**ASC CLD Q&A Session 2- Answers**

*On behalf of the CLD team, we wanted to thank you for your time and input in the Carer’s Q&A session. We have been working through the feedback and additional questions from this session.*

*Please see the questions and corresponding answers below:*

**Our grant-funded voluntary sector partners carry out some Carers Assessments which are non-statutory assessments and do not assess carers’ eligibility for services under the Care Act, but assess for voluntary sector carer services. Would it be correct to map these as “Short Term Assessments” under Assessment Type, due to the fact they are non-statutory/there is no eligibility determination?**

Local authorities will have a range of differing funding arrangements with third party organisations. In some instances, the grant-funded sector partners will be able to provide records containing the relevant details of carers they assess and support. Subject to appropriate data sharing agreements, these can be used to submit carers information within CLD.

In other instances, the funding may be more general (block grant) and the authority would have no expectation that the funded sector partner could provide carer records. In such cases, we would not expect an authority to submit records for this group.

In the scenario set-out in the question, the information should be submitted as short-term assessments if:

* The grant-funded sector partner is expected to maintain these records; and
* The appropriate data sharing agreements are in place

If these conditions are not met, this activity should not be included in the CLD return.

**Carers Joint assessments – Where carer assessment is the primary assessment and the cared for person does not require a long term service but we are supporting the carer therefore the cared for person is by association. How will this be recorded?**

If the assessment is of the carer only, this should be recorded as a carer assessment, where the client type should be recorded as ‘Carer’.

If it is a joint assessment of the carer and the cared for person, this should be recorded as a joint assessment with the assessment event capturing the cared for persons details. In this instance, a record can be provided with the ‘Carer known by association’ client type, to provide the carer’s personal details.

In this scenario set-out in the question, we appreciate that the carer may be the primary focus of the assessment, but if this is a joint assessment, it should be recorded as described in the above paragraph.

The recording of the assessment type depends on who is being assessed, not the service outcome. Further events will show the services provided to the carer.

**Is carers assessment classed as long or short term assessment? Especially if we have only provided info and advice.**

If eligible needs as set out under the Care Act are being assessed, this is classed as a long-term assessment.

The outcome of the assessment should not determine the assessment type categorisation. In the scenario set-out in the question, the outcome of a long-term assessment may be receiving info and advice.

**Is the expectation that the total hours caring per week will be captured at assessment and review and for all carers regardless of service provision? How does this work if the hours are flexible?**

We acknowledge that this information may not currently be collected in a structured way on systems, but LAs are invited to share the information if it is available.

In the scenario set-out in the question, if total hours caring per week are captured at assessment and review, this should be provided regardless of service provision. The information will be based on how carers report their hours per week.

**Replacement/respite care is recorded on the cared for persons file and not the carers file as it is the cared for person who is subject to the service. How should this be recorded?**

We acknowledge that carer respite may be provided in different ways by different LAs resulting in different ways of recording the information.

* If replacement/respite care is recorded on the cared-for person’s file, we expect that the record relating to the provision will contain the cared-for persons details. This should be recorded using: service type ‘Carer Support: Support involving the person cared-for’, service component as ‘Carer Respite’. If there is no other event in the submission file relating to the carer, a record should also be provided with the ‘Carer known by association’ client type, to provide the carer’s personal details.
* If replacement/respite care is recorded on the carers file, we expect that the record will contain the carer’s person details. This should be recorded using: service type ‘Carer Support: Direct to Carer’, service component as ‘Carer Respite’. Where it is through a direct payment, this can be recorded through the delivery mechanism ‘Direct Payment’.

In the scenario set-out in the question, the first of these two options apply.

**Where an individual is a client and a carer, their PSR would most likely be a non-caring reason, e.g. Personal Care. A person only has one PSR at any given time (as it is the 'primary' support reason and not a client category). Will the CLD expect a PSR of 'Social Support: Support to Carer' for any carer related events included in a submission?**

Yes, a PSR of “Social Support: Support to Carer” should be recorded for any carer related events in CLD submissions because this is the most relevant support reason for carer events. Therefore, we would expect to see a PSR of ‘Social Support: Support to Carer’

For the service user, the guidance remains that the PSR should be the most relevant PSR for each event.

**What does " support involving the cared for is provided" and "direct involvement" on page 16 of the Guidance specifically mean?**

“Support involving the cared for is provided”- services categorised as service type ‘Carer Support: Support involving the person cared-for’. Respite care is included in this as it is support for the carer but it is support for the cared-for person as they are receiving the care.

‘Direct involvement’ includes: all joint or carer assessments and reviews; services provided to the carer; and carer support involving the person cared for.

**Additional Questions:**

**Will there be opportunities to have follow-up discussions on these topics? e.g. another session like this one after the clarification has been released**

Yes, we are hoping to extend the Q&A sessions to review topics we have discussed and revisit any unanswered questions.

**We use a triage/conversation step between referral and assessment. A carer could receive info & advice or be referred for universal offer services from this conversation step- would we record this as a short-term assessment or should be included as part of the referral/contact?**

This is our answer from the assessment’s session: In general, an initial conversation that forms part of a multi-stage approach does not involve an assessment of eligible needs and should therefore be recorded as requests, not assessments.