



BRITISH GERIATRICS SOCIETY  
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Patron: H.R.H. The Prince of Wales

Submission by the British Geriatrics Society to the Department of Health on:

**COMMON ASSESSMENT FRAMEWORK FOR ADULTS: A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning**

The Society is delighted to be given the opportunity to contribute to this debate.

**Question 1: Do you have any general comments about the Common Assessment Framework?**

The principle is sound but requires information systems that are joined up between different health sectors and between health and social care; we are a long way from this!

**Question 2: Do you think there are any other advantages to be gained by making improvements in information sharing around assessment and care and support planning? Do you have any major concerns?**

Sharing of information / reduction of duplication should speed the assessment process and aid provision of service to patients / clients. A common database should ensure better delivery of care to all who need it. Recent cases of lost databases raise the concern of confidential information, relating to very vulnerable adults, getting in to the public arena. As stated earlier there is limited confidence in current information systems either within health or social care and therefore no confidence that they will be able to talk to each other. If this concern proves founded then staff will become disillusioned and cease to use these systems.

As individuals may move between health districts or social service areas then there needs to be a means of transferring information between areas not just within an area, hence we need a national system.

The finalised system must recognise the inherent differences in data gathering (history taking) between health and social care workers and individual workers will need to be educated as to what needs to be shared and what does not.

**Question 3: In your experience, are these mechanisms sufficient for developing improved information sharing around assessment and care and support planning to support delivery?**

No, as IT support is generally weak in health and social care and staff movement disrupts progress. Local solutions are not the answer this needs a national solution that can be implemented in all localities. Current information transfer systems are imperfect; do not work out of hours (1700-0900 Mon - Fri), week-ends or bank holidays. Health needs to be able to access information 24/7 365 days a year.

**Question 4: We would welcome your views, whether these are general or specific, on the set of principles for assessment and care and support planning. In particular, in your experience: a) are there any additional principles that should be included?**

No

**b) will these principles all retain their relevance within the developing context of self-directed support?**

Yes

**c) what will help ensure that they are sufficiently embedded into practice?**

That the CAF becomes an expected way of working, which not only improves delivery of care but is in itself easy to use. Improved joint working between health and social care will make sharing of information the norm rather than the exception.

**Question 5: We would welcome your views on care coordination. a) Should the care coordination role be open to people who are not professionally qualified (including the person themselves)?**

Yes

**b) Should carers be able to act as care coordinators?**

Yes although this will be difficult in a number of situations from the common 'not being good with forms' etc to the real issues that arise when the carer (usually a spouse in this situation) has mild cognitive impairment / early dementia or is just unrealistic about what is needed (in either direction).

**c) Are there specific circumstances in which carers should not undertake a care coordinator role?**

When they do not wish to take on this role or where there is any concern regarding Protection of a Vulnerable Adult

**Question 6: Assuming that appropriate arrangements for informed and explicit consent are in place, would you be content to share assessment and care and support planning information with others with a legitimate interest, including: a) health and social care practitioners? (for example, in community settings: GP, district nurse, acute and specialist hospitals and children's services)**

Yes

**b) wider community support services? (such as housing, neighbourhood services and organisations from the voluntary and private sectors providing support)**

Yes

**c) services providing financial and/or employment support? (such as benefits advice or applications, employment, education and training)**

No. There would need to be the obvious caveats regarding confidentiality and safety of data. As frail older people frequently attend acute hospitals there must be sharing of information between primary health care, social care and secondary health care. It should be possible to define user levels for data access so that not every agency was able to access all data.

**Question 7: We would welcome your views, whether these are general comments or detailed, in-depth ones, on the common shared information set proposed. In particular, are any aspects missing or are there aspects that should not be included?**

There is a danger that once these assessments are completed that no account is taken of changing circumstances - increasing / decreasing or fluctuating needs, as may occur with chronic progressive neurological conditions or fluctuations with dementia and delirium. Who will be responsible for updating assessments and validating them? Mental capacity is not an all or none phenomenon, the individual may have capacity in some areas and not in others.

**Question 8: Do you support the proposed approach in which NHS Connecting for Health systems would be used to provide the IT systems for sharing information across social care and wider community services? What difficulties or issues might this approach raise?**

Yes. See above

**Question 9: Are you aware of any alternative approaches that could be tested?**

No

Professor Graham Mulley  
President  
For and on behalf of British Geriatrics Society  
17<sup>th</sup> April 2009

### **The British Geriatrics Society**

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,500 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

### **Geriatric Medicine**

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.