

Frequently Asked Questions on the Referrals, Assessments and Packages of Care Collection (RAP)

For the collection period
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1 'R' Referrals

1. What should be recorded in the 'R' returns (i.e. is it all referrals that come into this team), or is it only those referrals that on commencement of the initial assessment have social care needs identified?

The RAP deals with social services and community based services therefore the number of contacts related to social care or both social and health care should be recorded in R1. Any contacts that are related to health matters only should **not** be captured in R1.

2. Where do we include support services provided to clients receiving Welfare benefits, for example tribunal representation? These clients are not necessarily assessed and are not given care plan.

If the services these clients receive are not part of a care plan following a Community Care Assessment then they are excluded from R1 and the RAP P forms.

Providing information and advice on welfare benefits at a general level, or providing a one off piece of assistance in assessing possible individual eligibility should be classed as a basic service and entered in R2.

If the contact is passed on for further assessment leading to ongoing support from the CSSR, 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 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.

3. Could you please confirm whether telephone provision is regarded as an R2 contact (i.e. as a basic service) or as an R1 contact (i.e. a contact that resulted in a further assessment of need).

Where you record telephone provision depends upon the process the client goes through to get it. If the contact is passed on for further assessment and as an outcome of this assessment there is telephone provision, then you would record this on R1 and on the P forms as a community based service. If the telephone is provided as a one-off at or near the point of contact, following an initial screening but no further assessment follows then this should be categorised as a basic service and entered on R2.

4. Where do we record contacts and referrals with the outcome "No Further Action"?

If a client is NOT passed on for further assessment nor given information, advice or a basic service at or near the point of contact they are classed as a 'casual contact' and excluded from RAP.

Casual contacts are those 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, current clients calling on their provider staff. The key point is that they are not presenting needs to the reception staff.

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The difference between an R2 contact and a casual contact is sometimes a matter of judgement. 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. 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 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.

5. For some basic services such as the issue of a blue badge, or registration as disabled, we often have a waiting list. This means that a contact for such a service will not be dealt with "solely at or near the point of contact" and work is being stored up for the future. Does this mean that these contacts should be counted in the R1 form, or should we still count them in the R2?

The key characteristics of an R2 contact is that the individual is given information, advice or a basic service but is not passed on for further assessment of need or commissioning of service. The phrase "at or near the point of contact" does not necessarily imply that immediate action is required, although it is assumed that in the vast majority of instances the needs of the individual would be attended to within a few days. Contacts who are put on a waiting list should still be included in R2, however it would be helpful if you included this information in the notes section of the return (quantify if possible).

6. Where do we record clients who receive help with welfare benefits?

Welfare benefits advice may be classified as both a possible one off basic service (R2 entry) or may involve a further community care assessment and/or be ongoing.

Informing and advising people at a general level on benefit entitlements, or providing a one off piece of assistance in assessing individual eligibility should be classed as a basic service and entered on R2.

If the individual is passed on for further assessment leading to a care package which may include items such as representation at a welfare rights tribunal, or ongoing help with domestic financial management then this should be treated as more than a basic service. These clients should be recorded on R1 and then follow through to the A and P returns.

7. Where do we include blue badges?

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.

8. If a child becomes 18 during the reporting year and transfers from Children & Families to Adults Services, are they regarded as a "new client" for RAP and therefore recorded as referral (and then assessment etc...) to the adult team, or are they considered to already be "on the books" of the CSSR and therefore not a "new client"?

A child who reaches the age of 18 during the reporting period and transfers to the adult team should be treated as a new client in RAP. They need to have a full community care assessment as an adult. If the client was referred to Adults Services by your Children & Families team then the source of referral recorded on R3 would be 'Internal (i.e. own CSSR)'.

9. Should the child be transferred to adult services when they are 18 even though the child is receiving education which comes from the children's budget?

The RAP is concerned with adults, those aged 18 and over, and relates to adult services following an assessment. Children who are receiving children's services from the same budget do not need to transfer to adult services simply because they are 18 unless they require adult services. However, they can be included in RAP as a new client if the children's services are no longer required.

10. What if two contacts are made by the same client (re the same problem)?

The referral (R) returns are concerned with contacts, not clients. It is possible that an individual may make more than one contact during the period. However, the R forms only include contacts from **new clients**, which 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 then ceased before the time of contact (i.e. is "off the books" when the second contact is made), should be included. If the client is still on the books of the CSSR when the second contact is made this does **not** count as a contact for RAP purposes.

11. How should I record referrals if they are received via a contact centre in R3?

Even though the contact was made to the contact centre and not directly to the CSSR, as the client made the first contact themselves this should be counted as a 'self-referral'. The contact centre would be counted as an automated service for the CSSR, therefore the contact needs to be counted only once as a self referral.

There is a paragraph in the guidance which explains this situation:

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.

Other departments of own CSSR or other CSSR refers to cases such as where a client has contacted the wrong department (i.e. housing), and is then referred to the CSSR by this department.

12. Does a section 5 take priority over any other previous forms of referral episode which may have happened for a client before admission into hospital?

- **Would the same answer apply if the client had been referred previously, initially assessed and then placed on a waiting list for full assessment, prior to their admission?**
- **What is the difference between section 2 and section 5 notices?**

It would be best practice to begin assessments and discharge planning when issued with a section 2 notice rather than waiting for the section 5. However, for measuring purposes the RAP guidance was agreed with our DH policy colleagues as section 5. This does not mean that social services should not begin planning a discharge until a section 5 is received, only that for the purposes of the RAP return the section 5 should be recorded as the first contact. The essence of the questions and the reason for changing from 2 to 5 are given below:

"The original RAP guidance for A7 and A9 (upon which the indicator is based) stated that, for clients in hospital, first contact is "the date when it is confirmed by an NHS hospital to a social services department by means of a 'section 2 notice' (subject to passage of the Community Care Delayed Discharges etc bill) that the patient is medically fit and ready for discharge."

However, a 'section 2 notice' is an assessment notification informing social services that an individual is likely to need community care services when discharged from hospital - meaning they are not necessarily ready to be assessed at that point. Further section 2 notifications can be issued up to 8 days before a client is admitted to hospital. This makes it likely that many CSSRs will not only be unable to meet the target of 48 hours between first contact and start of assessment, but also that it might not be effective to try to in some cases.

The question was raised as to whether the guidance should in fact refer to a 'section 5 notice' which is a discharge notification and is normally given about 24 hours prior to discharge. Although this could also create problems in that it then becomes possible for Social Services to complete a client's assessment before the section 5 notice is issued. This would result in the date of first contact being after the date of completed assessment. After discussions with policy colleagues it was agreed to measure waiting times based on the section 5 notice.

Given the difficulties outlined above in the use of section 2 notifications as the point of first contact for RAP, and the need to consider that the D55 indicator covers people awaiting an assessment outside of the hospital, the RAP guidance is to use section 5 as the first point of contact.

However, the actual assessment and discharge planning should still begin with the receipt of the section 2.

For recording purposes in RAP, where social services have contacted the client before 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". Similarly where the assessment is completed before the section 5 notice, the time between first contact and the completed assessment should be recorded in the lowest time band on A7. Therefore all the negative values will fit into the lowest time band.

13. Could you clarify if small items of equipment (where no other services are included in the package of care) should be included in R1 or R2?

A small item of equipment provided at or near to the point of contact, following an initial screening that can be done by an OT assessor and does not require any training or adaptation is categorised as basic service, such as: ferrule, grab rail, bath rail (including fitting), and walking stick. This must be recorded in **R2** of the RAP return.

If the OT assessment is the only assessment but contains a social care element and could lead to the client receiving services that also includes a small item of equipment as a part of care package then it should be recorded in R1 and follows through the 'A', 'P1 and P2f returns only. It can also be recorded in P2s if the small equipment is delivered on the last working day of the reporting period.

Any equipment (minor and major) that has been delivered to clients in the past and they are still benefiting from them should not be included in each year's return unless that equipment has an ongoing financial commitment for its maintenance and therefore clients remain on the books.

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2 'A' Assessments

14. When is an assessment complete?

A completed assessment is one where all the components of the assessment of needs 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 this assessment. It is not required that a financial assessment has been completed.

Include all assessments that were completed in the current reporting period regardless of whether or not they started in the period. Exclude any assessments that were not actually completed by 31 March.

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.

15. If a customer has an initial assessment at a contact centre and is then passed to an area team for a full assessment - how is this recorded under RAP? Is the whole process regarded as the first assessment for a new client?

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

If a new client is passed onto a community care team for a 'full assessment', the initial contact should be entered on R1. The details of the assessment process should then be captured on the A forms.

The assessment of a client's needs and eligibility for services can only be regarded as complete once all the components of the assessment of need have been undertaken and a care plan has been agreed. New clients who are given emergency interim services or equipment as part of a fast track process should not be regarded as having a completed first assessment until the community care team has completed the 'full assessment'. The 'full assessment' is not a review, it is part of the process of establishing the client's needs and eligibility for services and therefore part of the first assessment. Where an assessment involves the input of several different teams (for example, the client may require a specialist OT or disability assessment in order to fully determine their need) the individual work of these teams should not be recorded separately. The whole process should be recorded as a single assessment event. For the purpose of measuring waiting times, the first assessment is regarded as complete when social services complete their last assessment event within the whole assessment process.

16. What happens if a contact leads to both a community care assessment and welfare benefits assessment at the same time? Do we record both assessments or is the welfare benefits assessment treated as part of the community care assessment?

This would be regarded as a multi-disciplinary assessment and therefore would only be recorded as one R1 contact and one assessment event on A1. You should treat the welfare benefits assessment as a component of the community care assessment - it should not be recorded separately.

17. If a client dies during the reporting period, do we record their age as being their age when they died or as at 31st March?

On A1 you are asked to record those clients who were passed through for an assessment or review but where, during the period, it was terminated either before its start or while in progress. If a client dies, their age should be recorded as their age at death. For example, if a 64 year old client dies one month before their 65th birthday which is in November, you would ignore this birthday and record them in the 18-64 age group.

18. Can assessments done by rehabilitation workers and deaf workers be included?

Assessments completed by rehabilitation and deaf workers should be included in RAP provided they have been commissioned by the CSSR (i.e. the CSSR is paying for the work to be done) and are part of a community care assessment. If the individual assessments carried out by the rehabilitation and deaf workers are part of a wider multi-disciplinary team assessment then they should be regarded as a contribution to the whole assessment process and not recorded separately.

19. Could you please clarify the phrase: “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”? Does this mean that the R1 contact could have been received at any time in the past?

The total of clients with completed or terminated assessments refers to clients whose assessment was completed or terminated in the current period regardless of when the first contact was made. The criteria for inclusion in the RAP A forms is that the person must have appeared as a R1 contact at some time in the past.

20. What is meant by “Some or all (new) services intended or already started (incl. those started and finished)” on A5, Col 1? If a client does not have an existing care plan and the result of their first assessment is to provide services, but at the date of completion of the assessment none of these services have actually started, is this client counted in column 1? If the client receives their first service shortly after the completion of the assessment are they still counted in column 1?

If following the assessment it is anticipated or intended to provide the client with services but this intention has not yet been implemented then the client should be recorded in column 1. The client should also be recorded in this first column if the services have already been started when the assessment is completed (this is also the appropriate column for client's whose services started and finished before the assessment was completed)

21. Should assessments for out of area clients be recorded in RAP? Where on A5 should they be recorded if we assess them but their services are to be provided by another CSSR?

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 count clients from your patch assessed by another CSSR only if you pay for the assessment. The same principle applies to services.

With regard to the sequel recorded on A5, if following the assessment it is decided that services are warranted but will be provided by another CSSR (or agency) and are not funded or commissioned by you then you should record these clients under "No (new) services offered or intended to be provided".

22. How do I record a new client in A1 page 1 if they appear more than once in the same reporting period?

The new clients should only be counted once on the first box of the A1 page1. Therefore if a client has had more than one assessment event during the reporting period, then provide the details in relation to the most recently completed assessment event (i.e. no double counting). This is consistent with the recording of reviews on A1 page 2 where we only count the latest review.

23. What sequel to assessment should we record for fully funded clients, and do we record the services under P1, P2f, P2s etc?

If the services provided to clients are fully funded by health, then it should be recorded under 'other sequel to assessments' in A5 and should not be recorded in any of the 'P' returns. If Social Services are **not** paying for the service, then the client should be excluded from RAP.

24. What sequel to assessment should we record for clients who want to go private? When a review is done should we be issuing a care plan and recording the services that we are reviewing, even though we have no input or control or even knowledge of which services are being provided?

According to RAP guidance, a fully funded client is one who pays the full direct cost of his/her services and for their care management. A client who pays solely the direct costs (charges) for services, but whose care is managed (e.g. reviewed) at the expense of the CSSR is not 'fully funded' for these returns. (P1, P2f&s, P4).

You should record the fully funded clients in A1 and under 'No services offered or intended to be provided' in A5 of the RAP return. It is considered as a good practice to issue a care plan even if clients are paying for services themselves.

25. Can you confirm that the term "Not Stated" in fact covers all other eventualities including a) where the client has refused to provide this information and b) where the authority has failed to collect the data?

This assumption that the term 'Not stated' is correct. It would be expected that CSSRs record those clients who refused to disclose their identity or as noted, the authority has failed to record clients' ethnicity.

26. What can A5/A6 exclude that A1 can not? (NB: the total figure for A5 and A6 needs to be equal to or less than the sum of the total of A1 page 1 and 2. All three sets of reports are looking at the same thing (completed assessments and reviews) and it would therefore be expected that they should be exactly the same).

RAP proforma A5 and A6 should **only** record the outcome of assessments of new clients. So the validation will be **the total figure for A5 and A6 should be equal to the total of A1 page 1.**

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2.1 'OT' Assessments

27. Are OT assessments included in RAP?

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.

For items of equipment which are issued at or near the point of contact, 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.

Where social services refer the OT assessment to an outside agency and 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.

28. We have OTs employed by health and are currently recording OT referrals, assessments, reviews and equipment fully in RAP. The OTs carry out assessments for both 'social services type' equipment and 'health type' equipment. However, we have no management control over them and there is no formal section 75 agreement. As the health OTs are under-

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staffed and slow to assess, they are affecting our waiting times measures. Should we continue to count their assessments, or do we have a case for excluding them as they are not our staff?

If the CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006 then they should include all assessments carried out and social services provided by the health partner in RAP. Legally, joint teams can only operate 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** (i.e. the assessment includes a social care element and the outcome could be either health or social care services) carried out by the team should be counted for RAP whether made by a social services member of staff or not. If an assessment is carried out purely for health services then it should be excluded from RAP. If there is no formal section 75 agreement, and the OT assessments are paid for by health then they should be excluded from RAP.

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2.2 'Mental Health' Assessments

29. Are Mental Health assessments included in RAP?

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

30. We have section 75 joint MH teams and have some queries about what we should be recording in RAP in different scenarios:

There is a contact to the joint team. If the client is allocated to:

- an NHS worker for an assessment,
- a social services worker for an assessment,

how do we record this in RAP, and if it leaves the process where is it closed?

If the joint team is operating under section 75 of the NHS Act 2006 then ALL the social care related assessments carried out by the team should be counted in RAP whether they are carried out by a social services member of staff or not.

In the examples given, the assessment carried out by the NHS/SS worker should be included in RAP if it includes an assessment of the client's need and eligibility for social care services. If the assessment is purely for health services then it is excluded from RAP, regardless of who carries it out.

31. If, after the assessment.

a. The NHS purchases services (e.g. NHS care home) and the case goes to an NHS key worker for care plan and management,

b. Social Services purchase services (e.g. private care home) and the case goes to a Social Services key worker for care plan and management how do we record this RAP?

Any **social** services that are provided by the joint teams should be included in RAP, including those provided by health staff. The CSSR can choose to delegate the commissioning of services to an NHS organisation under section 75 arrangements but the statutory responsibility for the services must remain with the CSSR. The services must be specified in the clients care plan, and the client's package of care should be managed by the social services department.

If following the assessment it is decided that **social** services are required then the sequel to assessment recorded on A5 would be "Some or all (new) services intended or already started". Details of these services (including those provided by health staff) should then be given in the P returns. If it decided that only health services are required then the sequel to assessment for A5 would be "No (new) services offered or intended to be provided". Health services should NOT appear in the P returns.

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2.3 'Joint' Assessments

32. How do we deal with activity completed by joint health and social services teams?

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 teams 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 those 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.

33. What do we do if the result of the joint assessment is that the client only receives a health provision - perhaps a nurse visiting once a week? Is this classed as a service?

If the outcome of the joint assessment is that only **health** provides **health services** then the sequel to assessment recorded on A5 would be "No (new) services offered or intended to be provided". The expectation is that those clients recorded on A5 as receiving services follow through to the P returns and health services should NOT appear in the P returns.

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2.4 Single Assessment Process (SAP)

34. Can you clarify the position with regard to the contact assessment and where it sits with RAP

Contact assessments should be included in RAP, either as a contact whose needs were dealt with at source on R2 or as an assessment on A1 – this will depend on the nature of the situation.

According to the single assessment process, at contact assessment stage basic personal information is collected and 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 contact dealt with at the source.

35. Do all the stages of the Single Assessment Process (SAP) count as a completed first assessment? For example, if a client has a contact assessment and then goes on to have an overview or specialist assessment are all these assessments counted or do we only count the first as the client is no longer 'new' when they have the other stages?

Any of the four types of assessment referred to in the SAP can be included in RAP but they should follow the same recording principles as multi-disciplinary assessments, i.e. if a client receives more than one of the four assessment types the whole process should be recorded as a single event.

If a new client has a contact assessment and is then referred on for a specialist assessment this is still part of the first assessment and should not be recorded as a separate assessment event (this is assuming that the specialist assessment includes a social care element and needs to be completed before the client's needs and eligibility for services can be fully completed and a care plan drawn up). The same principle applies to the different assessments within the SAP. If a client needs a contact assessment, an overview assessment and/or a specialist assessment, then all these assessments need to be completed before the assessment process can be regarded as complete for RAP purposes. The same principle applies to multi-disciplinary assessments.

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2.5 'Other' Assessments

36. Should Approved Social Worker Assessments (Assessments undertaken by an Approved Social Worker under the Mental Health Act 1983) be counted as assessments in RAP?

Those clients in RAP whose assessments have been undertaken by an 'Approved Social Worker' (ASW) can be counted.

In RAP definition an assessment is that it must be carried out by a professional from the CSSR to determine the client's need and eligibility of social services. By 'professional' we mean an authorised and qualified person to carry out the assessment process. The person could be an 'approved social worker' or other professional person.

37. Does a Supporting People assessment count as a Community Care Assessment?

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.

The Community Care Act 1990 is available at

http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900019_en_1.htm, see Section 47 'Assessment of needs for community care services'.

38. Which government department is responsible for Supporting People?

The Department for Communities and Local Government is responsible for the Supporting People initiative; further information is available at

<http://www.spkweb.org.uk/>

39. We have a hospital team that does assessments for clients who live outside our geographical area. Should we be reporting these assessments in RAP and if so how do we record the sequel to assessment when the client is assessed as eligible for services, but they will be provided by another CSSR or agency and not us?

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 and carries out the assessments, then that area counts them in their return and you should 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 following the assessment it is decided that services are warranted but that they will be provided by another CSSR or agency (such as health) and are not funded or commissioned by you then the sequel to assessment recorded on A5 would be "No (new) services offered or intended to be provided". If the services are provided by another CSSR then the client would be included in their return.

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3 Reviews

40. Can Individual Programme Plans (IPPs) be included as reviews? They are programme plans for clients that review one element of their service, for example day care. They take place 2 to 3 times a year in addition to the client's annual review, which covers their complete care plan. If all the client had was an IPP could this be counted as a review in RAP?

The answer is **no**, the Individual Programme Plans (IPP) should not be part of the review. These cases should be treated as 'tweaks' as explained in the RAP guidance notes under '**Reviews**'

"A judgement has to be made about the difference between a review and what is often called a 'tweak' to an existing plan. Minor variations in the care package are permissible in many CSSRs, without the necessity of a review, and these should be excluded from the return (i.e. forms A1, A2)."

41. Could you please clarify the DH definition "... a review by an independent sector organisation is excluded unless commissioned by the social services department".

Reviews should only be included in RAP if they have been carried out by CSSR staff or by non-CSSR staff operating under a partnership arrangement (section 75 of the NHS Act 2006) and carrying out the review on behalf of the CSSR.

You might find the Fair Access to Care Services (FACS) guidance helpful, in particular sections 57 to 64 on reviews. FACS is available at

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009653&chk=nadbwl

42. Do re-assessments (which are classed as reviews under the RAP guidance) still exist under the Single Assessment Process (SAP) or do they become a continuation of the SAP process? If so do we still need to count them as reviews?

Yes, re-assessments do exist under SAP. They are an integral part of the review process, and not separate from it. A 'review' under RAP is an examination of an client's needs and **must** include a (formal) re-assessment. The assessment tools used in SAP will continue to be used when a clients needs are reviewed, these reviews will therefore include a re-assessment and should be counted on RAP.

43. What are the purpose of reviews?

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.

The re-assessment part of the review should follow the process as set out above. No assumptions should be made about an individual's needs, and either an overview assessment should be carried out or the same domains that were covered at the previous assessment should be explored again.

Agencies should record the results of reviews with reference to the purposes given above. For those service users who remain as eligible agencies, should update the care plan. For those people who are no longer eligible, agencies should record the reasons for closure and, where possible, share these with the individual.

The "Fair access to care services" guidance gives CSSRs more details on the review process (see previous).

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4 'P' Packages of Care

44. What is the difference between P2s and P2f?

The difference between P2f and P2s is that:

- P2f gives the number of adults who have received community based services provided or commissioned by the CSSR at any time during the period, i.e. 1st April to 31st March.
- P2s measures the number of current service users 'on the books' to receive community based services **on the last day of the period**, i.e. 31st March, and provides a snapshot of community based services received by different types of users.

45. What referral status is required for P2f?

The number of clients recorded in P2f would be those clients recorded in form R1 (the number of contacts for new clients during the period that resulted in further assessment of need or commissioning of ongoing service) that received a community based service.

46. How do we record respite care on P2s?

With the introduction of the carers proformas C1 and C2, there has been an impact on the proformas collecting information about services for clients, i.e. P2f and P2s. There is a particular on-going issue around services where the service benefits both the client and the carer. Respite care is a service which is given to the client to enable the carer to have a break. From a CSSR perspective overnight respite care is a planned break to meet the carer's needs, whereas a short term break is a service for the client. Therefore, respite care is not recorded on the P forms.

47. Residential care clients also receiving day care services are excluded from community based services, BUT are clients living within a group home, permanent residential placement, supervised flat let & other such schemes also excluded?

Residential clients receiving day care services should not be recorded under community based services. Group homes get recorded on the SR1 return as residential.

Unstaffed residential units should be categorised as a community based service, not as residential care. They should then be categorised according to the services that are provided, e.g. home care, professional support, etc.

If a group of people live together, independently, with a shared tenancy arrangement then they would be considered to be living in their own home and any services they might receive would be classified as community based services.

48. How do we record tribunals, as they are in addition to a review but part of the package of care?

Record them in the "Other" column in the P2s and P2f forms and detail the amount and reason in the textual comment box.

49. If a care plan is produced for board and lodging is it classified as residential or community care?

For asylum seekers this is likely to be temporary accommodation and fits in as community based short-term residential care.

50. Do High Dependency Units meet the criteria for inclusion in RAP?

High Dependency Units: Referrals are made through the social worker who then completes a full assessment of needs and arranges a visit to view. Families are encouraged to input on the admission. If a visit cannot be arranged the CSO visits the client and completes her assessment of needs. Social Services then commission services and a tenancy agreement is offered to the client. A care plan is agreed which sets out individuals care needs, this is reflected in the amount of care hours delivered to the individual, e.g. assisting to wash/dress, help with meals etc. All clients are encouraged to be as independent as possible, whilst **being supported by care officers. Care plans are reviewed and monitored for any changes.**

They should be included in RAP as they meet the requirements of having received an assessment, subsequent care plans and reviews. However whether they should be included in C32 is dependent on whether they are viewed as community based or residential services. If the arrangement is that the client is effectively a tenant in their own home, and they receive services such as home help, meals etc from outside agencies, then the services provided would be considered community based services and be recorded on P2f, P2s and the "helped to live at home" indicators. However if the services (e.g. help dressing) are being provided by a member of staff for the accommodation then this is more **residential care**. P2f and P2s should relate to people being helped to live at home in the community, so if they are in residential care they would be **excluded** from P2f and P2s returns and C32. In this instance they would be recorded as being in receipt of residential care on P1. So the key is whether the dependency units should be counted as residential care or care in the clients own home.

51. When we put a client into what we hope to be a permanent residential placement, we suspend community based services for 4 weeks. After 4 weeks we review the client and make a final decision about the client's situation. This would mean either the client stays in the placement and the community based services stop or the client returns home and the community based services continue. How and where do we record this on RAP?

When clients are placed in a residential care home for a trial period then they should continue be recorded under community based services as the services are suspended and not finished. They would not be recorded under residential services for this 4-week period. After the end of the trial period if the client becomes a permanent resident then he should start to be recorded under residential care. The key is though that they are only recorded under residential care. If the client is receiving community based services whilst living in a residential care then he should be treated as receiving concurrent services. They would not be recorded under community based services but **only** under residential services.

52. Two clients who were in receipt of day care from the start of April, however in July/August they were admitted to permanent residential care, but they also continued to receive day care. How do I record these clients in RAP?

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The clients should be recorded under P1 community based services for the period April-July. When they go into residential care in July they should move to the residential care column on P1. On P2f they should be recorded in day care for the period April – July when they are only receiving day care. They would not go on P2s as at the end of the period (31 March) if they are in residential care. Their community based activity is not recorded at this point.

53. If clients have been recommended for Residential Care service following Community Care Assessment, can clients be included in the 'P1' returns if the CSSR is paying for the first three months of their stay?

The answer is Yes. If you are paying for the service for a limited period you must include them in the P1 return for the first year of the service provided and you would not include those clients in the subsequent collection period unless you continue to fund their services again.

54. How do we record resources spent on services that are designated to prevent people becoming clients in the traditional sense? Some clients, who have not gone through a formal assessment, will receive a service included in P2f, e.g. attending a day care centre. Should these clients be recorded on P2f? If not, where should they be recorded?

P2f is concerned with people receiving services as the result of a Community Care Assessment, care plan and ongoing reviews. In this case if people have an invitation to use a resource like a drop in centre, but there is no record of actual people and no ability to cross reference them with the social services department clientele then they should not be included in P2f. These people can be recorded in the Grant Funded Services (GFS) return, which collects information on those people that are NOT currently in receipt of services as a result of a community care assessment.

55. Can we include mental health clients using a drop-in centre in the RAP P forms?

Visiting a 'drop in centre' does not require a Community Care Assessment, and therefore should not be included in RAP, but can be included in the GFS return. It can be included in RAP if the client has been recommended by the social services department to have this service following a Community Care Assessment and the service(s) is managed by the CSSR. This service must be a part of client's care plan.

56. How do we record these services to keep in line with RAP?

- Reimbursements of travel
- Meals on Wheels
- Direct Payments

1. If the travel is seen as a basic or one-off service, include it in R2. Or, if the client has an assessment which states they are entitled to a taxi to take them to a day care centre, the client pays for this but social services refund them, then this would be recorded as a transport service on P2f/s.
2. Meals on Wheels should be recorded under 'meals' on both P2f & P2s but Luncheon clubs should be recorded under 'Day care'.
3. The direct payment is the service recorded on both P2f and P2s. Any services purchased with the direct payment should NOT be recorded separately. That is, if a direct payment is made to enable the purchase of a specific community based service, e.g. home care, it should be included as a direct payment but not additionally as the service(s) purchased. If a client also receives service(s) in addition to those obtained through the direct payment, then they should be recorded on P2f/ P2s under the appropriate category.

57. Can those clients who are receiving services without being assessed or in receipt of a care plan be included in RAP?

The answer is No. In order to be included in RAP, any services provided to clients must be a part of care plan following a Community Care Assessment. However, the only place where a client can be recorded in RAP as receiving service(s) without being assessed is in R2. This is the area where a client can receive service(s) after an initial screening and no care plan is required.

58. Grants are given to various providers for the provision of meals and day care services. Should the clients receiving services from these providers be included in our numbers for RAP purposes?

These clients can only be included in RAP if the services they are getting from the grant-aided organisations are provided as part of a package of care following a community care assessment which is reviewed by the CSSR and whose care is managed by Social Services. This is covered in the RAP guidance to P1 and to P2f copied below:

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

However, the GFS return collects information on those people that are NOT currently in receipt of services as a result of a community care assessment, therefore these people can be recorded here.

59. Are there any circumstances where a CSSR may count the provision of mobile wardens in the help to live at home figures?

Warden service as we understand, is provided to those clients who are living in a sheltered accommodation and the services are funded by the housing department and not by the CSSR. Therefore it should not be included in RAP unless the services are provided and funded by the Social Services Department.

60. The 'Transport' service has not been collected since 2005-06. Should transport be removed from all the P reports? i.e. if a client is only receiving transport would they not be counted in P1 and P4 either?

'Transport' services are not collected as a separate service. We understand from CSSRs that clients who receive transport services often also receive other community based services from the CSSR, for example, the client who is receiving transport to go to a day centre, also receives other services like home care, meals etc. Therefore these clients are already included in the 'total of clients' column. If transport is the only service a client is receiving following a Community Care Assessment then it should be recorded as community based services in P1 and P4 and under 'Other' in P2f and P2s.

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4.1 Equipment and Adaptations

61. What are the RAP guidelines on recording of equipment that has been issued to older people?

Any equipment that has been issued to clients who are 18 and over following a community care assessment and is part of a care plan must be recorded in P2f. P2f is a volume count of the whole year and as such can include any equipment that has been provided during the period. It should only be that equipment which has been provided during that period and not a historical record of all equipment ever provided.

In order to be included in P2s, the equipment should be on the basis of any of the criteria below.

- 1) those provided on 31st March or the nearest day that any equipment is delivered;
- 2) equipment which has an ongoing financial commitment and thus remains 'on the books'
- 3) '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.

See table on page 90 of RAP guidance.

62. How do we deal with the equipment provided to clients on loan?

Equipment on loan is also considered as a service provided and should be included in RAP when it occurs, as would be the case if the equipment in question were given to the individual. Anything other than a minor item like a walking stick ought to be included in R2 rather than R1 as the explanatory notes say.

The question of ongoing financial commitment is trickier. Our view is that (in RAP terms) a piece of equipment should be included only once when it is provided and that it would not imply (in RAP terms) any ongoing commitment. The single exception would be where a maintenance or similar cost is actually incurred in order to continue to provide the service to the client. This would rule out situations where items on loan would continue to be counted in the data even though no additional costs were actually incurred by the CSSR.

The cost of the asset loaned would be incurred by the CSSR when it is purchased rather than when the service is provided, so it is logical to assume that any additional costs should only be included in RAP when they happen, rather than when they might happen. Ongoing financial costs would be solely those to maintain the service to the client using that equipment, and the cost of the equipment would exclude any amortised element of depreciation.

63. Can we include major adaptations such as installation of concrete ramps alterations to homes such as door widening or is it just equipment?

RAP collects information on equipment and adaptations. Therefore if the CSSR has an obligation to review the installation of concrete ramps, or any other construction works, like door widening or other alterations to homes on an annual basis, then it should be included in P2s. If any such construction work is done by the CSSR but the CSSR does not have any responsibilities towards its maintenance after the work is done then this should not be included in P2s.

64. Can we include any equipment delivered on the last day whether it was part of a care package or not? By this we mean delivery of a one off single piece of equipment such as walking aids.

If equipment like walking aids is delivered to a client as part of a care package, then it should only be recorded in P2f. If the walking aids are delivered on the 31st March or on the nearest working day, then they should be included in both P2f and P2s. If the walking aids are the only need of client and are delivered or provided at the time of contact after an initial screening, then it should only be recorded in R2 as a basic service.

65. Can community alarms and warden systems be counted within the 'Helped to live at home' indicator?

As a general principle, you should only include in RAP those clients who are receiving a service from the CSSR following a community care assessment. The service needs to be included in a package of care that is subject to regular review. If the community alarm is provided to anyone who wants it, and does not require the CSSR to assess the client's eligibility for services by carrying out a community care assessment, then you should only include these clients in RAP form R2 as a basic service. However if Social Services are running the alarm system as a part of a care package, then this should be included on RAP under the P1 and P2f forms. If the alarm is fitted on the 31 March or last working day of the reporting period then it should be included in P2s.

Normally access to a warden is paid for by housing services and therefore should **not** be included from RAP, However, below is the relevant extract from the RAP guidance on sheltered accommodation:

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.

66. What is meant by 'those provided on the 31st March or the nearest day that any equipment is delivered'?

Those provided on the 31st March or the **nearest day that any equipment is delivered** means any equipment (large/small, major/minor) that has been delivered to the client either on the 31st March, which is the last day of the reporting period or the actual last working day of the reporting period (**e.g. if equipment cannot be delivered on 31st March should the day be a Sunday, then the Friday or Saturday will be counted as the last working day**) should be included in P2s.

67. How and where to record if the equipment (such as a bath rail) that has been delivered to a client after a full assessment?

In general, equipment like bath rails (including fittings), grab rails, and walking sticks, are considered as small items of equipment and these items are usually delivered to clients following an initial assessment because a full OT assessment is not required.

If the full OT assessment is carried out to determine the user needs and the range of equipment required to meet those needs and results only in a provision of e.g. a bath rail, then it should not be counted as basic service and should be recorded in 'R1', 'A', 'P1' and the 'P2f' returns. You can only record them in P2s if the equipment is delivered on 31st March.

68. What does the "free community equipment" refer to?

On the 23rd July 2002, in a statement to the House of Commons, a target for community equipment was announced, that stated all equipment should be delivered within seven working days.

The Community Care (Delayed Discharges, etc.) Act 2003 removed the power of CSSRs to charge for equipment loan or supply. The regulations concerning this came into effect on 9th June 2003. They took away one of the main barriers to equipment service integration in those places where CSSRs currently make a charge.

Since 9 June 2003, all community equipment loaned or given to people is free of charge, as are adaptations costing under £1,000 (minor adaptations) provided by CSSRs. [This change was brought about by Regulations associated with the Community Care (Delayed Discharges, etc) Act.]

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4.2 Professional Support

69. What is the definition of “Professional Support”?

By ‘professional support’ we mean the professional activity of care managers, social workers or other professional staff that are NOT part of the care management process (i.e. assessing or reviewing care needs). For a client to be considered as having professional support, the service must be included as part of their care plan. Typically professional support occurs when the care manager goes on working with a client after the process of care management has been completed, or when another professional is involved to provide therapy, support or professional input (e.g. counselling) as part of the client’s care package.

70. Would it be reasonable to include clients of suitably trained staff, although without a professional qualification, but supervised by professionally qualified staff, when they are working with clients in a professional support role?

It would be possible to include clients of suitably trained staff without a professional qualification as long the service being provided was part of the clients care plan following a Community Care Assessment (and not just part of the process of care management).

71. The RAP guidance refers to professional support being provided by a CPN. Could you explain in what circumstances that would be included, given that they are health staff?

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 staff. Therefore, if a CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006, and the professional support provided by the CPN is specified as a service in the client’s care plan then this would be included in RAP.

72. Where do I record the provision of a social worker as is legally required between assessment and the provision of a package of care for mental health clients?

As professional support.

73. Under which column heading is the work of Occupational Therapists to be included?

As stated above, 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 staff. The inclusion of professional support as a ‘component of service’ is to enable the activity of professional/ clinical staff, such as social workers, Occupational Therapists, CPNs, qualified counsellors etc. to be identified. The only exclusion is work that has already been counted because it is part of the care management process or assessment activity.

74. How do we record funeral arrangements for clients? The general consensus was that they should be recorded as professional support, even if an assessment has not taken place.

The RAP guidance states that for client's to be included in the P forms the services that are provided or commissioned by social services or an NHS health partner must be part of care plan following a Community Care Assessment. Services provided to clients who have not received a Community Care Assessments should be excluded from RAP.

If the funeral arrangements are not agreed in the care plan then they should not be included in P2f and P2s. Otherwise they should be recorded in the category 'Other'.

75. A Client is not receiving services from social services. An enquiry regarding potential abuse (physical, emotional, financial etc. of the client is received by social services and an investigation launched.

The investigation is conducted by a senior care manager. Does the investigation count as the provision of professional support?

The answer is No. 'Professional support' is one of the components of community based services which can be provided to clients following a community care assessment. In this case, although the investigation is carried out by professionals this activity (in the context of RAP) is neither an assessment nor a service.

Therefore the investigation can not be counted as the provision of professional support.

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4.3 Direct Payments

76. What are 'Direct payments'?

'Direct payments' collected in RAP 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. Vouchers or similar 'credits' are not direct payments.

77. Where should services under direct payments be recorded?

Direct payments are one of the components of community based services and RAP does not need to know what services a client is buying from a monetary grant. Direct payments can be made as one-off payments or as ongoing payments at regular intervals. Any services provided to clients must be agreed in the care plan. If the service is stated as 'direct payments' in the care plan then it should be counted under the relevant column.

If the client has received a **one-off payment in a form of voucher** to buy equipment such as a washing machine then the client should only be recorded in P2f under 'Equipment and adaptations' and not under 'Direct payment'. Vouchers or similar 'credits' are not considered as direct payments.

If a one-off payment is made as a monetary grant to buy an item such as a washing machine then it should be recorded under the 'Direct payments' column in P2F. However, if the payments are made on the 31 March or the last working day of the period then those clients should be included both in P2f and P2s and the figure should be calculated for the PAF AO/C51.

78. Who cannot be included in RAP as receiving monetary grant under 'Direct Payments'?

Direct payments is one of the components of community based services that clients aged 18 and over receive from their Social Service Department which help them to live in their own home. Adults such as **parents of the disabled children and carers** should not be included in RAP even though they are receiving direct payments.

79. Are people who have had a one-off payment to purchase their own services at any point to be counted along with those who are planning on purchasing short term residential care – not respite?

Clients may be provided with a voucher in advance to buy 'short term residential care - not respite' service when needed, however, that one-off voucher payment does not come under the 'direct payments' category. Respite care should be recorded as a service for the carer in the C2 proforma.

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4.4 Sheltered Housing and Supported Living

80. Can the tenants in the very sheltered homes be included in RAP as we provide them with luncheon club meals?

Sheltered accommodation itself is not a service (e.g. a residential service). If they are not receiving any support associated with the accommodation and are effectively living in their own home, then any other support they might receive, such as luncheon club meals, would be considered community based. The meal service provision would be recorded under community based services (assuming that they have had an assessment to receive it and that you will be monitoring/reviewing their care). If the clients physically go to the luncheon club to receive their meal, then it should be recorded as 'day care'. If the luncheon club delivers the meal to the client's home then it would be recorded under 'meals'.

81. How are the following services treated in terms of the RAP?

- **Sheltered Housing: Is this considered a community based service or a residential service? Is the client's sheltered housing residence considered their own home or not?**
- **Dispersed Housing and Supported Living: Should these two services be community based or residential in nature?**

If the only support offered to these clients is a warden available for emergencies then this provision should not be recorded on RAP.

If a client is fitted with an alarm with access to a warden as a basic service provided by social services, this would be included on the RAP R2 form as there is no ongoing commitment.

As these clients receive regular input in terms of help with budget etc, which is considered home help, then for RAP they should be included under community based services and then under home help.

▪ In P2f/s could "Other" include sheltered accommodation?

Sheltered accommodation itself is not a service. If they are not receiving any support associated with the accommodation and are effectively living in their own home then any other support they might receive such as meals on wheels or home help (provided by someone not employed by the accommodation) would be recorded under the relevant community based services columns on P2f/s (note that these services must be part of a care plan following a Community Care Assessment). If they are receiving support from the accommodation then this is not their own home but residential accommodation and would be recorded as such on P1, not P2f/s.

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4.5 Jointly Funded Services

82. How do we deal with joint working teams where a health colleague completes an assessment for a client (considering both clinical and social care needs) and then continues to work with the client putting a package of care in place?

If the CSSR is operating a partnership arrangement under section 75 of the NHS Act 2006, then they can include these assessments 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.

83. If, given the situation above, the non-social services department worker completes the assessment and concludes that no package of care is required, but does provide on going professional support, can this service be counted as helping the client to live at home? In most cases MH clients receive professional support from a non social services department worker (such as a CPN).

This depends on whether you regard professional support as constituting a care plan. If the result of the assessment is that the client does not need a care plan then presumably the client has failed to meet the CSSRs eligibility criteria. If the support is regularly reviewed and a care plan in place then you could include it in the RAP P forms. Where delegated authority has been granted to the team, any social care related activity should be counted whoever carries it out within the team.

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4.6 Services not funded by the CSSR

84. Should services paid for by Supporting People be included in RAP?

In principle any services relating to adults and the elderly ought to be included in RAP where these services are delivered as part of a package of care following a Community Care Assessment and where the services are funded via the social services budget. 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.

85. Should Supported Housing Services be included in RAP?

If the supported housing service is provided by the housing department or other agencies, it should **NOT** be included from RAP.

86. Should clients receiving services from Voluntary organisations or Grant aided organisation be included in RAP?

Services provided via grants and grant-aided organisations, information should be recorded on the P proformas only if 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. Therefore any services provided by VO or grant aided organisations should not be included in RAP unless the client have a proper community care assessments. If the client is receiving services without having a community care assessment, then they can be recorded in the Grant Funded Services return.

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5 'C' Carers

87. Can you provide clarity in the breakdown of data for tables C1 page 2 and C2 page 2, particularly with regards whose age group is recorded?

Both C1 page 2 and C2 page 2 collect information about carers' assessments and services by the age group and the primary client group of the person cared for. The RAP proformas C1 page 2 and C2 page 2 were introduced to capture the information as follows:

1) **C1 page 2** captures the information on the number of carers assessed separately or jointly with the person cared for by the age group and the primary client group of the person cared for and **not by the age group of the carer.**

2) **C2 page 2** captures the information on the number of carers receiving services from the social services department by the age group and the primary client group of the person cared for **and not by the age group of the carer.**

88. Can you clarify that RAP guidance encourages the identification of ALL carers, not just substantial and regular ones? How do you decide if someone is substantial and regular if you haven't identified them?

The definition of a carer for RAP 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*'. 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 see the DH practice guidance on Carers & Disabled Children Act 2000 which is available at <http://www.carers.gov.uk/pdfs/practiceguidecarersparents.pdf>

89. Where do we record services received by carers in their own right? If they receive services from the voluntary sector do we record this and how?

The RAP Guidance says –

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.

For the inclusion in the carers return C2, the services provided to carers must be result of the outcome of the assessment. Therefore any services provided to carers without an assessment can **not** be recorded. You can only count those carers who are receiving services from the Grant Funded Organisation following an assessment provided the services are funded by the CSSR, otherwise include in the Grant Funded Services return.

90. How do we record a contact that comes to Social Services as a carer and requests a carer assessment, but the cared for is not known to Social Services?

If the cared for person is not a client of the CSSR or has refused an assessment for, or the provision of Community Care services then the carer has the right to an assessment of their needs under the Carers & Disabled Children Act 2000, provided the person cared for would be eligible for community care services.

The assessment should be recorded in the column "Number of carers assessed or reviewed separately" on C1.

91. A carer is receiving services in December 2007 but their last assessment/ review was in 2006-07. Should I include them in form C2 of the 2007-08 return?

No, where services are provided to a carer following an assessment or review they should be recorded in the reporting period that the carer's assessment or review took place. For RAP purposes, a carer cannot receive services in December 2007 on the basis of the assessment that has been carried out in 2006-07. The C2 return is the subset of C1, which means the number of carers receiving services within the reporting period following an assessment or review as reported in C1.

92. Where is the provision of information as part of the Carer's Grant recorded?

The provision of information as part of the Carer's Grant should be recorded under 'information and advice only' on proforma C2 **not** under 'other carers' specific services'.

93. In A5, we capture the outcome of the sequel to either assessment or reviews. Does the same rule apply to the carer in C2?

RAP table C2 is not exactly the same as A5 or the P forms for clients. C2 only collects information about services being provided to carers who have been assessed or reviewed during the period. If a carer is not assessed or reviewed during the period then they will not be recorded in C 1 or C2 forms.

Under "outcome of assessment or review" the C2 protocol states that where a carer receives a review, any new services agreed, as well as other services that are continuing should be recorded.

The Department of Health wanted to know more about the types of services being provided to carers but rather than asking for information on services being provided to all carers, it was linked to the assessment and review process. The carer data collection was set up in this way to make it practical for CSSRs to record this information. As the carers PI (C62) is about carers getting the services they need we need to include all the services they were getting, not just the new ones agreed at the latest assessment or review.

94. Where to record if the 'Direct Payments' service is provided to carer?

Direct payments service are not collected separately for carers. It will be recorded under 'other carers' specific services' column in C2.

Carer receiving direct payments for any carer services should be recorded in PSSEX1. A letter was sent to all CSSRs on 30/09/2004 about the changes in the data collection system from 2004-05 which is available at

<http://www.dh.gov.uk/assetRoot/04/11/80/68/04118068.pdf>

Below is the relevant extract -

Expenditure and Unit Costs (PSS EX1) Return
<u>Direct payments</u>
The PSS EX1 collects data on numbers receiving direct payments at 31 March for the following groups:
Disabled children (aged 16-17)
Carers (e.g. parents) of disabled children
Young carers (aged 16-17)
Carers (for carers services)
Adults aged 18-64 (all client types)
Older people (aged 65-74)
Older people (aged 75-84)
Older people (aged 85+).
An additional average payment would be calculated using the direct payments expenditure for family support services and the total of the activity data for disabled children (aged 16-17), carers (e.g. parents) of disabled children and young carers (aged 16-17).

95. If clients move into residential care, but the main carer, e.g. the wife/daughter etc, still providing a large amount of time giving emotional support etc to the client - Also these carers may still be receiving services in their own right, e.g. attending support groups/counselling to help them cope with the situation etc. Can we still count these people as carers receiving services in their own right, even though the cared for person no longer being supported in the community?

A carer can receive services in their own right only when they are a carer. For RAP, we consider a carer as someone who looks after the person in their own home. If the person moved to residential care, then the carers' responsibility diminished as these services will be carried out by staff in the care homes. Therefore they should not be included in C2.

However, a carer can be a client in their own right and can receive services like attending support groups and counselling as a client following an assessment. The services can then be included in 'P' returns under 'professional support' and not in C2.

96. Is the guidance saying that when a carer was offered a separate assessment at the point her father was assessed, yet declined it, can we still count it as a joint assessment, as her needs were considered, even though she felt she didn't have any at this point in time?

If a carer is offered a 'Joint Assessment' whilst assessing the client, but decides to decline then you should count this instance as a declined assessment and therefore should be recorded only in the third column of C1.

97. In some instances carers will continue to receive carers services in their own right after the person they are caring for has passed away - e.g. emotional support/counselling etc. These will be services that were set up specifically to meet the needs of their caring role (i.e. not services in their own right as a client) - in this example can we still continue to count these people in C2, even though the cared for person is no longer being counted for RAP purposes?? In some cases the services for the carer may continue for a significant length of time after?

You can still record these carers in C2 if they are receiving services even after the cared for person has passed away. However, CSSRs should reassess the carer's needs as soon as possible after their bereavement as it is likely that they will no longer be eligible for 'carer's' services. They may of course be eligible for a Community Care Assessment in their own right at any time. However, if your CSSR have agreed to provide the services to carers till June 2007 then you should include the carer in 2007-08 return as well as long as the carer has had a review during the next reporting period.

98. If a carer has been assessed and services identified, yet those services are to be provided by a voluntary organisation, in some instances the CSSR may provide a grant to the organisation, but in other instances the services may be provided to the carer by a voluntary organisation that the CSSR doesn't fund - can we still count these services for the client, as we have assessed the carer as needing them, even though there is no financial contribution from the CSSR in delivering the service?

If the services provided to the carer by the voluntary organisation are not funded by the CSSR then those carers should not be included in C2. If the carer has been provided with the information and advice about the voluntary organisation, such as giving them the names of those organisations and the contact numbers then they should be counted in C2 under 'Information and advice only' column. However, the carer should be recorded in C1 if they have been assessed by the CSSR.

99. Can you clarify whether a joint assessment of client & carer means that the assessment for both of them is carried out at the same time? Also, if the intention was to carry out a joint assessment, but the Social Worker is unable to do a carer's assessment at that time (for example, due to time pressures), but arranges to return at another time to do the carer's assessment, would that be classified as the carer being assessed separately?

Being physically present with the person cared for does not always constitute joint assessment. An assessment is classified as a joint assessment if the needs of the carer are considered as part of the client's assessment, i.e. the assessment looks at the needs of both the client and carer together.

If a client is assessed jointly with their carer then the carer should be included in C1 as having received a joint assessment and the assessment of the client should be recorded on A1 and the other assessment forms. The same applies to reviews. If the social worker completes an assessment of the clients needs and then returns at a later date to carry out an assessment that looks purely at the needs of the carer in relation to their caring role then this should be counted as a separate carer's assessment on C1.

100. Can we provide data for PAF C62 on carers under the age of 18?

Yes you can. However, in order to include this in PAF C62, the carer who is under 18 must be providing a substantial amount of care on a regular basis for another individual who is aged 18 or over. Therefore if the under 18 carer is caring for someone who is also under 18, then they should not be included in C62.

101. How do I record clients' details in the 'C' returns if the carer and the person cared for live in two different areas?

There is no specific guidance on whether the cared for person and their carers will have to be resident in the same geographical area. For example, if the carer lives in Salford then the carer's details will be recorded in Salford return and the 'cared for person's details can be obtained from the carer. We are aware that there are number of people who are not registered with their social services department for receiving any services but they have carers to look after them.

If you are unable to obtain the relevant information of the person cared for then you need to record the person in the total row and put an explanation in the notes box.

102. Would these carers be eligible for inclusion where the carers have declined an assessment and we do not have the carer's name?

The RAP return does not capture the names of the carer but the information is recorded by their age bands. Therefore, the number of carers declining an assessment should be recorded in the appropriate column in C1 by their age group. If carers declined assessment on the phone because they do not require and their personal details remain unknown then those carers should be **excluded** from C1 returns.

103. How do we determine 'who needs more care and attention'?

- **If the carer is looking after 2 people who have the same primary client type, same age and both of them receiving same service**
- **If one client may receive a day care service and another homecare - Is there an order that we should rank services in or should we just look at the total number of hours of care provided or cost?**

The CSSRs may have problems in identifying 'who needs more care and attention'. Our suggestion is:

Scenarios	Recording method
Both the cared for people have learning disabilities aged 65 and over but one of them is receiving 'day care' service where as other is receiving 'home care' service.	In these cases the one whose cost for services is more than the other should be recorded in C1 page 2 and C2 page 2.
The carer is caring for 2 or more people and both of them have identical PCT, age group and receiving same service with the same caring cost.	This recording will be on the arbitrary decision by the CSSR who needs more attention and care.

104. If a carer declines an assessment how should this be recorded in RAP?

If the carer refuses both assessments

- with the client and
- without the client,

then you should record this event under the column 'carers declining an assessment'. However, if the carer had a separate assessment at the beginning of the reporting period and after some time the carer had another assessment with the client then you should record the most recent event in the relevant column in C1. There should be no double counting.

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6 Waiting Times

Additional guidance for waiting times can be found in the 'Waiting times summary and guidance for CSSRs to sample data for the waiting times indicators' document at <http://www.ic.nhs.uk/pss/returns/2008>

105. Measurement of time from first contact to first contact with client: The PAF definition of D55 refers to 'less than or equal to 48 hours' but the RAP return A9 refers 'less than or equal to 2 days'? How are the two time bands interpreted?

Although there is a slight difference between the PAF definition of D55 and the actual data collection method used in RAP proforma A9, the information on waiting times is collected in RAP by days and weeks and not in hours as defined in PAF. The time band '**less than or equal to 2 days**' on A9 has been in use since 2003-04 with the approval of Policy Division, Strategic Information Group for Adult Social Care and Adult Review Group.

The waiting times in RAP are based on calendar days and not working days. All the waiting times are collected in RAP by days and weeks and not in hours. The clock starts ticking on the day of contact, not the day after contact. The correct interpretation is, for example, if a client contacted the social services department at 3pm on Monday, that date will be counted as first calendar day and the contact with the client should be made by the Tuesday afternoon which will be within two calendar days. In effect this means that for some clients the waiting time will need to be 24 hours or less if they make contact towards the end of the first day.

106. If an assessment has already been completed before a section 5 notice, should we use the section 5 date or the assessment completion date to calculate waiting times from assessment to service provision?

Yes, if the assessment is completed before the section 5 notice then the date for completed assessment should be counted when the section 5 notice has issued. However the waiting times for A7 and A9 should be recorded in the lowest time band. All the negative values must fit into the lowest time band.

Also, if the client has received all their services before the assessment has been completed, for RAP proforma A8 the date of receipt of all services should be the same as the date the assessment was completed, i.e. services were delivered within the same day. Therefore for A8 the client would be recorded in the shortest time band, namely 'within 2 days'.

107. How do I record the waiting times in A8 if the services started before the completion of the assessment?

Where the client has received all their services before the assessment has been completed, for RAP proforma A8 the date of receipt of all services should be the same as the date the assessment was completed, i.e. services were delivered within the same day. Hence for A8 the client would be recorded in the shortest time band, namely 'Less than or equal to 2 weeks'.

108. How should I record the waiting time 'from first contact made to the CSSR to the first contact with the client' in A9?

The first contact with the client should be counted when the CSSR first contacts the client. Contacts can be face to face or over the telephone. Both the methods of contact are accepted for recording in A9. This change was agreed by the Strategic Information Group for Adult Social Care as the intention behind this information was to ensure the client is contacted directly soon after the referral. The aim of the target and PI is around person centred care, so the key thing is to ensure the client is OK, let them know that there has been a referral to Social Services and to let them know what you are doing within a short space of time.

It is possible that assessment could be started on the same day when the CSSR first contacted the client. It is also possible that client can be contacted on the phone first in order to arrange a suitable date so that an 'appropriate member of staff' can visit the client and start the assessment process. However, as we are not capturing any information on the start of assessment, therefore if the contact day and the start of assessment are on the day then that date will count as first contact with client and that can be included in the denominator in part (i) of **AO/D55** (BVPI 195).

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7 Performance Indicators

109. Should clients in residential and nursing care at 31st March be counted in AO/C29-32 if they are also receiving a community based services?

No. The PAF indicators AO/C29 –32 are considered as ‘helped to live at home’ indicators. The young and adult clients receiving community based services which help them to live in their own home as independently as possible. These indicators will not work if clients live in residential care or nursing care other than living in their own home. Therefore the clients who are living in residential or nursing care and are concurrently receiving CBS should not be included in either P2f or P2s but only be recorded under P1. This means that these clients will be **excluded** from PAF indicators AO/C29-32.

110. Can people with learning disabilities, receiving concurrent services be counted under PAF C30?

No. This information should not be included in the indicator C30. The clients recorded as receiving community based services on any part of RAP should be those living at home. If a client is in a residential or nursing home care they should *only* be counted under this service category on the appropriate RAP return (P1 page 1-3) and hence would *not* be included in the indicator.

111. Can the following services be included in order to improve performance in the area of C32:

1) Community alarm and Warden services

2) Supporting people services e.g. shopping from RSL and housework

As a general principle you can only include in RAP and PAF C32 clients who are receiving a service from the CSSR following a Community Care Assessment. The service needs to be included in a package of care that is subject to regular review.

- 1) Clients in sheltered accommodation should be excluded from RAP. These clients should not be included in the P forms if they are not in receipt of a package of care that is regularly reviewed. The installation of an alarm with access to a warden is a basic service and should only be counted in RAP on the R2 forms, as there is no ongoing commitment.
- 2) These clients could be included in RAP under Home care provided their care is managed by the CSSR.

112. Would older people using a luncheon and leisure service funded by the CSSR, but not assessed, be included in C32?

No. Both luncheon and leisure service are part of ‘Day care’ service. Therefore the clients receiving *Day care* service can be included in the PI AO/C32 only if the clients have been assessed prior to receive service. If the clients are receiving services via grants provided by social services without a CC assessment then they should not be included in the RAP but you can record these clients in the ‘End sheet’.

113. We provide financial support, in the form of grants and non financial support to many voluntary organisations and groups. In some cases the clients may not be assessed or receive a care plan, but are indirectly helped by social services to live at home. If we can identify the clients and ensure that we are not already counting them into our return for receiving another service, can we include them in the relevant sections of P2f and P2s?

No, the clients you are referring to cannot be included unless they are receiving a package of care. The RAP guidance states that for inclusion in P1 a client should be receiving a package of care following an assessment. Clients counted in P2f and P2s are subsets of those in P1. These clients would be counted in the GFS return.

114. PAF D40: If a client's review is terminated because the client dies or because they refuse to continue with the review, can the client still be included in the numerator for D40?

The numerator of D40 is taken from the RAP proforma A1 page 2 (first box); the number of existing clients receiving a review during the period either by the social services department or non-social services department staff. Therefore if the client dies before the review is completed they should be recorded in A1 page 3 only and should **not** be counted for D40. However if the client dies after the completion of the reviews then that client will be recorded in A1 page 2 and should be counted for D40. The key point is that the details provided must relate to the most recent event. The client cannot have both a completed and a terminated review, and therefore it would **not** be possible for them to appear on all 3 pages of the return.

115. Could you please confirm that D55/D56 - A7, A8, A9 - only accept an assessment as started after a face to face meeting between worker and client?

In 2005-06 the RAP return A9 was redefined to capture the waiting time from first contact to CSSR to first contact with the client rather than 'first contact to start of assessment'. The first contact with the client should be counted when the CSSR first contacts the client. Contacts can be face to face or over the telephone. Both the methods of contact are now accepted for recording in A9. Previously telephone contacts were accepted when face to face contacts were not possible. In the additional Waiting Times guidance, examples (v), (vi), (vii) and (viii) in Annex H of Annex E are all examples of when the first contact with a client is through a telephone call. This guidance can be found at the following web link <http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections/collections-2008>

116. Can a carers voucher scheme that is processed through the direct payments service be included within the figures for C51, or as this is a service for the carer, it should be included within the C62 (Services for Carers) return and not the C51 return?

As the voucher is a carer's service it should be included in PAF C62.

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8 RAP – Internet Data Collection (IDC)

117. Is there any way I can see what my Performance Indicators taken from RAP will be, calculated on the data I have entered in my return?

Yes. If you click the 'Keystats' button at the top of the page on the IDC, you can view your CSSRs indicators for the previous year and also the indicators you will get for this year, based on the data you have entered.

118. I attempted to print out our return, but the lower parts of the forms do not print. Can you help?

If you choose to print the proformas, in order to obtain the best print format you should select print from the drop double FILE list menu and then from the print frames option you should select "As shown on screen". The default is "only the selected frame" so this will need to be manually changed hence the need to select print from the FILE menu.

119. Can we enter part of the data on a table - or do we have to enter all the data at once? We entered all the data for "P1 clients under 65" except one cell which we were uncertain about. When we saved it we got thrown right out of the system. When we went back there was no trace of the data, so we re entered the data and tried not to save it but were told that we would lose it. What are we supposed to do?

You can save the data at any point and then go back and fill in any missing cells later as long as you haven't authorised the return. It appears from the problem that you may have exceeded the time out period before hitting the save button.

120. Our RAP return is now completed; can you please advise me as to what action I have to take?

The system will not allow authorisation until all the proformas have been completed. This means that you cannot send us your data until they are authorised. Once all the data has been entered into the system and all validation errors resolved or explained the return must be authorised by the Data Manager. If you are unable to provide data for a proforma you should open the relevant proforma and save it as blank."

In order to authorise you must 'login' as RAPMAN because the return must be authorised by the Data Manager. You will then see the 'Authorised' button on the top.

121. How do we know that the authorisation process has been successfully completed?

To authorise the return you must be logged on as the manager. You need to choose the 'Authorise' option from the menu bar and then you should see the following text in red below the list of validation errors:

Please use the check box below to authorise this return
NOTE: Once authorised, no further amendments can be made
I hereby authorise this return:

You need to click on the check box in order to authorise the return. Once the return is authorised you will not be able to make any changes to the RAP data when you next log on the IDC system.

122. We have authorised our RAP return but wish to make some minor changes to our data. How can we do this?

If you wish to make changes to your data, you will need to contact us and we will change the status of your return back to “in progress”. Once you have made the necessary amendments you will have to re authorise your return.

123. Is there any validation button to see if the data I have entered is correct?

There is no such button as 'validation button'. Click the 'save' button after you have inputted the data. If you have any errors then all errors will come up with a space for explanation where you need to clarify the errors.

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