessment of needs was completed to the time the client was in receipt of **all** the services specified in their care plan, for new clients aged 65 and over. This material is cross-referenced with primary client type. The length of time is recorded in time bands.

Business case

There is a Ministerial target requiring that all new clients aged 65 and over receive all services in their care plan within 4 weeks of their completed assessment, and 70% within 2 weeks. The information from this and two other returns (A7, A9) will be used to build up a picture of the speed of response each CSSR is able to make to presented need, including emergency needs.

Inclusions and exclusions

- Figures refer only to older people aged 65 and over.
- The return is concerned with waiting times for **new clients**, and **excludes** existing clients.
- Waiting times are based on calendar days, not working days.

- **Baseline population**

The baseline population for A8 is the total of new clients with completed assessments who received all their services during the period. Clients who meet the above criteria but who contacted social services and/ or were assessed before the start of the current period should also be included. Generally, this should be less than the total number of new clients with completed assessments recorded on A1 page 1. Basically the return seeks to monitor how long each client group waited to receive all their services following the completion of the assessment process, and cross-reference this data with other variables.

- **Double counting**

A client may appear in only one time band and primary client type. If a client has had more than one assessment event during the reporting period, then provide details relating to the most recent assessment event. There should be no double counting across categories.

- **Waiting time to receipt of all services**

For RAP purposes, only include those clients actually in receipt of **ALL** services by the end of the financial year 2007-08.

For measuring the target for new clients these are all the directly provided, commissioned or purchased Social Care services which are in the client's care plan. In this context Social Care services will include any service which is paid for or recharged to Social Services budgets within CSSRs. It will also include social services provided as a result of an assessment made by a joint team operating under section 75 whether or not this team is funded directly by Social Services (e.g. via a pooled budget).

To meet the target of services starting within 4 weeks, **all** services must be provided within 4 weeks.

There are some rare circumstances where some of the services defined in a care plan are contingent on the delivery of other services. Therefore it is not sensible, and indeed would be detrimental to the client, for them to be delivered within 4 weeks of the assessment. On these very rare occasions, the *arrangements* for these services to be delivered should be put in place within the 4 week period, i.e. patient need is the only reason why services are provided outside the four week period.

An example of a rare circumstance is where a care plan specifies that a client needs rehabilitation services for 5 weeks but then requires home care after coming out of rehabilitation. In this case the client's needs mean that the home care services should not be delivered within 4 weeks of the assessment. Instead both the rehabilitation must start and the arrangements for home care be put in place within 4 weeks of the completed assessment.

There may be other exceptional circumstance beyond the control of CSSRs which mean that all services cannot be provided within 4 weeks of the assessment. These circumstances will be taken into consideration when setting the performance bandings for the waiting times to care packages indicator.

- **Date of receiving service**

This should be the date when the client **actually** first receives the service as opposed to the planned or desired date of receipt.

- **Equipment and adaptations**

For measuring the receipt of all services on proforma A8, this should include **all** equipment and minor adaptations provided or commissioned and funded by the CSSR.

In the case of equipment and adaptations, services are **not** complete until the equipment is received (and where necessary, satisfactorily installed).

- **Major adaptations**

The waiting time is measured as the time from completed assessment to the date that the request for a major adaptation is referred to a housing department or a housing association, or an application is submitted for a Disabled Facilities Grant (DFG). In some cases there may need to be a social services “top up” but reaching final agreement on the amount involved is excluded from the waiting time.

- **Professional Support**

For a client to be considered as having professional support, the service must be included as part of their care plan. This does **not** include the process of care management (i.e. assessing or reviewing their care needs, even if the case is “open” or “active” on 31st March), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, e.g. counselling. For professional support to be regarded as received the requisite input must be provided by or on the date recorded.

- **Guidance on specific services**

Several types of services are listed below with guidance on how to measure when these services are received.

- i) **Direct payments**

We understand that the process for arranging direct payments can be quite lengthy in terms of the legal and contractual issues. Hence for direct payments the waiting time is measured as the time from completed assessment to the date the amount of the direct payment has been agreed with the client **and** the relevant processes for setting up the direct payment have been completed.

- ii) **Other services that are booked in advance**

For example pre-hospital admission arrangements for home care. To cover other services that are booked in advance use the guidance below:

The guidance issued already states that services that are not actually required by the client within 4 weeks of completed assessment, are counted as being received as long as arrangements for those services have been put in place within 4 weeks. However there is an issue whereby the client is in need of a service, but because a date for the service has not been specified it is not possible to put arrangements in place.

If the arrangements for this service are not in place then all services have not been received, i.e. if no dates are specified in the care plan then arrangements for the service can not be put in place and therefore it is likely that the majority of these cases would miss the target of 4 weeks from completed assessment to receipt of all services.

In this situation the client would be considered to have received all their services once a date for the service had been given **and** the arrangements had been put in place, even if this is several months after receiving all other services.

Example: The client completes their assessment on 1st May. Their care plan includes meals, equipment and day care with no date specified. The meals are first received on 7th May and equipment is first received on 10th May. The client then asks for day care on 20th June to start at the end of July. The arrangements for day care are put in place by 25th June. The waiting time between the completed assessment and receipt of all services is measured as the length of time between 1st May and 25th June.

We understand this means it will be impossible for CSSRs to meet the target of 100% of services in place within 4 weeks for practical reasons. This will be taken into account when the bands for the indicator are set.

iii) Services that may be modified in light of experience

In this situation the waiting time is measured from time of completed assessment to receipt of all services in the **initial** care plan.

Example: It is decided initially that a client should receive 4 hours of home care a week and attend a day centre 3 times a week. It is agreed to review this arrangement in 5 weeks time. The initial home care and day care is started one week after the assessment. The waiting time is measured as the time between the completed assessment to when both the home care and day care are first received, namely one week.

Any future services included in the care plan, for example at the 5 week review, should still be put in place as soon as possible but will be excluded from the indicator as these services are following a review.

iv) Needs assessed during a residential placement

- (a) If the **initial** service in the care plan is to go into residential care for further assessment, then count the date that the client moved into residential care as the date when all services were received.
- (b) If the initial needs are still being assessed, the assessment has not been completed and the client does not have an agreed care plan for CSSRs to put in place. Hence these clients would be excluded from form A8 in the current reporting period.

Please note that Respite Care is now considered a service for the carer and is not recorded in the P forms.

Receiving services before the assessment is completed

Where the client has received all their services (or the arrangements were put in place for specific services) before the assessment has been completed, the time between completed assessment and receipt of all services should be recorded in the lowest time band, i.e. less than or equal to 2 weeks.

• Sampling Guidance

In December 2003 a document providing guidance on sampling for proforma A8 was issued. Copies of this document are available via the RAP website. In addition to this guidance, in April 2004, DH prepared a grossing up tool to help CSSRs apply weights to their data. This tool is available for download (in Excel format) from The Information Centre's website. The general sampling guidance from the Audit Commission for Best Value performance indicators is available at <http://www.audit-commission.gov.uk>.

If you intend to provide data based on a sample for 2007-08, some key areas to note are;

- a) A "random" sample must be taken of clients from across the whole period 1 April 2007 to 31 March 2008. The Audit Commission does **not** allow samples based on some months of the year and uprated to the whole year, for example the last 3 months multiplied by 4.
- b) As a minimum the sample sizes for 2007-08 should meet the requirements set out in table A of appendix A of the sampling guidance. **Any data based on a smaller sample size will not be accepted for RAP or the performance indicators.**
- c) **Sample data should be uprated to the whole population before it is submitted on the RAP return.**

Return:

For new clients aged 65 and over;

- Length of time for new clients from completed assessment to receipt of all services, in time bands.
- Length of time for new clients from completed assessment to receipt of all services, in time bands by primary client type.

A9

Length of time from first contact to first contact with client following referral. This is for new clients who were contacted following referral during the period, in time bands, age group and primary client type.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return aims to record how long it took, in calendar days, from the time a new client made contact with the CSSR up to the first contact with client. This material is cross-referenced with two variables used elsewhere in RAP – primary client type and age group. The length of time is recorded in time bands.

Business case.

There is a Ministerial target that requiring all assessments begin within 48 hours of the first contact with social services. The information from this and two other returns (A7, A8) will be used to build up a picture of the speed of response each CSSR is able to make to presented need, including emergency needs.

Inclusions and exclusions

- Figures refer only to adults aged 18 and over.
- The return is concerned with waiting times for **new clients**, and **excludes** existing clients.

- **Baseline population**

The baseline population for A9 is the total of new clients for whom the first contact with client was made in the period, and should be less than or equal to the number of contacts on R1. Basically the return seeks to monitor how long each client group waited between first contacting the CSSR and the first contact with client, and cross-reference these data with other variables.

- **Double counting**

A client may appear in only one time band and primary client type. If a client has had more than one assessment event during the reporting period, then provide details in relation to the most recent event. There should be no double counting across categories.

- **First Contact**

- a) *All individuals excluding those who are inpatients in hospitals:* This is the date when first contact is received from or on behalf of the client in relation to the needs that require assessment. The contact may be by way of personal call, phone call, letter or other form. It may be direct or through an intermediary (such as a neighbour, relative or GP). The date of first contact is not necessarily the same as the date of screening, though in many CSSRs screening will take place on the same day as contact.
- b) *Individuals who are inpatients in hospital:* This is the date when it is confirmed by an NHS hospital to a social services department by means of a 'section 5 notice' that the patient is medically fit and ready for discharge. The contact may be by way of phone call, letter or other form.

If a CSSR is informed that a patient's intended release is delayed for medical reasons, the time of the first contact should be reset to when the CSSR is re-notified by the hospital via a section 5 notice. Where CSSRs have contacted the client in hospital before receiving the section 5 notice, the time between first contact and the first contact with client should be recorded in the lowest time band on form A9, i.e. less than or equal to 2 days.

- **Measuring first contact for joint teams and SAP**

The waiting time from first contact should be measured from the time of first contact with social services or joint teams under section 75 arrangements. Three examples are given below:

- (i) A member of the joint team starts an assessment looking at both the health and social care needs of the client on 1st June. For RAP proforma A7 and A9 the first contact is counted on RAP as 1st June.
- (ii) A member of the joint team starts an assessment looking at the social care needs of the client on 1st June. They then contact the health part of the team to assess the health needs on 5th June. The first contact is counted as 1st June.
- (iii) A member of the health team starts an assessment looking at the health needs of the client on 1st June. Then on the 3rd June they contact social services as it is decided that the social care needs of the client need to be assessed. The first contact is then counted as 3rd June.

- **First contact with client following referral**

This is the date when, following or at referral, an appropriate member of staff first contacts the client;

- To discuss their needs and agree with the individual what further action should be taken
- or
- Arranges a suitable time with the client to discuss their needs.

Where the client cannot genuinely speak for themselves (perhaps they have a severe cognitive impairment), contact can be with the next of kin, carer or other independent person who is close to the individual.”

We will be sending out some scenarios to support this guidance later in the year. We realise that this change in definition will affect the meaning of the performance indicator AO/D55 and time series comparisons, however this will improve the data quality of this information by enabling better consistency in reporting by CSSRs.

- **Contacting the client before receiving section 5 notice**

Where CSSRs have contacted the client in hospital before receiving the section 5 notice, the time between first contact and first contact with client should be recorded in the lowest time band on RAP form A9, i.e. less than or equal to 2 days.

- **Measuring waiting times**

All waiting times are based on calendar days, not working days.

- **Measurement of time from first contact to first contact with client following referral**

To meet the target of two calendar days from first contact to first contact with client , if the first contact is on day one, then the CSSR should contact the client by the end of day two. This waiting time must be calculated based on 2 calendar days, NOT 48 hours.

Return:

- Length of time for new clients from first contact to first contact with client in time bands and age group.
- Length of time for new clients from first contact to first contact with client in time bands, primary client type and age group.

P1

Number of clients receiving services during the period, provided or commissioned by the CSSR, by primary client type, service type, and age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return aims to measure the number of adult clients who have been receiving services over the specified period, cross-referenced by three variables - primary client type, age group and service type. The return also seeks separate information on the number of clients formerly in receipt of preserved rights by age band and service type.

Business case.

The purpose of this return is to show which type of users receive which type of services in a given period. This is essential information for commissioning and planning, and provides a check for CSSRs and DH on the extent to which people are enabled to live in the community with the support of services. The volume measures of this return can be usefully analysed against related expenditure.

Inclusions and exclusions

- The intention is to return all adults aged 18 and over who have received a service or services provided or commissioned by the CSSR, or a NHS health partner, under section 75 arrangements at any time during the specified period.
- For clients to be included in the P forms the following criteria **must** apply;
 1. The services that are provided or commissioned by social services or an NHS health partner under section 75 arrangements must be **part of a care plan following a Community Care Assessment** and;
 2. Their care must be managed by the CSSR or an NHS health partner under section 75 arrangements.
- We realise that social services provide other preventative services for people in the community, for example through grants or service agreements. However only those clients who have been assessed by the CSSR or by a legally delegated NHS health partner under section 75 arrangements and have the service(s) that they receive specified in their care plan can be included in the RAP P returns.

This makes clear that those individuals, who have been assessed for and provided with a service by any other agency where the criteria above are not met, even though it is funded by social services, should **NOT** be included in the RAP P proformas. Details of these additional services should be included in the end sheet.

- The return is a volume measure of total service activity, to include both new service starts during the period and clients carried forward from a previous period. It is intended to cover the full population of clients who have been receiving services during the period, regardless of the time when they were first assessed or their care package initiated.
- The return should be drawn from those eligible for inclusion in R1 in the current or a previous period and should exclude those recorded only in R2. That is, the return is about clients who receive a package of care **following an assessment**, not clients who receive solely information / advice, a basic service (e.g. blue badge), or are simply added to a register.

- **Self funding clients**

A fully-funded client is one who pays the full direct costs of his/her services and for their management. These clients should be excluded for the RAP return. Clients who contribute in full or in part to the direct costs of the services they receive **but** whose care is by the CSSR should be included (see glossary entry for 'Fully-funded clients').

- **Double counting**

Since movement between service sectors is possible within the period there may be some double counting across service types. Double counting only applies to clients moving between services. There should be no double counting of primary client types. The column 'Total of clients' is intended as a measure of the number of clients involved; clients should only be counted once in this column irrespective of the number of services they are receiving. The figure entered in this column will be less than or equal to the sum of the other columns.

- **Concurrent receipt of residential and community-based services**

Some clients living in care homes may additionally receive community-based services (e.g. attendance at day centers). For RAP purposes these clients should be counted as in residential or nursing care in P1 and are therefore completely excluded from P2f/P2s. They should **NOT** be counted as receiving community-based services. The clients who appear in the community based services column should **only** be receiving community-based services at some point during the year or at the 31st March.

However, a client may be receiving community-based services for part of the year and then move into residential care. In this scenario the client should be included in P1 as having received both community-based services and residential care, and P2f for community-based services, but **not** P2s as they were in residential care by 31 March. For the first cell and first column on P1 they should be counted only once.

- **Short-term residential care – not respite**

This refers to the provision of short term residential care for the client for any purpose other than respite care of a carer. It includes the provision of rehabilitation services. (see glossary definition for 'Components of service' for clarification).

- **Rehabilitation services**

Rehabilitation services for clients with alcohol or drug related problems should be recorded under short-term residential care within community-based services. However, if the rehabilitation placement has exceeded 6 months then it should be included under residential care services on proforma P1, rather than community-based services and should not be picked up on P2f or P2s.

- **Small homes and Independent living**

If a client is living in a registered small home, then they are classified as receiving independent sector residential care. If, however, a group of people live together independently with a shared tenancy agreement then any services they receive should be classified as community-based. If the client is part of an **adult placement scheme** (formerly adult fostering), then this **should be included in the RAP P forms as 'Other' community based services.**

Comment [a1]: Delete from this section and include on pg 86 under 'Other specific services'?

Deleted: is considered to be residential accommodation and therefore they would be classified as receiving independent residential care.

- **Supporting People initiative**

Only services provided or commissioned by social services (or the health partner under section 75 arrangements) should be included in RAP. If a service is paid for by the housing department, for example access to a warden in sheltered housing accommodation, then it should be excluded from RAP. Services funded by the Supporting People initiative can only be included in RAP if the clients receiving these services have received a Community Care Act assessment *and* the relevant expenditure from the Supporting People grant is being classed as social services expenditure rather than housing expenditure. The services being provided must be part of a package of care that is managed and is subject to review by social services (or the health partner).

- **Services provided via grants and grant aided organizations**

For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centers. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

- **The Single Assessment Process (SAP)**

Services that are part of a care plan and are delivered by social services or on behalf of social services as a result of a SAP assessment should be included in RAP. Other services that result from the SAP assessment should not be included.

- **Individual Budgets**

Some CSSRs have been pilot sites for Individual Budgets. CSSRs involved in the pilots **only**, need to continue to include the clients on individual budgets within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via an individual budget should be included in RAP. We are aware that the individual budgets may be made up of funds from several different funding sources. Please include all clients *unless the individual has no social services funding*.

The clients should be recorded on the RAP P1 under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

- **In Control**

Some CSSRs have taken part in 'In Control' projects. The CSSRs involved in the projects need to continue to include the clients receiving services via 'In Control' within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via 'In Control' should be included in RAP. We are aware that 'In Control' may be made up of funds from several different funding sources. Please include all clients unless the individual has no social services funding. The clients should be recorded on the RAP P forms as follows;

P1 & P4 – record these clients under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

P2f & P2s – record the clients under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via 'In Control' should not be counted under direct payments unless a direct payment is provided as part of 'In Control'. The 'In Control' arrangement itself should not be recorded separately under 'other'. Some examples are set out below;

1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.

2) If the client is planned to receive both meals 5 days a week and a direct payment all within 'In Control', then they should be recorded under meals and direct payments.

3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of 'In Control', then the client should be recorded under 'other'.

Return:

A return, by age group, of the number of clients receiving services during the period by service type cross-referenced with primary client type.

'Total of all clients' for all age groups and services combined.

Age groups are defined as '18-64' and '65 and over'

Service types are –

- Community-based services
- LA Residential care
- Independent sector residential care
- Nursing care

P2(f)

Number of clients receiving community-based services during the period, provided or commissioned by the CSSR, by components of service, primary client type and age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description.

This return gives the number of adults who have received community-based services provided or commissioned by the CSSR at any time during the period. The return is broken down by age group, with client type cross-referenced with components of service. As such it expands on the information provided in P1 for clients identified as receiving community-based services.

Business case.

This return breaks down the community-based activity described in P1. Its purpose is to show which type of users receive which type of community-based services in a given period. This is essential information for commissioning and planning, and shows the part played by different services, in enabling users to live at home. The volume measures of this return can be usefully analysed against related expenditure. The return also provides useful information on the take-up of Direct Payments.

Inclusions and exclusions

- The intention is to return all adults aged 18 and over receiving community based service(s) provided or commissioned by the CSSR, or a NHS health partner under section 75 arrangements, at any time during the specified period, and as such it is a subset of P1.
- For clients to be included in the P forms the following criteria **must** apply;
 1. The services that are provided or commissioned by social services or an NHS health partner under section 75 arrangements must be **part of a care plan following a Community Care assessment** and;
 2. Their care must be managed by the CSSR or an NHS health partner under section 75 arrangements.
- We realise that social services provide other preventative services for people in the community, for example through grants or service agreements. However only those clients who have been assessed by the CSSR or by a legally delegated NHS health partner under section 75 arrangements and have the service(s) that they receive specified in their care plan can be included in the RAP P returns.

This makes clear that those individuals, who have been assessed for and provided with a service by any other agency where the criteria above are not met, even though it is funded by social services, should **NOT** be included in the RAP P proformas. Details of these additional services should be included in the end sheet.

- Exclude those clients who are receiving community-based services concurrently with residential services (see P1 protocol for more information).
- The return is a volume measure of total service activity, to include both service starts during the period and clients carried forward from a previous period. It is intended to cover the full population of clients who have been receiving services during the period, regardless of the time when they were first assessed or care package initiated.
- The key figure on which this return is based is the number of people provided with community-based services during the period (that is, the sum for 'total of above' in the community-based services column recorded on P1 for the age groups '18-64' and '65 and over').

- **Double counting**

It is assumed that there will be multiple entries in the service columns for many clients, given that they are likely to be receiving more than one of the components of community-based services.

The 'Total of clients' column should, however, be a measure of the number of clients involved and exclude double counting. Clients should only be counted once irrespective of the number of services they are receiving. Therefore the figure in the 'Total of clients' column will be less than or equal to the sum of the other columns.

As the 'total of clients' column on P2f relates to a unique number of clients all duplicate records should be removed. This should be done on an exact matching process, ideally using a unique identifier for individual clients. Where this is not possible, the client's name, address, postcode, date of birth etc. may need to be used to cross-match individuals

- **Components of service**

It is important to be aware of the definitions of 'Components of service' given in the glossary.

- **Direct payments**

Direct payments are defined as monetary payments made by local CSSRs directly to adult clients aged 18 and over in lieu of social service provisions, who have been assessed as needing certain services. RAP does not need to know what services a client is buying with the direct payment. Carers receiving direct payments should be excluded from the 'P' forms as these forms relate to clients only.

Double counting should be excluded with regard to direct payments. If a direct payment is made to enable the purchase of a specific community-based service, it should be included as a direct payment, but not additionally as the service(s) purchased. If a client receives other service(s) in addition to those obtained via the direct payment, then these should be included under the appropriate category.

Vouchers or similar 'credits' are not direct payments.

"For people who receive direct payments it may be their first experience of being an employer, and they may welcome support through the recruitment process whether they intend to employ a personal assistant, a self-employed assistant or an agency to provide services. Some people may also need help with managing the money. The payment may be made to a third party (nominee) for the recipient and day-to-day management of finances may be delegated in this way. However, the person to whom the direct payment is made must have control over how services are delivered. It is important that the information and help provided is clear and concise and not offered in such a way as to discourage them from accepting a direct payment". See *Direct Payments Guidance, issued in September 2003*: <http://www.dh.gov.uk/assetRoot/04/06/92/62/04069262.pdf>

- **Respite care**

Overnight respite care is defined as following an assessment or review where the carer's needs have been taken into account, planned overnight breaks(s) are arranged for the client either at home or in an alternative setting to allow a break primarily for the carer. As such this should **NOT** be included in any of the P returns.

Examples:

1) Every 5 weeks the carer has a long weekend away from home with another family member to ease the pressure of the caring role. Following a carer's assessment it is agreed to provide overnight respite care;

- (a) In a local residential home that have a number of respite care beds
- (b) In the client's own home by an agency

In both cases the overnight respite care is provided as a service for the carer to allow the carer to have a break. As such this should be recorded in C2, not in any of the P returns.

2) The carer is admitted to hospital so the client goes into a residential care setting for a week. There has been an assessment of the client.

In this scenario the service is short term residential care as it is for the benefit of the client. Even if this break is planned due to knowing the date of an operation, it is not respite care because the carer is not benefiting from the break - it is brought about by force of circumstance. In this instance this should be recorded in the P returns.

3) Following an assessment a client has been taken to a place of safety under adult protection procedures where emergency accommodation is provided because abuse has been established or suspected.

In this case the service is provided as a short term residential care as it serves the need of the client. In this instance this should be recorded in the P returns.

- **Home care**

The definition of home care follows (as closely as possible), that which is used in the central data collection HH1 return on home help/home care. The categories home help/home care (meaning all care that is not a short term break in the client's own home) and overnight short term break (for the benefit of the client) that is provided in the client's own home have been combined. If a client is receiving more than one type of home care service, e.g. personal care and shopping, they should only be counted once within home care.

- **Professional support**

For a client to be considered as having professional support, the service must be included as part of their care plan. This does **not** include the process of care management, (i.e. assessing or reviewing their care needs, even if the case is "open" or "active" on 31st March), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, e.g. counselling.

- **Rehabilitation services**

Rehabilitation services are generally classified as temporary residential places and as such should be recorded under short-term residential care within community based services. However if the rehabilitation placement has exceeded 6 months then it should be included under residential care services on proforma P1, rather than community based services and should not be picked up on P2f or P2s.

- **Equipment and adaptations**

Equipment and adaptations do not fit the recording pattern of other service provisions.

Major items of equipment, as defined by the Single Assessment Process, should be included in all collection periods that the client is still in receipt of the item of equipment. The Single Assessment Process states that CSSRs have an obligation to review "Major items of equipment" on an annual basis and therefore clients in receipt of major items need to be included in the review population (i.e. the P1 service population) for each period they receive equipment. This only applies to **major** items of equipment.

Items of equipment or adaptations that incur an ongoing financial commitment are defined as those 'requiring training (which is not yet completed) or ongoing regular contractual maintenance', e.g. stair lifts or hoists, if these are maintained by the CSSR or where the CSSR funds the maintenance. This does not include instances where the client takes over responsibility for maintenance after installation. It also does not include the responsibility of replacing one-off items if they break; these should be counted as one-off items of equipment rather than equipment with an ongoing commitment.

Items of equipment/adaptations that incur an ongoing financial commitment (e.g. for maintenance or training) should be included for as long as the financial commitment is in force.

For all other items of equipment/adaptations, once the item of equipment has been provided (plus fitting and training in use, etc), it ceases to be on the books and as such would not be included in subsequent collection periods unless there was an ongoing financial commitment such as training or maintenance.

- **Telecare**

Telecare should be treated in the same way as equipment. A small item of telecare provided at or near the point of contact, following initial screening but no further assessment, should be categorised as a basic service and entered in R2. In all other instances where telecare may be provided as the result of an assessment, there should be an entry on R1. To be included in the RAP P forms, this service like other services must be provided as part of a care plan following a Community Care Assessment. If the telecare requires ongoing financial commitment, then the client must be recorded in P2s. If telecare is provided via a direct payment, then the client should be recorded under direct payments, not under equipment.

- **Day care**

Day care includes the attendance at a day care centre for day care and/ or meals. Attendance at luncheon clubs and training centres should also be included.

Generally if a grant is made to a day centre that any person can attend (e.g. a drop-in day centre), then details of the funding should be given on the end sheet. If, however, the clients attending the day centre have received a community care assessment (under section 47 of the NHS and Community Care Act 1990), leading to a package of care and a care plan (with day care as a specified service), the information about these clients should be recorded on the P returns. In this case CSSRs should liaise with the appropriate agency to obtain sufficient information about the clients.

- **Services provided via grants and grant-aided organisations**

For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

- **Other specific services**

Below is a summary table published in the RAP March 2004 newsletter containing some examples of other services that should or should not be included in P2f/ P2s.

Service	Included	Excluded	Comments
Sitting service e.g. "Crossroads" care.	✓		Only if provided as short term residential care (not respite care) at home and specified as part of the client's care plan (see 'Carers services' below).
Sitting service e.g. "Crossroads" care provided for Carer Respite.		✓	No as it is a service for the carer (See 'Carers services') and it is not in the client's care plan.
Care provided by on-site staff in "very sheltered" accommodation.		✓	Unless directly paid for by social services.
Supported Living.	✓		Only if part of a care plan and funded by social services.
Care provided by joint teams.	✓		Only if there is a social care element that is specified as part of care plan and is funded by social services.
Continence laundry services.		✓	Unless specified as part of care plan, if so record under home care.
Shopping service provided by voluntary organisation.		✓	Unless specified as part of care plan, if so record under home care.
Luncheon Clubs.	✓		Yes, if specified in care plan, in which case it should be recorded as day care <u>not</u> meals.
"Meals on Wheels" or community meals services.	✓		Yes, but only if specified in care plan.
Travel passes (bus passes etc).	✓		Include only if part of a care plan along with other social services , otherwise count as basic service in R2 if it is for a new client.
Blue Badge	✓		Include only if part of a care plan along with other social services , otherwise count as basic service in R2 if it is for a new client.
Disability registration.		✓	Excluded.
Use of drop-in day centre facilities.		✓	Excluded.
Sensory needs equipment.	✓		Only if specified in care plan – this should be treated in the same way as other equipment.

- **Carers Services**

As a result of the Carers and Disabled Children Act 2000, carers are entitled to services as carers. However the provision of these services for carers **should not** be included in the RAP P returns as these are concerned with clients not carers. Details of services provided to carers as carers (as an outcome of an assessment or review) should be given on form C2.

- **Identifying who the service is for**

CSSRs should identify whether a service is for the client or for the carer. Where the service is for both the client and the carer, CSSRs need to make a judgement as to who benefits the most.

We recognise that there may be instances where the carer requests services that are delivered to the person cared for, such as a sitting service, but the cared for person is not actually a social service client. In this case, the provision of these services would not be captured on RAP.

- **Individual Budgets**

Some CSSRs have been pilot sites for Individual Budgets. CSSRs involved in the pilots **only**, need to continue to include the clients on individual budgets within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via an individual budget should be included in RAP. We are aware that the individual budgets may be made up of funds from several different funding sources. Please include all clients *unless the individual has no social services funding*.

The clients should be recorded on the RAP P2(f) under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via an individual budget should not be counted under direct payments **unless** a direct payment is provided as part of the individual budget. The individual budget arrangement itself should *not* be recorded separately under 'other'. Some examples are set out below;

- 1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.
- 2) If the client is planned to receive both meals 5 days a week and a direct payment all within their individual budget, then they should be recorded under meals and direct payments.
- 3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of the individual budget, then the client should be recorded under 'other'.

- **In Control**

Some CSSRs have taken part in 'In Control' projects. The CSSRs involved in the projects need to continue to include the clients receiving services via 'In Control' within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via 'In Control' should be included in RAP. We are aware that 'In Control' may be made up of funds from several different funding sources. Please include all clients unless the individual has no social services funding. The clients should be recorded on the RAP P forms as follows;

P1 & P4 – record these clients under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

P2f & P2s – record the clients under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via 'In Control' should not be counted under direct payments unless a direct payment is provided as part of 'In Control'. The 'In Control' arrangement itself should not be recorded separately under 'other'. Some examples are set out below;

- 1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.
- 2) If the client is planned to receive both meals 5 days a week and a direct payment all within 'In Control', then they should be recorded under meals and direct payments.
- 3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of 'In Control', then the client should be recorded under 'other'.

Return:

A return, by age group, showing the number of clients receiving different community-based services during the period cross-referenced with primary client type.

'Total of all clients' for each client group and service component.

Age groups are defined as '18-64' and '65 and over'.

The components of service are -

- Home care
- Day care
- Meals
- Short-term residential - not respite care
- Direct payments
- Professional support
- Equipment & adaptations
- Other

P2(s)

Number of clients on the books to receive community-based services on the last day of the period provided or commissioned by the CSSR, by selected components of service, primary client type, and extended age group.

Period: 31/03/08

Protocol:

General description

This return aims to measure the number of current service users 'on the books' to receive community-based services on the last day of the period. The measure is requested by extended age group, broken down by primary client type and selected components of service.

Business case

This return complements P2(f) by providing a snapshot of community-based services received by different types of users on a given day. Data from this return can also be used for commissioning and planning purposes.

Inclusions and exclusions

- This return is confined to adults aged 18 and over who are on the books to receive one or more of the selected components of community-based service on the last day of the period, 31st March.
- This does not mean that the client has to receive a specific service on the actual day. For example if the client is in receipt of day care they do not have to actually attend the day centre on 31st March but they are 'on the books' to receive the service.
- For clients to be included in the P forms the following criteria **must** apply;
 1. The services that are provided or commissioned by social services or an NHS health partner under section 75 arrangements must be **part of a care plan following a Community Care Assessment** and;
 2. Their care must be managed by the CSSR or an NHS health partner under section 75 arrangements.
- We realise that social services provide other preventative services for people in the community, for example through grants or service agreements. However only those clients who have been assessed by the CSSR or by a legally delegated NHS health partner under section 75 arrangements and have the service(s) that they receive specified in their care plan can be included in the RAP P returns.

This makes clear that those individuals, who have been assessed for and provided with a service by any other agency where the criteria above are not met, even though it is funded by social services, should **NOT** be included in the RAP P proformas. Details of these additional services should be included in the end sheet.

- Exclude those clients who are receiving community-based services concurrently with residential services (see P1 protocol for more information).

- **Double counting**

It is assumed that there will be multiple entries under the service columns for many clients, given that they are likely to be receiving more than one of the components of community-based services.

The 'Total of clients' column should, however, be a measure of the number of clients involved and exclude double counting. Clients should only be counted once irrespective of the number of services they are receiving. Therefore the figure in the 'Total of clients' column will be less than or equal to the sum of the other columns.

As the 'total of clients' column on P2s relates to a unique number of clients all duplicate records should be removed. This should be done on an exact matching process, ideally using a unique identifier for individual clients. Where this is not possible, the client's name, address, postcode, date of birth etc. may need to be used to cross-match individuals.

- **On the books**

A client is deemed to be 'on the books' for services if they are actually receiving services, or there is a current allocation of services for that client. A person who previously received services during the period which have ceased by the 31st March would not be considered to be 'on the books' and should not be recorded here.

- **Equipment and adaptations**

For proforma P2s the only equipment and adaptations that are included are:

- Those provided on 31st March or the nearest day that any equipment is delivered
- Equipment which has an ongoing financial commitment and thus remains 'on the books'
- 'Major items of equipment'. These are items that the CSSR has an obligation to review on an annual basis and involve the CSSR in an ongoing financial commitment to maintain or service the equipment. Such equipment might include stair lifts and orthopaedic beds or chairs.

NB. This definition relates to equipment being provided on one day.

Further to the guidance above, additional guidance has been set out below, with regards to the inclusion of reviews of clients who have received a one-off piece of equipment during the year on P2s.

ITEMS OF EQUIPMENT - that are maintained with ongoing financial commitment
The suggested list of equipment below covers the most frequently encountered items which should be included in P2s. These are items of equipment supplied following a community care assessment and are provided as part of the clients care plan. In addition to supplement the list and RAP guidance the key criteria as to whether an item can be counted within P2s are:

1. Include:

- Any item needing (as a minimum) annual or more frequent MAINTENANCE visits (e.g. stair climbers etc)
- Any item needing (as a minimum) annual or more frequent SAFETY CHECKS (e.g. those items with electrical components)
- In both instances items should only be included where the CSSR pays for the maintenance and testing, and where the cost exceeds £25

2. Exclude:

- Any item of equipment where the CSSR may contact the client once a year, (merely for example) to ensure the user is still using it. That is contact purely for the review of equipment should NOT be counted within P2s

ITEMS OF EQUIPMENT	
SANITARY WARE	
1.	Bath Lifts
2.	Special Baths
3.	Special Toilets (washer/dryer) and closomats
4.	Toilet Risers (electronically operated)
HOISTS	
5.	Patient lifter
6.	Patient Hoists – including gantry hoists
7.	Ceiling Track or overhead hoists
8.	Patient Hoists - Mobile
9.	Portable or mobile hoists
10.	Bed Head Hoists
BEDS	
11.	Special Beds (electronically operated)
12.	Profiling Beds
13.	Dynamic Mattresses
14.	Mattress Variators
CHAIRS & LIFTERS	
15.	Raising recliner chairs
16.	Lifting cushions
17.	Pillow lifters
18.	Leg lifters
ELEVATORS	
19.	Automatic door openers
20.	Stair lifts
21.	Through floor lifts
22.	Platform lifts
DEAF AND HARD OF HEARING AND VISUALLY IMPAIRED	
23.	Sound amplifiers
24.	Fire alarm system for the deaf
25.	Pager system
26.	Hand held scanner for the blind
27.	Minicoms – deaf/speech impaired
28.	Roller tips for white sticks
29.	Flashing light system for deaf

See further discussion on P2f and glossary definition for equipment.

- **Telecare**

Telecare should be treated in the same way as equipment. A small item of telecare provided at or near the point of contact, following initial screening but no further assessment, should be categorised as a basic service and entered in R2. In all other instances where telecare may be provided as the result of an assessment, there should be an entry on R1. To be included in the RAP P forms, this service like other services must be provided as part of a care plan following a Community Care Assessment. If the telecare requires ongoing financial commitment, then the client must be recorded in P2s. If telecare is provided via a direct payment, then the client should be recorded under direct payments, not under equipment.

- **Components of service**

These are the same as P2f.

See P2f protocol for further discussion on individual components of service.

- **Individual Budgets**

Some CSSRs have been pilot sites for Individual Budgets. CSSRs involved in the pilots **only**, need to continue to include the clients on individual budgets within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via an individual budget should be included in RAP. We are aware that the individual budgets may be made up of funds from several different funding sources. Please include all clients *unless the individual has no social services funding*.

The clients should be recorded on the RAP P2(s) under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via an individual budget should not be counted under direct payments **unless** a direct payment is provided as part of the individual budget. The individual budget arrangement itself should *not* be recorded separately under 'other'. Some examples are set out below;

- 1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.
- 2) If the client is planned to receive both meals 5 days a week and a direct payment all within their individual budget, then they should be recorded under meals and direct payments.
- 3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of the individual budget, then the client should be recorded under 'other'.

- **Number of clients planned to receive services by or on behalf of social services via an Individual Budget at 31 March 2007**

To help interpret the RAP data on services and to assess the impact of individual budgets on Performance Assessment Framework (PAF) indicators, an additional table has been included in P2s to collect the number of clients planned to receive services via an individual budget to be completed on a compulsory basis by the CSSRs piloting individual budgets. Please note, this table should only be completed by those CSSRs who are piloting Individual Budgets.

- **In Control**

Some CSSRs have taken part in 'In Control' projects. The CSSRs involved in the projects need to continue to include the clients receiving services via 'In Control' within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via 'In Control' should be included in RAP. We are aware that 'In Control' may be made up of funds from several different funding sources. Please include all clients unless the individual has no social services funding. The clients should be recorded on the RAP P forms as follows;

P1 & P4 – record these clients under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

P2f & P2s – record the clients under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via 'In Control' should not be counted under direct payments unless a direct payment is provided as part of 'In Control'. The 'In Control' arrangement itself should not be recorded separately under 'other'. Some examples are set out below;

- 1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.
- 2) If the client is planned to receive both meals 5 days a week and a direct payment all within 'In Control', then they should be recorded under meals and direct payments.
- 3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of 'In Control', then the client should be recorded under 'other'.

Return:

A return, by extended age group, showing the number of clients receiving selected community-based services on the last day of the period cross-referenced with primary client type.

'Total of all clients' for each client group and selected service component.

Extended age groups are defined as '18-64', '65-74' and '75 and over'.

The components of service are –

- Home care
- Day care
- Meals
- Short term residential - not respite
- Direct payments
- Professional support
- Equipment / adaptations
- Other

Return of the total number of clients aged 75-84 and 85 and over receiving direct payments

P4

Number of clients receiving services during the period, provided or commissioned by the CSSR, by ethnicity, service type, primary client type and age group.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return aims to monitor clients receiving services during the period according to their ethnicity. Ethnic categories are those used in the 2001 Census. A breakdown is sought by type of service, primary client type and age group

Business case

The data on ethnicity will give CSSRs and DH an indication of the effectiveness of referral processes in identifying those from ethnic minorities who have needs, and will permit analysis related to equality and 'Fair Access to Care'. SIGASC (Strategic Information Group for Adult Social Care) agreed to this collection in principle, although the information may be difficult to fully collect in practice. Thus if the data can be provided for new clients only, this should be highlighted in the notes section.

Inclusions and exclusions

- Figures refer only to adults aged 18 and over.
- **Baseline population**

The baseline population for P4 is the total of clients receiving services, as provided for P1 (or lower if new clients).

- The intention is to return the ethnic origin of all adults aged 18 and over who have received a service or services provided or commissioned by the CSSR, or NHS health partner under section 75 arrangements at any time during the specified period.
- For clients to be included in the P forms the following criteria **must** apply;
 1. The services that are provided or commissioned by social services or an NHS health partner under section 75 arrangements must be **part of a care plan following a Community Care Assessment** and;
 2. Their care must be managed by the CSSR or an NHS health partner under section 75 arrangements.
- We realise that social services provide other preventative services for people in the community, for example through grants or service agreements. However only those clients who have been assessed by the CSSR or by a legally delegated NHS health partner under section 75 arrangements and have the service(s) that they receive specified in their care plan can be included in the RAP P returns.

This makes clear that those individuals, who have been assessed for and provided with a service by any other agency where the criteria above are not met, even though it is funded by social services, should **NOT** be included in the RAP P proformas. Details of these additional services should be included in the end sheet.

- **Double counting**

Since movement between service sectors is possible within the period there may be some double counting across service types. Double counting only applies to moving between services. There should be no double counting of primary client types or across ethnic groups.

The column 'Total of all clients' is intended as a measure of the number of clients involved. Clients should only be counted once in this column irrespective of the number of services they are receiving. The figure entered in this column will be less than or equal to the sum of the other columns.

- **Concurrent receipt of residential and community-based services**

Some clients living in care homes may additionally receive community-based services (e.g. attendance at day centres). For RAP purposes these clients should be counted as in residential or nursing care in P1 and P4. They should **NOT** be counted as receiving community-based services. The clients who appear in the community based services column should **only** be receiving community-based services at some point during the year or at the 31st March.

However, a client may be receiving community-based services for part of the year and then move into residential care. In this scenario the client should be included in P4 as having received both community-based services and residential care, and P2f for community-based services, but **not** P2s as they were in residential care by 31 March. For the first cell and first column on P4 they should be counted only once.

- **Short-term residential care – not respite**

This refers to the provision of short term residential care for the client for any purpose other than respite care of a carer. It includes the provision of rehabilitation services. Short-term residential care (not respite) qualifies as a community-based service, not as residential care (see glossary definition for 'Components of service' for clarification).

- **Rehabilitation services**

Rehabilitation services for clients with alcohol or drug related problems should be recorded under short-term residential care within community-based services. However, if the rehabilitation placement has exceeded 6 months then it should be included under residential care services on proformas P1 and P4, rather than community-based services and should not be picked up on P2f or P2s.

- **Small homes and Independent living**

If a client is living in a registered small home, then they are classified as receiving independent sector residential care. If, however, a group of people live together independently with a shared tenancy agreement then any services they receive should be classified as community-based. If the client is part of an **adult placement scheme** (formerly adult fostering), then this is considered to be residential accommodation and therefore they would be classified as receiving Independent residential care.

- **Supporting People initiative**

Only services provided or commissioned by social services (or the health partner under section 75 arrangements) should be included in RAP. If a service is paid for by the housing department, for example access to a warden in sheltered housing accommodation, then it should be excluded from RAP. Services funded by the Supporting People initiative can only be included in RAP if the clients receiving these services have received a Community Care Act assessment *and* the relevant expenditure from the Supporting People grant is being classed as social services expenditure rather than housing expenditure. The services being provided must be part of a package of care that is managed and is subject to review by social services (or the health partner).

- **Services provided via grants and grant aided organisations**

For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

- **The Single Assessment Process (SAP)**

Services that are part of a care plan and are delivered by social services or on behalf of social services as a result of a SAP assessment should be included in RAP. Other services that result from the SAP assessment should not be included.

- **Individual Budgets**

Some CSSRs have been pilot sites for Individual Budgets. CSSRs involved in the pilots **only**, need to continue to include the clients on individual budgets within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via an individual budget should be included in RAP. We are aware that the individual budgets may be made up of funds from several different funding sources. Please include all clients *unless the individual has no social services funding*.

The clients should be recorded on the RAP P4 under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

- **In Control**

Some CSSRs have taken part in 'In Control' projects. The CSSRs involved in the projects need to continue to include the clients receiving services via 'In Control' within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via 'In Control' should be included in RAP. We are aware that 'In Control' may be made up of funds from several different funding sources. Please include all clients unless the individual has no social services funding. The clients should be recorded on the RAP P forms as follows;

P1 & P4 – record these clients under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

P2f & P2s – record the clients under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via 'In Control' should not be counted under direct payments unless a direct payment is provided as part of 'In Control'. The 'In Control' arrangement itself should not be recorded separately under 'other'. Some examples are set out below;

- 1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.
- 2) If the client is planned to receive both meals 5 days a week and a direct payment all within 'In Control', then they should be recorded under meals and direct payments.
- 3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of 'In Control', then the client should be recorded under 'other'.

Return:

Clients receiving services during the period, by ethnicity, service type and age group

Clients receiving services during the period, by ethnicity, primary client type and age group

Age groups are defined as '18-64' and '65 and over'

The ethnic categories for the return are as given in the protocol for A6.

Please identify in the notes section whether information being provided refers to all clients receiving services or just new clients.

C1

Number of carers for whom assessments or reviews were completed during the period, by (i) age group of carer, and (ii) client group and age group of the person cared for.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return seeks to monitor the number of carers assessments or reviews carried out during the period within the context of the Carers and Disabled Children Act 2000.

Business Case

For both practice and planning reasons, it is important for CSSRs to know and record whether service users have family or other carers, particularly those aged under 18 and those aged over 65. The presence of family carers will often have a bearing on what services are provided to users. Carers themselves might need support, and data from this return will enable CSSRs and DH to gauge the extent to which Carers legislation is being implemented by CSSRs.

Inclusions and exclusions

- This return refers to carers of adults (people aged 18 or over) only.
- **Page 1 of the return relates to the age group of the carer and page 2 relates to the age group of the person cared for**
- Although the Carers and Disabled Children Act refers only to carers aged 16 or over, younger carers of adults should be included in this return. Carers of people aged 17 and under should be excluded.
- The return seeks to distinguish between carers assessed or reviewed separately and carers assessed as part of a joint client / carer assessment. It also captures the number of carers declining an assessment.
- Declined reviews should NOT be included.
- The focus of this return is on carers as carers and the information requested relates to carers in their caring role. Where carers have needs / packages of care in their own right, independently of their caring role, then this should be recorded separately on the appropriate RAP returns. It is possible, therefore, for a person to appear in the returns as a client assessed for their own needs on A1 and as a carer on C1. However a carer in their caring role should not be included in A1.

- **Double counting**

In order to avoid double counting, if a carer has been assessed or reviewed more than once during the period (for example separately and jointly with the client) they should only be counted once. Please provide details in relation to the latest assessment or review event. For example if a carer who is aged 32 is assessed separately in November and then receives a review jointly with client in February they should be recorded once only, in row 2, column 2 of the table.

- **Carer**

The definition of a carer is taken from the Carers & Disabled Children Act 2000, which states that the Act affects “*carers (aged 16 or over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over*”. Although the Act refers only to carers aged 16 or over, younger carers of adults should be included in this return. The Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation.

- **Carers Assessment**

A carers' assessment under the Carers and Disabled Children Act 2000 is carried out at the request of the carer in order:

- To determine whether the carer is eligible for support.
- To determine the support needs of the carer (i.e. what will help the carer in their caring role and help them to maintain their own health and well-being).
- To see if those needs can be met by social or other services.

There are no restrictions as to who carries out the carers assessment or part of it (e.g. OT assessments should be included). For more information on the content of carers assessments see DH publication “A practitioner's guide to Carers assessments under the Carers and Disabled Children Act 2000”, which is available at <http://www.carers.gov.uk/carersdisabledchildact2000.htm?>

- **Carers assessments carried out by other organisations**

The duty to carry out a carer's assessment lies with the local authority and cannot be delegated except to an NHS body as part of partnership arrangements under section 75 of the NHS Act 2006. However, a local authority may arrange for the actual process of carrying out the assessment to be undertaken by someone else, for example a voluntary organisation funded by the local authority for this purpose. A voluntary organisation's assessments can be counted in RAP only if the local authority funds the organisation to undertake assessments and checks the process and outcomes of each assessment. That process could include interviewing the carer, carrying out research on the assistance available and preparing a report for the local authority. That report could even include a recommendation as to what assistance should be provided to the carer. The local authority remains responsible at all times for ensuring that each assessment process is valid, fair and comprehensive and for considering the implications of any resulting assessment for its provision of services. Local authorities must therefore have some means of checking the assessment process to ensure that it fulfils the above requirements. Regardless of who carries out the various parts of an assessment process, a local authority retains the statutory responsibility for the assessment itself.

Authorities should therefore treat the results of all assessment processes in precisely the same way as they would treat those carried out by their own staff.

- **Assessment and review of carers**

An assessment is defined as the first assessment for a new carer. All subsequent assessments, which must include a reassessment, will be defined as a review.

- **Carers of more than one person**

If a carer is caring for 2 or more clients they should only be counted once in the 'age group of carer' table on C1 (Pages 1 and 2) as this refers to the carer. If the carer was assessed separately or jointly in relation to each client then provide details in relation to the latest assessment or review event. For page 2 record the carer under the client and the age group of the client from latest assessment or review or the person who needs more care and attention.

- **Clients with more than one carer**

If a client has more than one carer then information about both carers should be recorded.

- **Joint assessments (or review) of clients and carers**

If a client is assessed jointly with their carer the assessment of the carer should be included in this form and the assessment of the client should be included in A1 and the other assessment forms. The same applies to reviews.

- **Carers for whom the person cared for is not a client**

Carers have a right to an assessment of their needs even where the person cared for has refused an assessment for, or the provision of community care services, provided the person cared for would be eligible for community based services.

- **Joint teams**

The treatment of assessments carried out by joint teams should be consistent with the guidance provided in RAP for assessments of clients. This is that if an assessment carried out by a joint team includes a social care element then the assessment should be included in RAP regardless of who carries out the assessment.

The examples below illustrate the spectrum of carers' assessments.

Joint assessment:

A working daughter looking after her father who is alert and orientated but limited physically. He is able to cope at home during the day whilst his daughter is at work. They are managing well independently. As part of the assessment of her father's needs the daughter's needs were assessed and she was offered a separate assessment. She didn't feel she needed any services for herself and therefore declined the assessment. She was given information about local support services and a number to ring should the situation change.

As part of holistic assessment:

An elderly couple living at home. The husband is caring for his wife who has moderate dementia despite the fact he is quite frail himself. A holistic assessment carried out of the whole situation and covers both his and her needs. The assessment establishes he needs some support to be able to continue caring and would benefit from a regular break to visit his daughter. This is built into the care plan and alternative care is provided for the wife when he has his break.

Individual full assessment:

A husband looking after a severely disabled wife with MS who is completely dependent on others for all her personal care needs. She is refusing to have any services but he has chronic back pain, which is getting worse, when offered a separate assessment he accepts. The assessment is done without the presence of his wife and results in a care plan for the husband with services provided to him to support him in caring for his wife. This includes the purchase of a mobile phone to enable him to be reached if he wants to go out.

Return:

C1 Page 1

A return showing the number of carers for whom assessments or reviews were completed during the period **1 April 2007 to 31 March 2008 by age group of carer.**

- Number of carers assessed or reviewed separately during the period.
- Number of carers assessed or reviewed jointly with the client.
- Number of carers declining an assessment.

Age group of carer defined as:-

- Under 18
- 16-64
- 65-74
- 75 and over
- All ages (total)

C1 Page 2

A return showing the number of carers for whom assessments and reviews were completed during the period 1 April 2007 to 31 March 2008 by client group and age group of the **cared for person.**

Age group of cared for person defined as:-

- 18-64
- 65 and over

C2

Number of carers receiving different types of services provided as an outcome of an assessment or review, by (i) age group of carer, and (ii) client group and age group of the person cared for.

Period: 01/04/07 to 31/03/08

Protocol:

General description

This return seeks to collect information on the number of carers receiving service(s) following an assessment or review within the context of the Carers and Disabled Children Act 2000.

Business Case

A new carers PI has been developed, as it is acknowledged that the previous carers PI was difficult to interpret and therefore did not provide a good tool for CSSRs, policy makers, CSCI and others to understand national and CSSRs' performance on services for carers. Also from 2004-05 the ring fence on the Carer's Grant has been removed. Both of these issues have driven the need to develop a new carers PI. The definition of the new PI is "the number of clients receiving a specific carers service as a percentage of clients receiving community based services".

Inclusions and exclusions

- This return refers to carers of adults (people aged 18 or over) only.
- **Page 1 of the return relates to the age group of the Carer and page 2 relates to the age group of the person cared for**
- Although the Carers and Disabled Children Act refers only to carers aged 16 or over, younger carers of adults should be included in this return. Carers of people aged 17 and under should be excluded.
- The focus of this return is on carers as carers and the information requested relates to carers in their caring role. Where carers have needs / packages of care in their own right, independently of their caring role, then this should be recorded separately on the appropriate RAP returns. It is possible, therefore, for a person to appear in the returns as a client receiving their own services on P1 and as a carer receiving services on C2. However a carer in their caring role should not be included in P1.
- **Double counting**

In order to avoid double counting, if a carer is assessed or reviewed more than once during the period the outcome of their most recent assessment or review should be recorded. For example, Carer A is assessed in November and receives a review in February, the services that are agreed to be provided following the review in February should be recorded as well as any other services that are continuing.

If following a review it is agreed that no new services will be provided but that previous services should continue, then these ongoing services should be recorded.

- **Recording carers services**

Each carer receiving a service should appear just once in the table. For example, if a carer receives all three types of services defined for carers following an assessment or review they should appear in column 1 of the table as their services include at least one of 'respite for the carer' and 'other specific carers services'. If they receive information and advice only they should be counted in column 2, as their services don't include respite for the carer or other carers' specific services.

- **Carer**

The definition of a carer is taken from the Carers & Disabled Children Act 2000, which states that the Act affects "carers (aged 16 or over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over". Although the Act refers only to carers aged 16 or over, younger carers of adults should be included in this return. The Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation.

- **Carers of more than one person**

If a carer is caring for 2 or more clients they should only be counted once in the 'age group of carer' table on C2 (Pages 1 and 2) as this refers to the carer. If the carer was assessed separately or jointly in relation to each client then provide details in relation to the latest assessment or review event. For page 2 record the carer under the client and the age group of the client from latest assessment or review or the person who needs more care and attention.

- **Outcome of assessment or review**

The outcome specified should be those services put in place following an assessment or review completed during the reporting year either by social services or on their behalf. Therefore a carer receiving services should not be counted in C2 unless they have been assessed or reviewed within the same reporting period. Where the assessment or review occurred during the period and it is intended to provide the carer with services but they are not yet put in place, CSSRs should include the services that were agreed in the care plan at the end of the assessment or review. This should only be a minority of cases.

Q – A carer is receiving services in December 2007 but their last assessment/review was in 2006-07. Should I include them in form C2?

A - No, where services are provided following an assessment they should be recorded in the reporting period that the carers assessment or review took place.

When a carer receives a review any new services agreed as well as other services that are continuing should be recorded.

Services that are identified as being needed following a carer's assessment and are then provided should be included regardless of whether they are provided directly by social services or by an organisation on behalf of social services. If a carer receives a service that was not identified as an outcome of their assessment or review they should not be included when reporting the outcome of the assessment.

- **Identifying who the service is for**

CSSRs should identify whether a service is for the client or for the carer. Where the service is for both the client and the carer, CSSRs need to make a judgement as to who the service benefits the most.

- **Carers services**

The three categories of services for carers are:

- Respite for carers
- Other specific carers services
- Information and advice only

Respite for the carer

As defined in the Carers Grant Guidance: A 'respite service' is to be construed as one which actually gives the carer a break from direct responsibility of supervising or caring for the relevant person by providing a service to that person. This would include day care at home or elsewhere &/or residential and there is no requirement for an overnight stay. This category does not include short term breaks intended for the person needing services. To illustrate the difference an example is given below.

1. A carer supporting a person with Multiple Sclerosis (MS) living independently might be assessed as needing respite which could be provided through a short stay in residential accommodation or care services at home.
2. In contrast a person with MS might, in order to maintain their independence, need to go into short term residential care (not respite) for rehabilitation / skin care on a regular basis. Though it is clear that the carer benefits indirectly in the latter case, the intention is to support the person with MS.

Other 'Specific' Carers' Services

The Carers and Disabled Children Act 2000 enables local CSSRs to offer direct carers support. Services for carers are not defined in the Act as such, but the CSSRs may provide any services which, in their view, will support the carer in their caring role and help them to maintain their own health and well being. These services may take any form and examples described in the Carers Grant Guidance include provision of emotional support, driving lessons, moving and handling classes or access to training opportunities for the carer.

The provision of information as part of the Carer's Grant should be recorded under "information and advice" (column 2 of the form C2). Therefore the provision of information through the Carer's Grant is excluded from the performance indicator on carers AO/C62.

This is not as clearly defined as the RAP definitions of components of service for users, but this reflects the heterogeneity of carers as a group. This would of course include direct payments for carers' services, which can be given to carers under the 2000 Act.

Respite care

Overnight respite care is defined as following an assessment or review where the carer's needs have been taken into account, planned overnight breaks(s) are arranged for the client either at home or in an alternative setting to allow a break primarily for the carer. As such this should NOT be included in any of the P returns.

Examples:

1) Every 5 weeks the carer has a long weekend away from home with another family member to ease the pressure of the caring role. Following a carer's assessment it is agreed to provide overnight respite care;

- (a) In a local residential home that have a number of respite care beds
- (b) In the client's own home by an agency

In both cases the overnight respite care is provided as a service for the carer to allow the carer to have a break. As such this should be recorded in C2, not in any of the P returns.

2) The carer is admitted to hospital so the client goes into a residential care setting for a week. There has been an assessment of the client.

In this scenario the service is short term residential care as it is for the benefit of the client. Even if this break is planned due to knowing the date of an operation, it is not respite care because the carer is not benefiting from the break - it is brought about by force of circumstance. In this instance this should be recorded in the P returns.

3) Following an assessment a client has been taken to a place of safety under adult protection procedures where emergency accommodation is provided because abuse has been established or suspected.

In this case the service is provided as a short term residential care as it serves the need of the client. In this instance this should be recorded in the P returns.

Information and advice

This would be defined as a baseline minimum set of information, for example:

- social service phone number for emergencies;
- national voluntary sector contact information;
- local numbers if available;
- national financial support line number;
- general advice on back care / moving and handling;
- anything else relevant to the individual circumstances.

The provision of information as part of the Carer's Grant should be recorded in this category **not** under "other specific carers' services".

'Information and advice' that is provided as a one-off should be counted in this category. However, if there is an ongoing financial or resource commitment, it should be counted under 'other specific carers' services' **irrespective of the funding source**.

- **Welfare benefits**

Providing general welfare benefits information/advice, or a one-off piece of assistance in assessing possible individual eligibility, should be recorded under 'Information and advice only'. Further assessment leading to ongoing support with welfare benefits or financial matters should be treated as more than a basic service, and recorded under 'other specific carers services'

- **Carers receiving services from a grant funded organisation**

Services provided to carers following an assessment should be included in C2 even if they are provided by voluntary organisations. Carers who receive a service from an agency funded by the CSSR but who have not been assessed should not be included in C2.

Return:

C2 page 1

A return showing the number of carers receiving different types of services provided as outcome of an assessment or review during the period April 2007 to 31 March 2008 by **age group of carer.**

Services include:

- Respite for the carer and/or other carers' specific services
- Information and advice only

Age group of the carers defined as:-

- Under 18
- 18-64
- 65-74
- 75 and over
- All ages (total)

C2 page 2

A return showing the number of carers receiving different types of services provided as an outcome of an assessment or review by client group and **age group of cared for person.**

Age group of cared for person defined as:-

- 18-64
- 65 and over

End Sheet

There is a final sheet in the returns which invites the CSSR to:

State any cost-bearing activity undertaken by your CSSR in relation to meeting the needs of adults, which you have not been able to include within the preceding returns. If possible both describe and quantify.

Please see 'End sheet' in the Glossary for intended content. Also relevant are glossary entries for grants and subsidies.

Section 5 - Glossary of Terms and Definitions

Age group: Defined as '18 to 64' and '65 and over'. If the age of the client is 'not known' please give details in the notes section of the proforma. Age is calculated as at the last day of the period. If a client dies, their age should be recorded as their age at death.

If only the year of birth of the client is known, as opposed to the month, then their age should be calculated by assuming that their birthday falls between March and December. For example, if a client was born in 1960, then for the collection period 2007-08, they would be recorded as being 46 years of age (*see also 'Extended age group'*).

Age group of carer: The age group categories for carers are as in 'Extended age group', but since it is possible for a carer to be under 18, an additional category of carer age, 'Under 18', is added. (C1 and C2)

Assessment: The process of gathering data for the purpose of determining a client's need and eligibility for services. The Community Care Act specifies that all services offered to a client should be the outcome of an assessment of needs. There are no restrictions as to who carries out the assessment or part of it (e.g. OT assessments should be included).

An "assessment" is defined as the **first** assessment for a **new** client. All subsequent assessments which include a reassessment are defined as a **review**.

RAP distinguishes between 'screening' and 'assessment', though both would qualify as an assessment under the terms of the NHS and Community Care Act 1990. Screening in RAP is seen as the process through which a contact is checked for their relevance to the CSSR, i.e. whether they are already known to the CSSR, what appropriate information, advice or basic service should be offered, and whether further assessment is needed (*see 'Screening' for further detail*).

An assessment in RAP is any aspect of further assessment of need. Assessments may be given a variety of labels by the CSSR, such as 'General assessment', 'Specialist assessment', 'Simple assessment', or 'Complex assessment'. 'Multi-disciplinary assessments' and assessments under the Single Assessment Process (SAP) should be included (*see 'SAP' for further details*).

In some CSSRs partial self-assessment (by the client) is possible, which may lead to a basic service, or onto further CSSR assessment. For the purposes of R1 and R2, if the self-assessment leads only to a basic service then make an entry in R2. If it leads to further CSSR assessment then make the entry in R1.

Assessments that stop because the users needs do not meet the Fairer Access to Care (FACS) eligibility criteria should be treated as completed assessments.

Assessment completed: See 'Completed assessment'.

Assessment or review terminated: Some clients are passed through for an assessment or review of need, but for a variety of reasons the assessment or review is not completed, but rather is brought to an end before completion.

Asylum seekers: This category is defined as people who have fled their home country and applied for asylum in another country. Also included are refugees. Assessments completed for asylum seekers under the National Assistance Act 1948 or the Asylum and Immigration Act 1996 should not be included. Only Community-Care assessments for asylum seekers should be included in RAP.

At or near the point of contact: 'At or near the point of contact' is normally used to describe events that take place prior to a decision to undertake further assessment. It is the phase during which a person may be registered, information / advice given, or basic services initiated (see *glossary entry for 'Basic services'*). In some CSSRs it will be contained within Customer Services (i.e. reception point), while in others it may be handled by a duty system. Some time may be given to attending to the request, often described as a screening interview, but the outcome will be within such categories as 'information / advice given', 'no further action', 'registration', 'passed for further assessment', and 'provide blue badge' (see also *'Information and / or advice'*).

Appropriate member of staff: An appropriate member of staff is defined as a member of staff who has been suitably trained to carry out a Community Care assessment. This could include a support worker in a 'contact team' or a health staff working as part of a joint team who are suitably trained and speak to the client. It does not mean they have to be a qualified member of staff. *For further details see the SAP guidance issued in January 2002, pages 14-19 of the annex.*

Basic services: These are services where there is an initial but no ongoing financial or other resource commitment on the part of the CSSR.

This term is used to describe the issue of blue badges, bus passes or administration of other comparable provisions, such as keys to public toilets for disabled people. CSSR blind / deaf registrations are also included. Many CSSRs do not distribute or fund the distribution of these provisions, whereas others do. The full range of provisions is extensive, if in doubt make an entry and describe in the notes section exactly what the provision is. Careful judgement is needed with regards to equipment (see *'Equipment / adaptations'*).

Where the CSSR does not administer a basic service please exclude these cases. CSSRs are not asked to gather figures for services that are handled by another department except through a contract with the CSSR for which the CSSR pays. The return should only be of CSSR provided or funded services.

Block Grants: These are grants typically provided to voluntary organisations, for preventive and other services, where the service users are not identifiable or not capable of linkage to CSSR client files. There may also be comparable expenditure within the CSSR, e.g. for preventive measures.

For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

Care Direct: Care Direct is an organisation that older people and disabled people can approach with queries about matters such as social care, community health or housing. The Care Direct advisor will contact service providers as required and may refer client's on to social services for assessment. This referral would be dealt with on R1 as usual. However Care Direct are also able to provide basic services such as blue badges or issue items of equipment. Information on the provision of these services should be recorded on R2.

If an R1 or R2 contact is referred from an agency such as Care Direct then the source of referral recorded on R3 should be 'other'.

Care plan: A 'care plan' is a description of the client's needs and how these will be met that is developed and agreed as a result of an assessment or review.

The Fair Access to Care Services guidance states that the written record of the care plan should include as a minimum: –

- A note of eligible needs and associated risks.
- The preferred outcomes of service provision.
- Contingency plans to manage emergency changes.
- Details of the services to be provided, and any charges the individual is assessed to pay, or if direct payments have been agreed.
- Contributions which carers and others are willing and able to make.
- A review date.

Carer: The definition of a carer is taken from the Carers & Disabled Children Act 2000 which states the act affects '*Carers (aged 16 and over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over*'. Although the act only refers to carers aged 16 and over, younger carers of adults should be included in this return. The Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation.

There is no definition in the Act of substantial and regular care. It is a matter of professional practice to identify the impact of the caring role on the carer in light of the carer's age, general health, employment status, interests and other commitments. Key factors relevant in deciding the impact of the caring role on the carer are the sustainability of the caring role and the extent of risk to the sustainability of that role. Issues relevant to identifying sustainability of the caring role are Autonomy, Health and Safety, Managing daily routines and involvement.

For further information on see the DH practice guidance on Carers and Disabled Children Act 2000 which is available at

<http://www.carers.gov.uk/pdfs/practiceguidecarersparents.pdf>

It is possible for a client to have more than one carer, and for a carer to additionally be a client in his or her own right.

Carer assessment or review: The return on this topic seeks to monitor the number of carer assessments or reviews carried out during the period, with a division between carers assessed separately or jointly with the client for whom they provide care. The focus is on carers **as carers**. Information recorded should relate to individuals in their role and needs as a carer. If a carer is also a client in their own right and is assessed for their needs **as a client** then details should be recorded in the relevant **client** returns.

A carer assessment under the Carers and Disabled Children Act 2000 is carried out at the request of the carer in order:

1. To determine whether the carer is eligible for support
2. To determine the support needs of the carer (i.e. what will help the carer in their caring role and help them to maintain their own health and well being).
3. To see if those needs can be met by social or other services.

Carers have a right to an assessment of their needs even where the person cared for has refused an assessment for, or the provision of community care services, provided the person cared for would be eligible for community care services.

For more information on the content of carers assessments see the DH publication 'A practitioner's guide to Carers assessments under the Carers and Disabled Children Act 2000' which is available at <http://www.carers.gov.uk/pdfs/practitionersguide.pdf>

Carers Services: As a result of the Carers and Disabled Children Act 2000, carers are entitled to services as carers. The provision of these services should be included in RAP on the proforma C2.

CSSRs should identify whether a service is for the client or for the carer. Where the service is for both the client and the carer, CSSRs need to make a judgement as to who the service benefits the most.

The three categories of services for carers are:

- Respite for carers
- Other specific carers services
- Information and advice only

Respite for the carer

As defined in the Carers Grant Guidance: A 'respite service' is to be construed as one which actually gives the carer a break from direct responsibility of supervising or caring for the relevant person by providing a service to that person. This would include day care at home or elsewhere &/or residential and there is no requirement for an overnight stay. This category does not include short term breaks intended for the person needing services. To illustrate the difference an example is given below.

1. A carer supporting a person with Multiple Sclerosis (MS) living independently might be assessed as needing respite which could be provided through a short stay in residential accommodation or care services at home.
2. In contrast a person with MS might, in order to maintain their independence, need to go into short term residential care (not respite) for rehabilitation / skin care on a regular basis. Though it is clear that the carer benefits indirectly in the latter case, the intention is to support the person with MS.

Other 'Specific' Carers' Services

The Carers and Disabled Children Act 2000 enables local CSSRs to offer direct carers support. Services for carers are not defined in the Act as such, but the CSSRs may provide any services which, in their view, will support the carer in their caring role and help them to maintain their own health and well being. These services may take any form and examples described in the Carers Grant Guidance include provision of emotional support, driving lessons, moving and handling classes or access to training

opportunities for the carer. The provision of information as part of the Carer's Grant should be recorded under "information and advice" (column 2 of the form C2). Therefore the provision of information through the Carer's Grant is excluded from the performance indicator on carers AO/C62.

This is not as clearly defined as the RAP definitions of components of service for users, but this reflects the heterogeneity of carers as a group. This would of course include direct payments for carers' services, which can be given to carers under the 2000 Act.

Respite care

Overnight respite care is defined as following an assessment or review where the carer's needs have been taken into account, planned overnight breaks(s) are arranged for the client either at home or in an alternative setting to allow a break primarily for the carer. As such this should NOT be included in any of the P returns.

Examples:

- 1) Every 5 weeks the carer has a long weekend away from home with another family member to ease the pressure of the caring role. Following a carer's assessment it is agreed to provide overnight respite care;
 - (a) In a local residential home that have a number of respite care beds
 - (b) In the client's own home by an agency

In both cases the overnight respite care is provided as a service for the carer to allow the carer to have a break. As such this should be recorded in C2, not in any of the P returns.

- 2) The carer is admitted to hospital so the client goes into a residential care setting for a week. There has been an assessment of the client.

In this scenario the service is short term residential care as it is for the benefit of the client. Even if this break is planned due to knowing the date of an operation, it is not respite care because the carer is not benefiting from the break - it is brought about by force of circumstance. In this instance this should be recorded in the P returns.

- 3) Following an assessment a client has been taken to a place of safety under adult protection procedures where emergency accommodation is provided because abuse has been established or suspected.

In this case the service is provided as a short term residential care as it serves the need of the client. In this instance this should be recorded in the P returns.

Information and advice

This would be defined as a baseline minimum set of information, for example:

- social service phone number for emergencies;
- national voluntary sector contact information;
- local numbers if available;
- national financial support line number;
- general advice on back care / moving and handling;
- anything else relevant to the individual circumstances.

The provision of information as part of the Carer's Grant should be recorded in this category **not** under "other specific carers' services".

'Information and advice' that is provided as a one-off should be counted in this category. However, if there is an ongoing financial or resource commitment, it should be counted under 'other specific carers services' irrespective of the funding source.

Casual contacts: These are people who make contact with the CSSR but are not put through a screening process, and who will not be logged at all by many CSSRs. They may, for example, be people dropping in to pick up a leaflet, people needing redirection to another service, or current clients calling on their provider staff. The key point is that they are not presenting needs to the reception staff (*see also 'Contacts'*).

Clients: Customers of the CSSR who are 'on the books' for an assessment, or review, or the receipt of services. A client can be an individual, family or group, though this begs the question of whether a family is treated as a single unit, or can contain several clients. This may be determined by custom and practice in the CSSR, for example whether separate files are held on different individuals, or whether requests for the provision of services are treated on an individual basis or for the family as a whole.

Individuals being considered as a service provider, for example, as a carer or foster parent in adult fostering scheme, should not be counted as clients. See entry for 'End sheet' for further details on this matter.

Clients receiving community-based services: Definition is as below for 'Clients receiving services' except that only community-based services are covered (*see also 'Components of service', 'Clients' and 'Services'*).

Clients receiving services: Clients who are or have been recipients of services during the period, or who are still 'on the books' for services on the last day of the period. These clients may also be labeled as 'open cases', or 'current clients' in some CSSRs, but not in those CSSRs where the division between an 'open' and 'closed' case is the point of transfer from purchaser to provider responsibility.

Clients assessed, or reviewed, by the CSSR who subsequently go on to fully fund the direct costs of their own services and care management should be included as assessments, or reviews, in the A returns. They should not be included as clients receiving services in the P returns. The reasons for this are that many CSSRs do not keep records of clients funding their own services, but more pertinently the returns are concerned with services provided or commissioned by the CSSR that require an ongoing resource commitment (*see definitions for 'Fully funded client', 'Clients' and 'Services'*).

Community-based services: See 'Components of service' for more detail. These are services provided to support clients living in the community.

Some clients living in care homes may additionally receive community-based services (e.g. attendance at day centres). For RAP purposes these clients should be counted as in residential or nursing care in P1 and are therefore completely excluded from P2f/P2s. They should **NOT** be counted as receiving community-based services. The clients who appear in the community-based services column should **only** be receiving community-based services at some point during the year or at the 31st March.

However, a client may be receiving community-based services for part of the year and then move into residential care. In this scenario the client should be included in P1 as having received both community-based services and residential care, and P2f for community-based services, but **not** in P2s as they were in residential care by 31 March. For the first cell and first column on P1 they should only be counted once.

Short-term residential care should be included as a community-based service not as residential care. Adult fostering (short or long term) should be placed under independent sector residential care (see 'Service type').

Completed assessment: For RAP purposes include all assessments which were completed in 2007/08 whether or not they started in 2007/08. Exclude any assessments that were not actually completed by 31 March 2008. This clarifies the current guidance as set out below.

A completed assessment for RAP purposes is one where all the components of the assessment of an individual's needs and eligibility for services have been undertaken, and either a care plan has been agreed with the client or a decision taken that there should be no (further) services as a result of the assessment. A financial assessment is not included within the definition of an assessment of need; therefore a client's financial assessment need not have been finished for the purposes of this categorisation. It is recognised that services may well commence before an assessment is complete, and that revisions to assessments typically continue to the first review of a care package. Onset of services is not, therefore, an indication of the completion of the assessment.

The total of new clients with completed assessments refers to assessments completed in the current period regardless of when the first contact was made. For the purpose of the A returns a person may have been logged as a new client contact (R1) in either the current or previous period.

The return of completed assessments should include those clients who subsequently go on to fully fund their own services, or who decide not to accept the offer of service.

For the purpose of measuring calendar days to the completion of assessment, the preferred time point is when the statement of needs and how these are to be met (care plan) is logged. The waiting time to completed assessment should be measured as the time social services complete their last assessment event within the whole assessment process.

Three examples are given below;

- a) A multi-disciplinary assessment is carried out within social services. This includes two assessment events, an overview assessment carried out by a social worker that was completed on 3 June and an OT assessment that was completed on 10 June. The date the assessment is counted on RAP as complete is 10 June.
- b) A SAP assessment is carried out to look at both the health and social care needs of the client. The social services element of the assessment is completed on 3 June and the assessment of the health needs is completed on 10 June. The date the SAP assessment is counted on RAP as complete is 3 June when the social services part is complete. This example is also applicable to joint teams under section 75 arrangements. [From the service users perspective this is not ideal but reflects the possible problem of not knowing when the health part of the assessment is complete.]

- c) A joint assessment is **coordinated by social services**. Social services have completed their part of the assessment by 3 June but the assessment of health needs is not completed until 10 June. The date the assessment is counted on RAP as complete is 10 June.

Where CSSRs have completed the assessment for a client in hospital before receiving the section 5 notice, the time between first contact and completed assessment should be recorded in the lowest time band on RAP form A7, i.e. less than or equal to 2 days.

Completed review: For RAP purposes include all reviews which were completed in 2007-08, whether or not they started in 2007-08. Exclude any reviews that were not actually completed by 31 March 2008.

Components of service: These are referred to solely in the P2f and P2s returns, and relate to those clients receiving community-based services only.

Clients living in care home settings who additionally receive community-based services should be counted as in residential or nursing care on P1 and are therefore completely excluded from P2f/P2s. These clients should **NOT** be counted as receiving community-based services.

The components of service are -

- **Day care.** (See separate glossary entry).
- **Meals.** (See separate glossary entry).
- **Home care.** (Personal and/ or domestic care).

Previously the categories home help/ home care and overnight short term break that is provided in the client's own home were combined under the heading 'Home care'.

Include in this category all forms of domiciliary care and support for people in their own homes except for those specified below. The definition is as similar as possible to that used on the HH1 return.

Home help/home care. 'Traditional' home help services are practical services that assist the client to function as independently as possible and/ or continue to live in their home. Services may involve routine household tasks, personal care, taking a client out for appointments or shopping, training by non-professionals (for example help with household budgeting), overnight short term break, live-in and 24 hr services.

- **Short-term residential – not respite.** This refers to the provision of short-term residential care for the client for any purpose other than respite of a carer. It includes the provision of rehabilitation services (*see glossary entry 'Rehabilitation services' for further detail*).

- **Direct payments.** (see separate glossary entry)
- **Professional input / support.** (see separate glossary entry)
- **Transport.** This information will not be collected in P2f and P2s from 2006-07. If the client receiving another service e.g. day care as well as transport, then record them under day care. If transport is the only service in the care plan, then include the client under 'Other'. If the travel is seen as a basic or one-off service include it on R2 (for new clients only) but exclude it from the P forms.
- **Equipment & adaptations.** (see separate glossary entry).
- **Other.**

Contacts. The referral (R) forms were redefined in 2003-04 to include contacts from **new clients** only, that is clients not "on the books" of the CSSR at the time the contact was made. A person who has previously received services, which have ceased before the time of contact (i.e. the client is "off the books" when the contact is made) should be included. A client may be on the books of the CSSR but not actually receiving a service. This would **not** count as a new contact for RAP purposes.

For the R forms all contacts made by new clients in the year should be included, whether or not they received an assessment or service during the year. For example, a contact on 30 March 2008 who did not receive an assessment until 2 April 2008 would be included in RAP 2007-08 as a contact only. The waiting time for such an individual would be counted in RAP 2008-09.

A 'contact', often called an enquiry, is a person visiting, writing, phoning or making a request of the CSSR in some other way. In the broadest sense a 'contact' is anyone who has made a request of the CSSR, at any of its access points (including those shared with others, such as in health settings). For the R returns 'contacts' are divided into those who are screened and passed on for further assessment (R1), and those who are screened and their needs met at or near the point of contact (R2).

A contact for R1 purposes is one that leads to an assessment or commissioning of ongoing services. The initial contact is entered on R1, but any later contacts in relation to the assessment process or to service provisions arising from the initial contact should not be included. For each episode of assessment or provision of ongoing services there should be just one R1 entry.

If a contact is given information, advice or a basic service at or near the point of contact but not passed on for further assessment or commissioning of service then they should be recorded on R2. As for R1, it is only the initial contact that should be recorded. If, for example, a new client contacts the CSSR to request a blue badge make just one R2 entry. Any further contacts in the context of determining eligibility for the badge should be seen as 'casual contacts'.

The difference between a R2 contact and a casual contact is sometimes a matter of judgment. This is especially so with information and advice. In some CSSRs the defining difference will be whether the reception staff consider it worth taking some personal details from the individual (a contact), or not (a casual contact). In others the difference will be whether or not reception staff take the individual through some form of screening process, or may be based on the amount of time/ attention given to the person. In practice the most common area for making a distinction will be whether or not an activity amounts to a screening leading to information and/ or advice (R2 entry), or is a smaller activity.

Taking some personal details from a new contact and giving them information on the range of services that might be relevant should be recorded as an R2 entry. Simply responding to a request for the phone number of an area office would be a casual contact.

As with 'clients' above, a contact can be an individual, family or group. The defining feature of a contact (or what may come to be called a client) is that he / she / they are treated as a single unit for the purposes of handling their reception (*see 'Clients' for further comment*).

First contact with the client: This is the date when, following or at referral, an 'appropriate member of staff' first contacts the client;

- To discuss their needs and agree with the individual what further action should be taken or
- Arranges a suitable time with the client to discuss their needs.

Where the client cannot genuinely speak for themselves (perhaps they have a severe cognitive impairment), contact can be with the next of kin, carer or other independent person who is close to the individual."

Current service users: Clients who have an existing package of care in operation.

Day care (As in Components of service): This category is for attendance at a day care centre for day care and/ or meals and includes the attendance at training centres and luncheon clubs. The provision of funding to day centres that any person can attend (e.g. a drop-in day centre), or other grant funded organisations, should be included on the end sheet. If, however, the clients using the day centre have received a Community Care assessment (under the NHS and Community Care Act 1990) and day care is specified as a service in their care plan, then they should be recorded in the P returns. In this case CSSRs should liaise with the appropriate agency to obtain sufficient information about the clients.

Dementia: The subset 'Dementia' is defined as a set of symptoms in which there is evidence of a decline in memory and thinking which is of a degree sufficient to impair functioning in daily living, present for six months or more. Dementia is not a disease in itself but a term used to describe the symptoms that occur when the brain is affected by one of many specific diseases, the most common being Alzheimer's and stroke. It is characterised by a progressive decline of mental abilities accompanied by changes in personality and behaviour. Dementia is more common in older people but may occur earlier. For a client to be recorded in the subset 'Dementia' they do not have to be clinically diagnosed with dementia.

There are lots of different symptoms of dementia. A few scenarios are listed below as examples to use alongside the definition.

1) Failing or loss of short term memory, which significantly impairs capacity to maintain conversation and 'normal' social interaction, for example repeating the same topic in conversation several times without realising.

2) Difficulty in performing familiar tasks, for example they may not know what order to put their clothes on or the steps for preparing a meal.

3) Disorientation to time, place and patterns of normal living, for example getting up in the middle of the night and having breakfast or become lost within the area they live and not know how to get home.

4) Declining capacity to carry out essential domestic routines resulting from deterioration in functioning of memory, for example forgetting to do the washing, shopping or turning off the cooker.

5) Misplacing items, for example putting items in unusual places such as an iron in the fridge or a watch in a fruit bowl.

Direct payments: Direct payments are defined as monetary payments made by local CSSRs directly to adult clients aged 18 and over in lieu of social service provisions, who have been assessed as needing certain services. RAP does not need to know what services a client is buying with the direct payment.

Vouchers or similar 'credits' are not direct payments.

"For people who receive direct payments it may be their first experience of being an employer, and they may welcome support through the recruitment process whether they intend to employ a personal assistant, a self-employed assistant or an agency to provide services. Some people may also need help with managing the money. The payment may be made to a third party (nominee) for the recipient and day-to-day management of finances may be delegated in this way. However, the person to whom the direct payment is made must have control over how services are delivered. It is important that the information and help provided is clear and concise and not offered in such a way as to discourage them from accepting a direct payment". See *Direct Payments Guidance, issued in September 2003*: <http://www.dh.gov.uk/assetRoot/04/06/92/62/04069262.pdf>.

End sheet: This refers to the final page of the return, which asks the CSSR to 'State any cost-bearing activity undertaken by your CSSR in relation to meeting the needs of adults which you have not been able to include within the preceding returns. If possible both describe and quantify'.

Below are two identified areas of activity that should be covered here, and there may be more.

For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. Brief details of the services provided through grant funded services (GFS) can be given on the end sheet. However, this activity will be captured in more detail on the GFS01 return.

Information on the amount of funding provided to these organisations will be captured via the PSS EX1 expenditure return.

The second area concerns work assessing and supporting people who are under consideration as, or become, service providers for the CSSR. One example is foster carers in adult fostering, and there may be others. Please describe the types of service and give numbers wherever possible, distinguishing between total activity in the area and activity during the current period. The exception here is carers, who should be returned in C1 and C2.

Equipment / adaptations: (As in 'Components of service').

The provision or commissioning of equipment and adaptations does not conform to the recording pattern of other service components.

A small item of equipment provided at or near the point of contact, following initial screening but no further assessment, should be categorised as a basic service and entered in R2. In all other instances where equipment or adaptations may be provided as the result of an assessment, there should be an entry on R1.

Any items of equipment which are issued at or near the point of contact as a basic service and are recorded in form R2 should be excluded from the waiting times forms (A7, A8, A9).

There is an element of judgement as to what constitutes a 'small item', and it is not possible to be prescriptive. A ferrule, walking stick or bath rail (including fitting) would normally be seen as a basic service, unless provided as part of a wider care package. Any equipment given in the context of a wider package, or where there are ongoing needs for supervision or maintenance, should be recorded as a service (as in 'Components of service'), and arise from an entry in R1. As a client cannot be recorded on both R1 and R2, if the client is receiving an assessment for other services the provision of equipment would be picked up as part of the R1 entry. If a contact regarding equipment/ adaptations is recorded in R1 then the provision of the service should be included in the P returns under community based services.

Major items of equipment, identified by the Single Assessment Process, should be included in all collection periods that the client is still in receipt of the item of equipment. The Single Assessment Process states that CSSRs have an obligation to review "Major items of equipment" on an annual basis and therefore clients in receipt of major items need to be included in the review population (i.e. the P1 service population) for each period they receive equipment. This only applies to **major** items of equipment.

The waiting time for major adaptations is measured as the time from completed assessment to the date that the request for a major adaptation is referred to a housing department or housing association, or an application is submitted for a Disabled Facilities Grant (DFG). In some cases there may need to be a social services "top up" but reaching final agreement on the amount involved is excluded from the waiting time.

Items of equipment or adaptations that incur an ongoing financial commitment are defined as those 'requiring training (which is not yet completed) or ongoing regular contractual maintenance', e.g. stair lifts or hoists, if these are maintained by the CSSR or where the CSSR funds the maintenance. This does not include instances where the client takes over responsibility for maintenance after installation. It also does not include the responsibility of replacing one-off items if they break; these should be counted as one-off items of equipment rather than equipment with an ongoing commitment.

Items of equipment/adaptations that incur an ongoing financial commitment (e.g. for maintenance or training) should be included for as long as the financial commitment is in force.

For all other items of equipment/ adaptations provided as part of a care package, once the item has been provided (plus fitting and training in use, etc), it ceases to be 'on the books' so is only counted in the first year it was issued. As such it would not be included in subsequent collection periods unless there was an ongoing financial commitment such as training or maintenance.

For proforma P2s the only equipment and adaptations that are included are;

- Those provided on 31st March or the nearest day that any equipment is delivered;
- Equipment which has an ongoing financial commitment and thus remains 'on the books';
- 'Major items of equipment'. These are items that the CSSR has an obligation to review on an annual basis and involve the CSSR in an ongoing financial commitment to maintain or service the equipment. Such equipment might include stair lifts and orthopaedic beds or chairs.

NB. This definition relates to equipment being provided on one day.

Ethnicity: The ethnic categorisation for RAP returns is that used in the 2001 Census and which the IC uses for all statistical collections. This is a three tier structure, with five top level categories, each with a second tier of sub-categories. There is also a 'Not stated' category. This constitutes the list printed on the return protocols and proformas for A6 and P4.

Extended age group: 'Extended age group' is defined as '18 - 64', '65 - 74' and '75 and over'. Age is calculated as at the last day of the period.

Fairer charging: These assessments and reviews can only be included in RAP if they are part of an assessment or review process for a client whose need and eligibility for services is being assessed or reviewed under section 47 of the NHS and Community Care Act 1990. If this is the case, the assessment or review should not be counted separately as it is the whole process that is being captured on RAP. (*see 'multi-disciplinary assessments' and 'Single Assessment Process'*)

If the process only involves an assessment or review of whether the charge for services to the client is fair it is not be eligible for inclusion in RAP and PAF AO/D40.

First contact:

- a) *All individuals excluding those who are inpatients in hospitals:* This is the date when first contact is received from or on behalf of the client in relation to the needs which require assessment. The contact may be by way of personal call, phone call, letter or other form. It may be direct or through an intermediary (such as a neighbour, relative or GP). The date of first contact is not necessarily the same as the date of screening, though in many CSSRs screening will take place on the same day as contact.
- b) *Individuals who are inpatients in hospital:* This is the date when it is confirmed by an NHS hospital to a social services department by means of a 'section 5 notice' that the patient is medically fit and ready for discharge. The contact may be by way of phone call, letter or other form.

If a CSSR is informed that a patient's intended release is delayed for medical reasons, the time of the first contact should be reset to when the CSSR is re-notified by the hospital via a section 5 notice. If an assessment has already been carried out before the release date changed and no further assessment is required, the first contact with client must be the new date of discharge.

Fully funded client: A fully funded client is one who pays the full direct cost of his or her services and for their management. These clients should be excluded from RAP. A client who pays solely or in part the direct cost (charges) of the services they receive, **but** whose care is managed (e.g. reviewed) at the expense of the CSSR is not 'fully funded' and should be included in the P returns.

Further assessment of need or commissioning of ongoing service: See 'Assessment'. The word 'further' is used to clarify the difference between screening or filtering that might take place 'at or near the point of contact' (*see entry above*), and later assessment activity. 'Commissioning of ongoing service' refers to a decision to set up a package of care, or put in interim/ emergency services, on the basis of the screening already undertaken. This has to be kept distinct from basic services (*see 'Basic services'*); the key is that a package of care has the intention of an ongoing resource commitment. Whereas a basic service is a 'one-off' with an initial but no further resource commitment (*see glossary definitions 'interim/ emergency services' and 'Equipment & adaptations'*).

Health funding: Only services provided or commissioned by social services (or the health partner under section 75 arrangements) should be included in RAP. If Health are paying for the provision of social care services for a client and there is no resource cost to the CSSR then these clients should be excluded from the P returns. However, if the CSSR funds the care management of the client (following a Community Care assessment) any services that are provided can be included in the P returns. This only applies to social care services not health services. If health is paying for health services and CSSR resources are paying for care management then these clients should still be excluded for the P returns. It would be useful if you could indicate in the notes section the number of clients were CSSR funds the care management process but the client is receiving services funded by other agencies.

Individual Budgets

Some CSSRs have been pilot sites for Individual Budgets. CSSRs involved in the pilots **only**, need to continue to include the clients on individual budgets within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via an individual budget should be included in RAP. We are aware that the individual budgets may be made up of funds from several different funding sources. Please include all clients *unless the individual has no social services funding*.

In Control

Some CSSRs have taken part in 'In Control' projects. The CSSRs involved in the projects need to continue to include the clients receiving services via 'In Control' within the current IC central data collections.

Services which are delivered by social services or on behalf of social services via 'In Control' should be included in RAP. We are aware that 'In Control' may be made up of funds from several different funding sources. Please include all clients unless the individual has no social services funding. The clients should be recorded on the RAP P forms as follows;

P1 & P4 – record these clients under the high level type of service they are planned to receive, although it is probable that most clients would be receiving community-based services.

P2f & P2s – record the clients under the specific component(s) of service they are planned to receive. If the service does not fit under one of the existing components of service, then record the client under the category 'other'. Clients planned to receive services via 'In Control' should not be counted under direct payments unless a direct payment is provided as part of 'In Control'. The 'In Control' arrangement itself should not be recorded separately under 'other'. Some examples are set out below;

1) If the client is planned to receive 6 hours of home care and 3 sessions of day care, then the client should be recorded under home care and day care.

2) If the client is planned to receive both meals 5 days a week and a direct payment all within 'In Control', then they should be recorded under meals and direct payments.

3) If the client is planned to receive day care provided by attendance at a local leisure centre which is funded with part of 'In Control', then the client should be recorded under 'other'.

Information and / or advice: Information and / or advice for RAP purposes is something given during or as a sequel to an initial screening as is appropriate for the individual. While typically information and advice will be given by reception staff or a duty social worker, in some instances the individual may be passed to someone else for more specialised input, such as help with welfare benefits matters.

Interim / emergency services: These are services provided in response to the urgent or severe nature of a client's needs. Generally they will be provided either while further assessment is being carried out and prior to the preparation of a care plan; or while a care plan is in existence, but the client is waiting for a planned service to become available (e.g. community services provided while a client is waiting for a place in a residential setting).

Jointly assessed clients: See 'Out of area and jointly assessed clients'.

Known or anticipated sequel to assessment: (*See also 'Sequel to assessment'*) At the time the assessment process is completed some sequels may be firmly known, in the sense that some elements of a care plan may already be in place or resources allocated, or a decision has been taken not to offer services. In other circumstances there will be an intention to move in a particular direction as a result of the assessment, but no action may have been taken, and no assurance can be given that the eventual outcome will be in line with intention. The aim is to make a return based on both known and intended sequels, even though the actual outcome of the assessment may eventually differ from the intended one.

Last day of the period: The last day of the period designated to be covered by the RAP returns. Under present arrangements this is the 31st March each year, keeping the period in line with the financial year. The last day of the period is used for snapshot returns, and is also the date on which client and carer age is calculated.

Meals (As in 'Components of service'): Includes "meals on wheels" or community meals services delivered to the client as part of a care plan. Exclude luncheon clubs.

Mental health assessments: Mental health assessments should be included in RAP. If you have joint health and social services teams (operating a partnership under section 75 arrangements) then assessments completed by social workers or health staff should be included, providing they include a social care element and the outcome could be either health or social care services. If the outcome of the assessment is the provision of health services then the sequel to assessment would be "no (new) services offered or intended to be provided". If the assessment is purely for health services then it should be excluded from RAP (*see also 'Out of area and jointly assessed clients'*).

Multi-disciplinary assessments: Multi-disciplinary assessments involve activity by several different teams. The individual work of these teams should **not** be recorded separately. Instead, the whole assessment process should be recorded as a single assessment event. This also applies to assessments under the Single Assessment Process (*see the glossary definition 'Single Assessment Process (SAP)'*).

New clients: A new client is someone who is not 'on the books' of the CSSR at the time of contact. Individuals who have previously received services but that have ceased before the time of contact (i.e. the client is "off the books" when the contact is made) should be included (*see glossary entry for 'On the books'*).

New service(s): The term 'new service(s)' is used to distinguish between those services a client may already be receiving (usually as a result of a previous assessment), and those which are new in the sense that they arise as a result of the latest review. For the purposes of the return, a new service may be a new type of provision or an extension to an existing type. If a client has an increase in some services and the removal/ reduction of others, that is, a changed pattern of services, then categorise this situation as "new services".

Older people classification: There is not a primary client type for older people. Clients who may have previously been classified as 'elderly' or 'older people' should be reassigned to one of the primary client types. Information regarding older people is picked up via the age breakdown details.

'On the books': A client is deemed to be 'on the books' for services if they are actually receiving services, or there is a current allocation of services at the time under consideration (i.e. either during the period or as at 31st March). A person who previously received services, but which has now ceased, is not deemed to be 'on the books'. If that person comes forward again for an assessment and services then in RAP terms he / she should be categorised as a 'new client' (*see glossary entry 'new clients'*).

Receipt of a basic service (as covered in R2), does not constitute being 'on the books'.

OT Assessments: Assessments completed by Occupational Therapists (OT) and Occupational Therapy Assistants (OTA) and paid for by social services should be included in RAP. If the OT/OTA contributes to a multi-disciplinary team assessment, then the OT assessment would be one assessment event within the whole assessment of the client's needs. In the Single Assessment Process OT assessments are captured under 'Specialist' assessment. If the OT assessment is the only assessment then it should still be recorded on RAP.

Any items of equipment which are issued at or near the point of contact as a basic service and are recorded in form R2 should be excluded from the waiting times forms.

Where social services refer the OT assessment to an outside agency, if social services have funded the assessment then it should be included in RAP; however, if social services have not paid for the assessment then it is excluded from RAP.

Out of area and jointly assessed clients: In order to ensure that everyone takes the same route, the rule is to count what your CSSR pays for. If you assess clients from another area, at your expense, then count them in your figures. If the other area pays you to do the assessments then that area counts them in their return and you do not. Similarly, you may count clients from your patch that have been assessed by another CSSR only if you pay for the assessment. The same principle applies to services.

If the CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006 they should include assessments carried out and social services provided by the health partner in RAP. Legally, joint teams can only operate (in terms of assessing needs for social services) within section 75 where they have delegated authority from social services to do so. Where this is the case ALL the social care related assessments carried out by the team should be counted for RAP purposes whether made by a social services member of staff or not.

We expect all the **social** services that are provided by joint teams operating under section 75 to be included in RAP, including those provided by health service staff. The local authority can choose to provide both the assessment itself and the provision of services following the assessment through mixed teams under Section 75 integrated provision arrangements. The local authority could choose to delegate the commissioning of such services to an NHS organisation if it wanted to, again under Section 75. The key point is that the statutory responsibility for those services remains with the local authority, so, however it chooses to organise these responsibilities in partnership, they should still be covered on the RAP return. These services should be specified in the client's care plan, and the client's package of care should be managed by the social services department.

Package of care (care package): A service or set of services agreed as part of the care plan arising from the first assessment or subsequent reviews. These services can be residential and / or community-based.

Period: The period to be covered by most of the returns is from 1st April to 31st March. Form P2s captures information as at 31st March.

Personal and / or domestic care: Synonyms for home care, as in 'Components of service'.

Physical disability, frailty and sensory impairment: (As in 'Primary client type'). Includes physically frail people and those with illness or incapacity. The following subsets of this primary client type are also identified:

- Physical disability, frailty and/or temporary illness.
- Hearing impairment.
- Visual impairment.
- Dual sensory loss.

(See definitions for Hearing impairment and Visual impairment for further clarification).

Primary client type (group): People should be allocated to their primary client group wherever possible. This should be a professional decision based on the client's circumstances, not solely an administrative categorisation for the purposes of allocation to a particular specialist team. In some CSSRs each client has an overarching client classification, but may receive a different classification for a specific assessment, in these circumstances use the overarching client type for the return.

A client may appear in only one primary client type, so there should be no double counting. However, it is possible for a client to appear in none or more than one subset of a primary client type, and hence the total of entries in subsets is not expected to equate to the total of clients in each primary client type. The restriction to this is that a client can only be double counted within subsets of a single primary client type.

The categories of 'primary client type' are -

- Physical disability, frailty and sensory impairment (*for more details see above definition*).
- Mental health needs: includes mentally ill or confused people, and those with dementia. Dementia is requested as a subset.
- Vulnerable people: a general heading to include those whose situation cannot be appropriately fitted in any of the preceding groups. Asylum seekers/refugees and welfare benefits clients should be included here.
- Learning disability.
- Substance misuse: includes those with drug and / or alcohol related problems.

Professional support: (As in 'Components of service'). This distinguishes between the process of care management, which should not be returned as professional support, and other professional activity by the care manager, social worker or other professional staff, which is the intended activity for return. Typically this occurs when the care manager goes on working with the client after the care management process has been completed, or another professional is involved as part of the care package to provide therapy / support / professional input. In some CSSRs there are procedures for identifying the use of professional support (i.e. it is listed in the care plan as a service, or social worker involvement continues after all care management work has been completed). In other CSSRs the matter is less clear, and new data may need to be gathered. Except in a few instances CSSRs have told DH that professional input / support is often carried out, unrecorded, or not distinguished from care management. The purpose of including professional support as a 'Component of service' is to enable the activities of professional/ clinical staff, such as social workers, Occupational Therapists, CPNs, qualified counsellors etc. to be identified. Professional support can be included in PAF indicator D56 (form A8) if it is specified as one of the services in the care plan.

For a client to be considered as having professional support, the service must be included as part of their care plan. This does not include the process of care management (i.e. assessing or reviewing care needs, even if the case is “open” or “active” on 31st March), but typically occurs when the care manager goes on working with the client after the care management process has been completed (as part of the care plan/package), or another professional is involved to provide therapy, support or professional input, e.g. counselling. For professional support to be regarded as received the requisite input must be provided by or on the date recorded.

Provided or commissioned by the CSSR: Assessed clients receiving services, whether through direct CSSR provision, purchased from the independent sector, or supported by CSSR staff in another setting.

Only services provided or commissioned by social services (or the health partner under section 75 arrangements) should be included in RAP. If a service is paid for by the housing department, for example access to a warden in sheltered housing accommodation, then it should be excluded from RAP. Services funded by the Supporting People initiative can only be included in RAP if the clients receiving these services have received a Community Care Act assessment *and* the relevant expenditure from the Supporting People grant is being classed as social services expenditure rather than housing expenditure. The services being provided must be part of a package of care that is managed and is subject to review by social services (or the health partner). For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

Receipt of all services: For RAP purposes, only include those clients actually in receipt of **ALL** services by the end of the financial year 2007-08.

For measuring the target for new clients these are all the directly provided, commissioned or purchased Social Care services which are in the client’s care plan. In this context Social Care services will include any service which is paid for or recharged to Social Services budgets within CSSRs. It will also include social services provided as a result of an assessment made by a joint team operating under section 75 whether or not this team is funded directly by Social Services (e.g. via a pooled budget).

To meet the target of services starting within 4 weeks, **all** services must be provided within 4 weeks.

There are some rare circumstances where some of the services defined in a care plan are contingent on the delivery of other services. Therefore it is not sensible, and indeed would be detrimental to the client, for them to be delivered within 4 weeks of the assessment. On these rare occasions, the *arrangements* for these services to be delivered should be put in place within the 4 week period, i.e. patient need is the only reason why services are provided outside the four week period.

An example of a rare circumstance is where a care plan specifies that a client needs rehabilitation services for 5 weeks but then requires home care after coming out of rehabilitation. In this case the client's needs mean that the home care services should not be delivered within 4 weeks of the assessment. Instead both the rehabilitation must start and the arrangements for home care be put in place within 4 weeks of the completed assessment.

In the case of equipment and adaptations, services are **not** complete until the equipment is received (and where necessary, satisfactorily installed). This includes **all** equipment and minor adaptations.

There may be other exceptional circumstance beyond the control of CSSRs which mean that all services cannot be provided within 4 weeks of the assessment. These circumstances will be taken into consideration when setting the performance bandings for the waiting times to care packages indicator.

- **Guidance on specific services**

Several types of services are listed below with guidance on how to measure when these services are received.

i) Respite Care

Overnight respite care is defined as following an assessment or review where the carer's needs have been taken into account, planned overnight breaks(s) are arranged for the client either at home or in an alternative setting to allow a break primarily for the carer. As such this should NOT be included in any of the P returns.

Examples:

1) Every 5 weeks the carer has a long weekend away from home with another family member to ease the pressure of the caring role. Following a carer's assessment it is agreed to provide overnight respite care;

(a) In a local residential home that have a number of respite care beds

(b) In the client's own home by an agency

In both cases the overnight respite care is provided as a service for the carer to allow the carer to have a break. As such this should be recorded in C2, not in any of the P returns.

2) The carer is admitted to hospital so the client goes into a residential care setting for a week. There has been an assessment of the client.

In this scenario the service is short term residential care as it is for the benefit of the client. Even if this break is planned due to knowing the date of an operation, it is not respite care because the carer is not benefiting from the break - it is brought about by force of circumstance. In this instance this should be recorded in the P returns.

3) Following an assessment a client has been taken to a place of safety under adult protection procedures where emergency accommodation is provided because abuse has been established or suspected.

In this case the service is provided as a short term residential care as it serves the need of the client. In this instance this should be recorded in the P returns.

ii) Direct payments

We understand that the process for arranging direct payments can be quite lengthy in terms of the legal and contractual issues. Hence for direct payments the waiting time is measured as the time from completed assessment to the date the amount of the direct payment has been agreed with the client **and** the relevant processes for setting up the direct payment have been completed.

iii) Other services that are booked in advance

For example pre-hospital admission arrangements for home care. To cover other services that are booked in advance use the guidance below:

The guidance issued already states that services that are not actually required by the client within 4 weeks of completed assessment, are counted as being received as long as arrangements for those services have been put in place within 4 weeks. However there is an issue whereby the client is in need of a service, but because a date for the service has not been specified it is not possible to put arrangements in place.

If the arrangements for this service are not in place then all services have not been received, i.e. if no dates are specified in the care plan then arrangements for the service can not be put in place and therefore it is likely that the majority of these cases would miss the target of 4 weeks from completed assessment to receipt of all services.

In this situation the client would be considered to have received all their services once a date for the service had been given **and** the arrangements had been put in place, even if this is several months after receiving all other services.

Example: The client completes their assessment on 1st May. Their care plan includes meals, equipment and day care with no date specified. The meals are first received on 7th May and equipment is first received on 10th May. The client then asks for day care on 20th June to start at the end of July. The arrangements for day care are put in place by 25th June. The waiting time between the completed assessment and receipt of all services is measured as the length of time between 1st May and 25th June.

We understand this means it will be impossible for CSSRs to meet the target of 100% of services in place within 4 weeks for practical reasons. This will be taken into account when the bands for the indicator are set.

iv) Services that may be modified in light of experience

In this situation the waiting time is measured from time of completed assessment to receipt of all services in the initial care plan.

Example: It is decided initially that a client should receive 4 hours of home care a week and attend a day centre 3 times a week. It is agreed to review this arrangement in 5 weeks time. The home care and day care is started one week after the assessment. The waiting time is measured as the time between the completed assessment to when both the home care and day care are first received, namely one week.

Any future services included in the care plan, for example at the 5 week review, should still be put in place as soon as possible but will be excluded from the indicator as these services are following a review.

v) Needs assessed during a residential placement

(a) If the service specified in the initial care plan is to go into residential care for further assessment, then count the date on which the client moved into residential care as the date when all services were received.

(b) If the client's initial needs are still being assessed, the assessment has not been completed and the client does not have an agreed care plan for CSSRs to put in place. Hence these clients would be excluded from form A8 in the current reporting period.

Receiving services before the assessment is completed: Where the client has received all their services (or the arrangements were put in place for specific services) before the assessment has been completed, the time between completed assessment and receipt of all services should be recorded in the lowest time band, i.e. less than or equal to 2 weeks.

Referral: Processes vary between CSSRs, but a referral is commonly at the point at which it is decided that a 'contact' should be passed on for further assessment. In many CSSRs this is also the point at which the person becomes a 'client' and / or is 'allocated', in the sense of becoming part of the caseload of a team or individual. It can also represent the point at which responsibility is passed from reception or customer services staff who have carried out an initial screening / filtering, to care managers or those designated as responsible for carrying out assessments (social workers, OT's).

Referral category: The referral category is a composite of the source of referral, as used in return R3, which seeks to differentiate between primary and secondary health and non-health sources. The categories of referral are:

- Primary health / Community health (GP, community-based profession allied to medicine, etc.)
- Secondary health (Accident and Emergency, hospital OT, ward, hospice, etc.)
- All other referral sources.

Registration: Registrations, as determined in legislation, of persons with disability.

Rehabilitation services: Rehabilitation services are generally classified as temporary residential places and as such should be recorded under short term residential care within community-based services on the P returns. However if the rehabilitation placement has exceeded 6 months then it should be included under residential care services on P1, rather than community-based services and should not be recorded on P2f/P2s.

Respite care:

Overnight respite care is defined as following an assessment or review where the carer's needs have been taken into account, planned overnight breaks(s) are arranged for the client either at home or in an alternative setting to allow a break primarily for the carer.

As such this should **NOT** be included in any of the P returns.

From 2007/08, this should be recorded in C2 as "Services including breaks for the carer and/or other carers' specific services".

Review: A “review” is an examination of the client’s needs for an **existing** client and **must** include a (formal) reassessment, irrespective of whether it was a scheduled or unscheduled review.

A review is an examination an existing client’s needs and services (the care plan where it exists) undertaken at regular intervals at or by a predetermined date. A review, to be valid for these returns, must have been carried out or commissioned by the CSSR. A review by an independent sector organisation, unless commissioned by the CSSR, is not valid for inclusion.

A further defining characteristic of a review is that it is about both the presenting needs and service provision of the individual. That is, a review is not just about services or about a general service provision of which the client is one recipient. A review can take many forms, including face-to-face, by post, or by telephone. Reviews should:

- Establish how far the support and treatment have achieved the outcomes, set out in the care plan.
- Re-assess the needs and issues of individual service users.
- Help determine users continued eligibility for support and treatment.
- Confirm or amend the current care plan, or lead to closure.
- Comment on how individuals are managing direct payments, where appropriate.

For further information see the Fair Access to Care Services (FACS) guidance which is available at <http://www.dh.gov.uk/assetRoot/04/01/96/41/04019641.pdf>

A judgement has to be made about the difference between a review and what is often called a ‘tweak’ to an existing care plan. Minor variations in the care package are permissible in many CSSRs, without the necessity of a review, and these should be excluded from RAP.

Scheduled/unscheduled reviews: The distinction between scheduled and unscheduled reviews is no longer required for RAP.

Screening: This is the initial phase with a contact, when basic ‘card index’ type data is gathered (name, address, etc.) along with a sufficient indication as to the purpose of the contact. This enables staff to determine whether information / advice only or a one off basic service is appropriate, or whether further investigation and assessment are warranted. It is also the stage at which callers who have come inappropriately to the CSSR will be filtered out and / or redirected.

Processes vary between CSSRs, but commonly the end of screening is the point at which a ‘contact’ is formally re-labeled as a ‘referral’ (i.e. in those agencies where a referral is defined as a person in need of further assessment) or ‘new client’. In other CSSRs there is a distinction between types of assessment activity according to the pace at which services are put in place. For example, very simple screening assessments may be carried out for ‘fast track’ services, with a slower more thorough assessment process where it is considered necessary to provide a formal written care plan. See also *‘Referral’*.

Sequel to assessment: This measure seeks to categorise those who have received an assessment according to a range of possible sequels. It only concerns new clients. The return should be made in relation to the whole package of care and not specific services. The sequels are:

- *Some or all (new) services intended or already started (including those started and finished).* This refers to clients who are either already receiving (new) services, or who are on the books to receive (new) services, provided or commissioned by the CSSR, following an assessment; **or** clients for whom it is anticipated or intended to offer (new) services, but the intention has not yet been implemented.
- *No (new) services offered or intended to be provided.* These are people for whom the CSSR determined that there should be no new service provision following an assessment (i.e. NFA by decision of the CSSR). This may be because the assessment has indicated that no (new) services are warranted, or because the CSSR is aware that services will be provided by another agency (that is, not commissioned by the CSSR). It is also possible that (new) services are warranted but no resources are available to provide them. This would also be the relevant category for those clients who are fully funded and thus pay for their own service provision following assessment.
- *(New) service(s) offered but declined.* This is where the client declines the offer of services. It will normally apply when the client becomes aware that a payment will have to be made, and at that point withdraws any request for help.
- *Other sequel to assessment.* E.g. people who complete the assessment process but then go into hospital, pass away, or leave the area etc. before service(s) get underway.

Services: For reporting purposes there is no restriction on what qualifies as 'services', and the return should not reflect a limited definition of 'package of care'. 'Services' can be a single service or a number of different services and may be residential and / or community-based.

Services from the CSSR: Services from the CSSR are those directly provided, commissioned or funded by the CSSR. (R2.)

Service type: This has 4 categories:

- **Community-based service in own home** (includes short term residential – not respite care, and rehabilitation services).
- **LA residential care** (excludes short term residential – not respite care). Residential care provided by the CSSR.
- **Independent sector residential care** (excludes short term residential – not respite). Includes residential care provided by another CSSR. Also includes adult fostering.
- **Nursing care** (excludes short term residential – not respite).

Note that client's living in unstaffed residential units should be categorised as receiving a community-based service and not as residential care. They should then be recorded (in 'Components of service') according to the type of services that are provided, e.g. home care, professional support, etc.

Single Assessment Process (SAP): The Single Assessment Process refers to four types of Assessment - Contact, Overview, Comprehensive and Specialist. Any of these assessments can be included in RAP but they should follow the same recording principles as multi-disciplinary assessments. Therefore, if a client receives more than one of the four types of assessment referred to in the SAP then this should be recorded as one assessment event.

At contact assessment stage, according to the Single Assessment process, basic personal information is collected, the nature of the presenting problem is established and the potential pressure of wider health and social care needs is explored. Where presenting needs are straightforward and people have indicated there are no other needs or issues, it would usually be inappropriate for professionals to regard every such contact as amounting to a contact assessment as defined here. Such instances include: reversible and immediate needs, request for information about services, services under the Road Traffic Act 2000, and the provision of assistive equipment such as grab rails or bath mats. The provision of these services should not be recorded on A1 as an assessment but instead should be recorded on R2 as a new client whose needs were dealt with at or near the point of contact.

Background

CSSRs will be required to assess older people using the single assessment process from April 2004; however some CSSRs have already adopted the approach. One of the implications of the approach is that some information will be recorded just once by one professional and where necessary this will be shared with others.

Recording assessments in RAP

An example of how a client might be assessed under the Single Assessment Process is that they would first be seen by a community nurse who would initially assess the client and if there appeared to be a social care need the person would be referred to social services and would be seen by a care manager. This process should be counted as one assessment and since it includes a social care element, i.e. a Community Care assessment (carried out under section 47 of the NHS and Community Care Act 1990), it should be included in RAP.

The underlying principle is that if a Community Care assessment is conducted (under section 47) it should be included in RAP. This applies to the single assessment process in that if an assessment is carried out under SAP and it contains a social care element it should be counted in RAP. This is the case regardless of who carries out the assessment. For example if through joint working arrangements (under a section 75 agreement) a health worker carries out a Community Care assessment (under section 47) this should be counted in RAP.

If a nurse carries out a SAP assessment in which a care worker is not involved and does not include a social care element (i.e. it is not carried out under section 47), this assessment should not be counted in RAP.

Recording reviews in RAP

If someone has had a SAP assessment and is in receipt of services, then in the same way as is currently the case their needs will be reviewed, or if their circumstances change they may require an unscheduled review. Both these cases should be recorded in RAP as a review if it includes a social care element (i.e. it is a Community Care assessment carried out under section 47).

Recording services in RAP

Services which are part of a care plan and are delivered by social services or on behalf of social services as a result of a SAP assessment should be included in RAP. Other services should not be included.

Source of referral: Sources of referral in the following categories:

- Primary health / Community health (GP, Community-based professions allied to medicine, etc).
- Secondary health (Accident and Emergency, hospital occupational therapist, ward, hospice, etc).
- Self referral (including automated referrals for basic services).
- Family / friend / neighbour.
- Internal (i.e. own CSSR).
- LA Housing Department or Housing Association.
- Other departments of own LA or other LA.
- Legal agency (policy, court, probation, immigration).
- Other
- Not known.

Special services (non-typical provisions): It is known that a number of CSSRs offer assessments / services in a format or to an extent that is not typically offered by all or most CSSRs. This may be due to the particular circumstances of the community served by the CSSR, or its location. If the existence of such services is not noted in the RAP return then seemingly inexplicable discrepancies between CSSRs will be presented. Hence CSSRs offering special assessments / services are asked to identify them and quantify their use in the context of returns about new clients passed forward for further assessment (R1) and completed assessments or reviews (A1). To an extent CSSRs are asked to use their judgement in what they report, since the full range of special services is not known at DH. The current list for return includes:

- Assessments re. welfare benefits
- Assessments re. asylum seekers
- Other special services (with a request to describe them)

Subsidies (also grants): In some cases, CSSRs may provide a subsidy to an agency to provide a particular type of service or services (e.g. domestic care). For services provided via grants and grant-aided organisations, information should only be recorded on the P proformas in respect of the users of such services where the users (clients) have had a Community Care Act assessment carried out by the CSSR (or legally delegated NHS partner) and where that service forms part of their care plan, e.g. day centres. The details of the services provided through grants and grant-aided organisations should be given on the end sheet.

Information on the amount of funding provided to these organisations will be captured via the PSS EX1 expenditure return.

Time bands: These are the bands used in the waiting times returns to determine how long new clients waited for an assessment or service(s). All waiting times are based on calendar days (or weeks), not working days. The bands are:

A7 – Length of time from first contact to completed assessment for new clients whose assessments were completed during the period.

- Less than or equal to 2 days
- More than 2 days and less than or equal to 2 weeks
- More than 2 weeks and less than or equal to 4 weeks
- More than 4 weeks and less than or equal to 3 months
- More than 3 months

A8 – Length of time from completed assessment to receipt of all services for new clients aged 65 and over for whom all services were put in place during the period.

- Less than or equal to 2 weeks
- More than 2 weeks and less than or equal to 4 weeks
- More than 4 weeks and less than or equal to 6 weeks
- More than 6 weeks

A9 – Length of time from first contact to first contact with client following referral. This is for new clients who were contacted following referral during the period, in time bands, age group and primary client type.

- Less than or equal to 2 days
- More than 2 days and less than or equal to a week
- More than a week and less than or equal to 2 weeks
- More than 2 weeks

Visual Impairment: This includes those who are or who could be registered as blind or partially sighted. The statutory definition of blindness is that a person should be "so blind as to be unable to perform any work for which eyesight is essential". There is no equivalent definition of partial sight but in practice this category refers to persons who are substantially and permanently disabled by defective vision caused by congenital defect, illness or injury.

Waiting times: All waiting times are based on calendar days, not working days.

The waiting time from first contact should be measured from the time of first contact with social services or joint teams under section 75 arrangements. Three examples are given below:

1. A member of the joint team starts an assessment looking at both the health and social care needs of the client on 1st June. For RAP proforma A7 and A9 the first contact is counted on RAP as 1st June.
2. A member of the joint team starts an assessment looking at the social care needs of the client on 1st June. They then contact the health part of the team to assess the health needs on 5th June. The first contact is counted as 1st June.
3. A member of the health team starts an assessment looking at the health needs of the client on 1st June. Then on the 3rd June they contact social services as it is decided that the social care needs of the client need to be assessed. The first contact is then counted as 3rd June.

For the purpose of measuring calendar days to the completion of assessment on A7, the preferred time point is when the statement of needs and how these are to be met (care plan) is logged.

To meet the target of two calendar days from first contact first contact with client (A9), if the first contact is on day one, then the CSSR should contact the client by the end of day two. This waiting time must be calculated based on 2 calendar days, NOT 48 hours.

Welfare benefits: Help with welfare benefits matters may be classified as both a possible one-off basic service (i.e. R2 entry) or may involve a further Community Care assessment and/ or be ongoing (i.e. R1 entry).

Informing and advising people at a general level on benefits entitlements, or providing a one-off piece of assistance in assessing possible individual eligibility should be classed as a basic service and entered on R2.

If the individual is passed on for further assessment, leading to ongoing support such as assistance in gaining due benefits (e.g. providing help at a tribunal) or handling financial matters then this should be treated as more than a basic service. These clients should be recorded on R1 and then in the P forms as receiving a Community-based service (provided the service is part of a care plan/ package).

Onward referral of the client to another agency outside the CSSR should be excluded.

Section 6: Flowchart of RAP Proformas

