


# Common Assessment Framework for Adults

*A consultation on proposals to improve information  
sharing around multi-disciplinary assessment  
and care planning*



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# Executive summary

This consultation document is about improving the quality and efficiency of care and support through improvements in the sharing and use of the information that people provide during assessment and care and support planning. Its focus is on care and support for adults, underpinning the continuing development of personalisation.

The sharing of people's personal information within assessment and care and support planning is an essential component in:

- providing a better experience for those who contact and use health and social care services, their families and their carers; and
- building further capacity, capability and efficiency into care and support arrangements.

'Putting people first' (Department of Health, December 2007) set a clear focus for improvements in the personalisation of care and support, the development of self-directed support and the need to continue moving towards better targeted and earlier intervention to support individuals. It emphasises the wider nature of community support arrangements and the importance of sharing information appropriately across health and social care, and more widely with organisations involved with housing and supporting people, and with providers in the third and private sectors.

At the same time, people's expectations of what the different professionals involved in their care and support should be aware of have continued to change. People have told us of their increasing frustration at having to repeatedly provide the same information to the different organisations and professionals involved in their care and support arrangements.

What can be shared through computers and information technology (IT) rather than on paper has increased significantly over the years. Use of IT, by the individual, within and between local organisations and by professionals has grown. However, across health, social care and wider community support arrangements, the sharing of information has developed at differing rates, using different approaches from paper-based exchange to more high-tech solutions. These have developed to meet local needs and do not facilitate exchanges of information beyond local boundaries.

The advantages that sharing the right information at the right time give to the quality of an individual's care and support arrangements must be set against the potential for disadvantage from the underlying risks of unauthorised access. It is important to maintain the security of personal information, making sure that consent arrangements are explicit, understood and recorded, and that only those people who are authorised and need to can access it.

**Section 1 of this consultation** sets out the reasons for the development of the Common Assessment Framework (CAF) for Adults. There are further gains and improvements to be made, building on the practical implementation of the Single Assessment Process (SAP) for Older People and the Care Programme Approach (CPA) in mental health. People's expectations of care and support arrangements have also grown. They have voiced a clear need to reduce the number of occasions when they are asked for the same information by the different people who may be involved in assessing, planning or delivering their support needs.

The scope of what a CAF for Adults would cover is set out in **Section 2**. The development of the CAF looks to support the investment already made in local areas by building on existing assessment and care management frameworks rather than replacing them.

**Section 3** identifies the principles on which the CAF for Adults should be built and under which assessment and care planning should take place. Again, this builds on what we know from the SAP and the CPA. The general principles on which they were based have been introduced at a local level, and now need to be developed and reframed to ensure that they take account of personalisation and self-directed support, placing the individual at the centre of how assessments are made and care and support plans are developed.

**Section 4** responds to the fact that there are wider elements of support that underpin people's independence and the personal outcomes they want for their lives and, as a consequence, the support available to them. This will often require wider sharing of relevant information – about housing, for example – with outside statutory or user-led organisations, or third sector or private providers. Within established guidelines, all sharing of information is based on the premise of explicit and informed consent by the individual. Section 4 addresses the extent of information sharing across traditional organisational boundaries, as well as the potential use of collated, anonymised data in planning and research.

To optimise use of IT, the current electronic information systems that hold individual care and support records need to be able to interconnect and interface with a range of different types of electronic assessment. **Section 5** sets out an example of a personalised outcome-focused set of information, common and appropriate to a range of different assessments, that could form the basis of what information could be regularly shared.

**Section 6** covers proposals for the IT systems or mechanisms that could be used to store and share information records so that they can be held securely and safely and be accessible only where appropriate consent has been provided and only to those who have a legitimate interest. It proposes a development of the current approach taken by NHS Connecting for Health, but also asks for suggestions on alternative approaches that could offer similar or enhanced security.

## The consultation process

To respond to this consultation, please visit:

[www.dh.gov.uk/en/Consultations/index.htm](http://www.dh.gov.uk/en/Consultations/index.htm).

The online consultation has been designed to make it easy to submit responses to the questions. On registration you will be provided with a user name and password to enable you to edit or update your submission as many times as you wish while the consultation is open. The consultation runs from 22 January 2009 to 17 April 2009.

**We would prefer you to make your response online.** However, if you are unable to respond online, you can request a paper feedback form by writing to, or telephoning:

Sarah Alder, Project Manager  
Dialogue by Design  
Ambassador House  
Brigstock Road  
Thornton Heath  
Surrey CR7 7JG

Tel: 020 8683 6602

**All postal responses** should be sent to:

CAF Consultation  
Department of Health  
Room 123  
Wellington House  
133–155 Waterloo Road  
London SE1 8UG

**All responses by email** should be sent to [caf@dh.gsi.gov.uk](mailto:caf@dh.gsi.gov.uk).

**Please note:** After the consultation has closed, all responses will be published unless respondents specifically request that their response be kept confidential. Your name will **not** be displayed against your comments. Submissions made on behalf of organisations will be displayed with the organisation name. This will apply to all responses whether submitted online, posted, faxed or emailed. Please indicate on your response if you want us to treat it as confidential. You should also read the information below about confidentiality and data protection.

## Criteria for consultation

This consultation follows the Government's Code of Practice on Consultation. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks, with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[www.berr.gov.uk/whatwedo/bre/consultation-guidance/page44420.html](http://www.berr.gov.uk/whatwedo/bre/consultation-guidance/page44420.html)

## Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator  
Department of Health  
3E48, Quarry House  
Leeds LS2 7UE

e-mail: [consultations.co-ordinator@dh.gsi.gov.uk](mailto:consultations.co-ordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

## Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

The Department of Health will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary of the consultation

A summary of the responses to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:

[www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm).

# Introduction

1. This document sets out our proposals for and seeks views and consensus on the development of a Common Assessment Framework (CAF) for Adults. The high-level objectives of the CAF are to support:
  - delivery of a better experience for those who use health and social care services and their carers, including those with long-term conditions, by promoting and supporting a proportionate but thorough and more person-centred assessment of need and care and support planning; and
  - improvements in the capacity, capability and efficiency of the health and social care systems, by providing a basis on which the development of shared electronic care records can be taken forward – this will facilitate more efficient, timely and secure exchange of information around assessments, support and care planning and allow better coordinated support to be delivered, placing the individual, family and carers at the centre of the process.
2. Looking at an individual's requirements for care and support, by means of a needs assessment, is an essential part of both health and social care practice. Although it may take a number of different forms, it is this assessment, its focus, proportionality and the manner in which it is undertaken that should deliver a shared understanding of a person's wishes and their requirement for care and support. This is the basis for an individual and the professionals involved to develop and agree a care plan and arrangements for support. The secure sharing of appropriate information must be central to ensuring that effective, efficient, person-centred care and support plans are developed and put into place. It also provides the basis on which any associated risks can be managed, and changes kept under review.
3. We expect to see increased demands placed on the NHS and social care services because of people's rising expectations and an ageing population. There is a wealth of evidence that increased numbers of disabled people, people with long-term medical conditions and people with physical frailties due to the ageing process are all living longer. Many will need health and social care support. All will expect and demand a more personalised approach to the advice and support services that should be available to help meet their particular needs and allow them to continue to live good quality, independent lives. There is also a growing understanding of how the needs of the whole family and the individual impact on each other and how it should be taken into account.
4. At the same time, people have told us of their irritation at being asked for the same information by different organisations, and their growing expectation that all those

involved in their support arrangements will share relevant information. Maintaining the security of people's information and making sure that consent is understood and recorded must underpin any sharing of personal information.<sup>1</sup>

5. Over the past five years a consistent policy agenda around personalisation has been developed and the following documents have been published:
  - *Improving the life chances of disabled people*<sup>2</sup>
  - *Independence, Well-being and Choice*<sup>3</sup>
  - *Our health, our care, our say*<sup>4</sup>
  - *Creating Strong, Safe and Prosperous Communities*<sup>5</sup>
  - *Think Family: Improving the life chances of families at risk*<sup>6</sup>
  - *Independent Living Strategy*<sup>7</sup>
  - *Carers at the heart of 21st-century families and communities*.<sup>8</sup>
6. The direction of these policies and the practice that is being put in place respond to what people have told us they want. This includes:
  - support and advice that will help them to remain independent and healthy and give them increased choice and control;
  - services, advice and support, delivered safely and effectively in the community or at home, that are seamless and proactive; and
  - services, advice and support that are integrated with and tailored to their individual circumstance, needs and wishes.
7. The Social Exclusion Unit published *Think Family: Improving the life chances of families at risk*, which showed the dramatic impact that parent-based family circumstances have on the outcomes and life chances of children. It demanded a more family-focused approach from agencies that work with adults and those that work with children.
8. Further policy developments have resulted in a formalised, sector-wide agreement on a shared vision covering the components of transformation and the implementation of personalisation and self-directed support to deliver independent living for all adults. This has been set out in the following documents:
  - 'Putting people first'<sup>9</sup>
  - 'Transforming social care'<sup>10</sup>
  - *High Quality Care For All* (Lord Darzi's Review).<sup>11</sup>

9. It is within this context of personalisation and self-directed support that the CAF proposals have been set and will be further developed. The CAF needs to provide a flexible approach to enable arrangements to support and respond to these and future challenges.
10. The proposals for the CAF are designed with a focus on the information and support necessary for the delivery of multi-disciplinary assessment and the encouragement of self-assessment. The proposals aim to support and foster practice that is both holistic and person-centred. The CAF is not intended to be another assessment tool or assessment toolkit. Rather, it is a framework for more effective information exchange to enable independent living through the improved integration of community support services, support received in hospitals and intermediate care and longer-term support in the community and in residential care settings.
11. The CAF for Adults will need to enable, drive and support the delivery of improved personalised outcomes for all people, but especially those with complex longer-term support needs by:
  - delivering a person-centred approach to assessment (self-assessment) and support and care planning;
  - facilitating better identification of the needs of people with complex longer-term support needs (including carers with support needs); and
  - underpinning seamless service delivery between the NHS and social care by improving integrated multi-disciplinary working.
12. The proposals are built on the past experience of implementing the Single Assessment Process (SAP) for Older People, the Care Programme Approach (CPA) and person-centred planning. During the development of these proposals, the views and experience of around 60 organisations from across the health, social care and the independent and third sectors were captured through a Department of Health Policy Collaborative.
13. The CAF does not seek to replace the various approaches to the SAP, CPA or other evidence-based specialist assessment but aims, through the common information they collect, to provide a framework for sharing information which is useful to the individual, the different professionals that may be involved in the assessment and, ultimately, to independent and third sector providers. As such it will encompass all adults, including:
  - older people;
  - people with long-term medical conditions;
  - people with mental health needs;
  - people with a learning disability;
  - people with a physical and/or sensory impairment;

- people with other complex support needs; and
- carers.

It is essential that the CAF for Adults is connected to similar developments for children, and is linked, particularly at the transitional stage from child to adult.

14. This consultation asks questions on the general direction of the framework and, where appropriate, on more specific, practical aspects of its implementation and operation. We will report back on the responses to the consultation and seek to take account of them in a practical way as part of the development work being undertaken through a small number of demonstrator sites.
15. The demonstrator sites will look at the practicalities of implementation over the next three years. Support for the CAF demonstrator site programme has been provided through the Comprehensive Spending Review 2007 (CSR07) capital funding of £11 million per year (covering the years 2008/09, 2009/10 and 2010/11). A call for expressions of interest to take part was issued prior to this consultation<sup>12</sup> and responses from local partnerships are currently being considered. The work of these local sites will be the subject of a detailed and in-depth evaluation that will test and seek evidence of effectiveness and cost-effectiveness.
16. Additional funding to all authorities through the Social Care IT Infrastructure Capital Grant<sup>13</sup> (£15 million in 2008/09, £16 million in 2009/10, £17 million in 2010/11) has been made available. This is aimed at helping authorities to develop their IT infrastructure and to facilitate improved information sharing. This is expected to deliver benefits to information exchange locally and, subject to the evaluation of demonstrator sites, allow a more rapid and effective take-up of the CAF, as and when appropriate.
17. This consultation document is supported by three appendices which contain:
  - evidence relating to the benefits reported from local communities where the SAP has been implemented, at Appendix 1;
  - guidance on proposals to develop a CAF Information Set, as the basis for enabling health, social care systems and others to interface and as the basis for integrated electronic care records, at Appendix 2; and
  - recommendations of the Assessment and Care Planning Policy Collaborative in respect of the assessment process, at Appendix 3.
18. The consultation document is also supported by the following initial impact assessments:
  - an initial regulatory impact assessment; and
  - an initial equality impact assessment.

19. As part of the consultation and through the work of the CAF demonstrator sites, a privacy impact assessment at an appropriate level will be conducted.
20. During the consultation period and throughout the practical work to be undertaken by the CAF demonstrator sites, we are particularly interested in comments, ideas and evidence concerning the potential impact of the proposals on equalities.

**Question 1:**

Do you have any general comments about the Common Assessment Framework?

(Please note that subsequent questions will relate to the specific sections of the document.)

# 1. Rationale for developing a Common Assessment Framework for Adults

## Public views and expectations

1. From a number of public consultations about health and social care undertaken in recent years, we have received a clear message from the public about being asked the same questions and giving the same information time and time again. For those who have regular contact with a range of health and social care services, this is not just a significant irritant – it also diminishes their feeling of being treated as an individual and seems to confirm a view that the information they give is not valued. There is now an overwhelming expectation that all the professionals involved in the assessment of a person's needs and their care and support planning should be aware of the individual's general circumstances and preferences and to start from a common understanding. The reality is that this is not always matched by current practice.
2. The idea and development of a Common Assessment Framework (CAF) builds on the local and national approaches already undertaken and aims to respond in a practical way to the wider cross-government commitment to provide more personalised and integrated public services.

## Professionals

3. Similarly, for those involved in the assessment of a person's needs and their support and care planning, there is a multiplicity of information, including a person's agreed needs, individual preferences and life aims or personal outcomes, which will be essential to discussions and agreements on person-centred, individualised care and support planning. Evidence gathered from the introduction of the Single Assessment Process (SAP) for Older People (Appendix 3) shows this and, as we develop self-directed support and personalisation, the ability to access a range of information will become more important.

## Potential for cost efficiencies

4. There is persuasive evidence that the duplication of information that should be shared not only reduces the effectiveness of joint working and its focus on the individual, but is also inefficient. It is believed that there are efficiencies and cost efficiencies to be gained from improving information sharing. There is some initial evidence to support this view from the evaluation of the SAP and practical experience provided by the Assessment and Care Planning Policy Collaborative. This is set out in Appendix 1.

5. Based on the analysis that local communities have produced about the potential benefits of sharing information through electronic care records to support multi-disciplinary working, we believe that the proposals for a CAF for Adults will also help to prevent avoidable admissions to hospital and residential care and reduce lengths of stay on longer hospital admissions.
6. The proposals set out in the consultation are, therefore, based on the views and the available evidence from the introduction of the SAP for Older People and the Care Programme Approach (CPA), that all adults from all service-user groups with longer-term support needs could benefit further from improved integrated multi-disciplinary working. In particular, we have taken the view that the general principles on which these are based and within which they are framed are sound, appropriate and will support the personalisation of care and support.
7. From the development and local implementation of the SAP and the CPA we have a range of experience and evidence that has assisted in putting together proposals on the CAF. While many authorities have extended the use and approach of the SAP from older people to all age groups, local experience indicates that obstacles to multi-disciplinary working persist. These have a wider resonance with the experience of information sharing across wider community settings and include:
  - problems of information transfer at key transition points, particularly between support delivered in the community and hospitals;
  - lack of infrastructure and incentives to facilitate multi-disciplinary assessment and integrated working across agency divides and between adults' and children's services;
  - inefficient information-sharing processes and failure to adopt a proportionate (tiered) approach to assessment, creating unnecessary burdens on front-line staff;
  - lack of engagement from clinical staff who frequently saw the introduction of the SAP as increased paperwork;
  - poor integration – the SAP has not always been well integrated with other processes, such as the CPA, assessments of registered nursing care contributions and continuing care assessments;
  - inconsistent implementation of the SAP and its IT support across England;
  - the need for developments in self-assessment tools and support to be better integrated into the wider approach to assessment; and
  - challenges to effective and efficient information sharing between areas and across England caused by the diversity of existing SAP tools in use.

These and other complex issues will need to be addressed if a CAF for Adults is to be successfully implemented.

**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?

## 2. What would a Common Assessment Framework for Adults look like?

1. 'Putting people first'<sup>14</sup> set out a shared vision which the Common Assessment Framework (CAF) for Adults is designed to support:

'Ultimately, every locality should seek to have a single community based support system focused on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.

This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens.'

2. The proposals for a CAF for Adults are intended to provide a generic framework within which improved multi-disciplinary and inter-agency working will be fostered. The proposals include a specific focus on improving the interface between health and social care provided in the community. However, the principles and processes proposed have the potential to be extended further, for example to include housing support services, employment, financial or benefit information and education and training.
3. Local arrangements for sharing information across health and social care, and across the wider community, are at different stages, have been developed to respond to local conditions and use a range of approaches from paper and fax to connected IT systems. The development of the CAF looks to support the investment already made in local areas by building on existing assessment and care management frameworks rather than replacing them.
4. A CAF for Adults will:
  - set out the principles which should inform assessment, care planning and support based on a personalised and person-centred approach (Section 3);
  - establish how best to fit information sharing into developing assessment and care and support planning arrangements and the introduction of self-directed support and personalisation (Section 4);
  - establish the basis of a shared set of information (Section 5); and
  - be supported by mechanisms to hold and share information securely and appropriately between electronic care records across the NHS, social services and, subsequently, other organisations involved in care and support (Section 6).

5. The CAF is **not** intended to be:

- another assessment tool or document of practice guidance;
- a rigid structure to be followed under all circumstances;
- a barrier to the policy of personalisation and self-directed support; or
- primarily a performance management tool.

**Question 3:**

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

# 3. Principles of a Common Assessment Framework

## Introduction

1. The principles we outline below have been informed by the practical advice of the Assessment and Care Planning Policy Collaborative and evaluation of the introduction of the Single Assessment Process (SAP). From this we have taken the view that the general principles on which the SAP and the Care Programme Approach (CPA) are based and within which they are framed are sound, appropriate and will support the personalisation of care and support.
2. The Common Assessment Framework (CAF) will need to develop within the context of assessment processes that are compatible with council duties in law and with policy guidance.
  - Councils have a statutory duty to assess needs and to provide help to people who meet their eligibility criteria.
  - Councils also need to continue to meet their statutory duties to carers.
  - Councils need to ensure that financial upfront allocations/resource allocation systems are compatible with guidance on fair access to care.
3. The introduction of self-directed support and personal budgets will require systems that are compatible with requirements for assessment and review, including the single assessment process and the development of a common assessment framework.<sup>15</sup>

## Consent

4. A right to confidentiality is provided under common law and essentially requires that information held in confidence should not be disclosed or used for purposes that the individual concerned has not consented to. Confidentiality may, however, be set aside in the public interest or where statute requires it. Further guidance can be found in *Confidentiality: NHS Code of Practice*.<sup>16</sup> The Data Protection Act 1998 (DPA) regulates the processing of personal data through an enforceable set of good practice handling rules known as the data protection principles. These principles are expressed in general terms. Amongst other things, they require personal data to be processed fairly and lawfully; obtained only for specified and lawful purposes, and not further processed (including disclosure to third parties) in a way that is incompatible with the original purposes for which the data were collected.
5. A multi-disciplinary assessment should only be undertaken where a person has given their consent to the assessment process. Similarly, consent must be given before a person's information is shared with and within separate organisations, in line with legal

requirements and obligations. In some cases people may specify that they are content for some services, but not others, to have access to their integrated care record and such a preference must be respected (in some cases this could prevent information being shared electronically). It should normally be explained to the person that the consequences of withholding consent could prevent further assessment and care which might benefit them. Where information is shared between the NHS and social care, or indeed with wider community services, explicit consent for information to be shared will be a requirement of any system.

6. An NHS Care Record Guarantee already exists; it provides a commitment that NHS organisations will only use health records in ways that respect people's rights and promote their health and well-being. This document should continue to inform decisions about who can access a person's care record. A similar Social Care Record Guarantee is being developed by the Electronic Social Care Record Implementation Board.

'We will not share health information that identifies you (particularly with other government agencies) for any reason other than providing your care, unless:

- you ask us to do so;
- we ask and you give us specific permission;
- we have to do this by law;
- we have special permission for health or research purposes; or
- we have special permission because the public good is thought to be of greater importance than your confidentiality.<sup>17</sup>

7. There is a clear consensus that the sharing of information is essential to providing the background for improved multi-disciplinary working which should support better person-centred and personalised approaches to care and support. However, views begin to diverge significantly when considering exactly what information it is most useful to share and how far or wide that information sharing should go. Our proposals have been developed within the context of the Data Sharing Review<sup>18</sup> and the principles set out in the NHS Care Record Guarantee, which itself builds on legal requirements.
8. The initial proposals outlined for the CAF have a specific focus on improving the interface between health and social care provided in the community. However, we anticipate that the principles and processes proposed could be extended more widely in the future, for example to include housing support services, financial or benefit-related information. The CAF demonstrator sites have been encouraged to test out the practical implications of extending the information exchange to other agencies within their area of work and ensuring adequate data security arrangements.

## Mental capacity

9. Consideration should always be given to a person's mental capacity to consent to an assessment and information sharing, in line with the Mental Capacity Act 2005, Code of Practice.<sup>19,20</sup> If a person lacks the capacity to give consent, then a decision should be taken:
  - with due regard to any advance directives which that person may have authorised; and
  - by a Deputy, or a person who has Lasting Power of Attorney (where one exists).
10. Where neither of the above applies, a decision must be taken in a person's best interests and the response must be proportionate to the level of need or risk; such a decision is ultimately a professional judgement. In due course, NHS Connecting for Health will be issuing guidelines about information sharing where a person lacks capacity to give their consent.

## Proportionate assessment of need

11. The Assessment and Care Planning Policy Collaborative agreed that the different levels of assessment defined within the SAP were generally helpful, and they stressed that levels of assessment should always be proportionate to need. Evaluation of the SAP showed a significant increase in multi-disciplinary assessments recorded following the introduction of the SAP, but this was more likely to be a response to greater integration of health and social care (around intermediate care, for example) than an increase in health needs. This suggests that that some improved targeting of multi-disciplinary assessments is needed both on the grounds of cost and to more accurately identify those who would benefit from the process.
12. Our proposals for the CAF for Adults begin with a focus on improving the basis for information sharing at the multi-disciplinary level, but appropriate information needs to flow through and inform all levels of assessment. Where information from a one-off assessment (for example through a web-based self-assessment for community equipment) falls outside the local arrangements for the SAP, this may have implications for sharing information and the connectivity of local IT systems. These local systems will need to respond to and take account of developments.
13. Assessment is about putting together information on a person's needs and circumstances, making sense of that information in order to identify needs, and agreeing what advice, support or treatment to provide. Throughout the process, re-ablement is a critical part of assessment, especially when care, support and treatment are being considered.
14. **Self-assessment.** The term 'self-assessment' has developed to cover a range of potential options within which an individual is in control of their own assessment. This can, in

some respects, be seen as a component of proportionality and as engendering a person-centred approach. Increasingly, self-assessment is being provided for some aspects of support through web-based systems (for community equipment, for example); these allow for a person to provide details of their circumstances and needs so that they can be provided with appropriate support or advice. Wider developments such as the Expert Patients Programme, for people with long-term conditions, increasingly allow people to exercise control over how their conditions are best managed.

15. Self-assessment may also be extended to become part of how an assessment and care plan are undertaken. Linked specifically to the development of personalisation and self-directed support, people are encouraged to assess their own circumstances and support needs in partnership with the professional whose role is to advise, support and help to identify and resolve potential risks.<sup>21</sup> This is often referred to as **supported assessment**.
16. **Contact assessment.** Contact assessments should be about 'screening-in' people who have more complex needs or who may require support from a number of different services. Contact assessments take a number of different forms, depending on the context or the agency leading the assessment. The underlying principle should be to identify the nature of a person's needs, to identify whether a more in-depth assessment is required to understand the impact of their needs on daily life and to identify the full range of support needs.
17. **Overview (or multi-dimensional) assessment.** Where a health or social care worker believes that a person may benefit, individuals should be offered an overview assessment of need. This should include consideration of their mental, physical and social well-being, as well as any needs arising from their immediate environment (for example their family environment or unsuitable housing). Multi-dimensional assessments can support multi-disciplinary working by identifying the need for a range of other health and social care workers to contribute to the assessment process.
18. As part of an overview assessment, it is important that the impact of a person's needs on their family, carer(s) and any other dependants be considered throughout.
19. **Specialist assessments.** Specialist assessments are undertaken when an assessor identifies the need for more information about the cause or nature of a presenting need, or about how to meet or manage that need.
20. **Review of needs.** Although individual assessments are often a snapshot of a person's situation at a specific point in time, a number of assessments undertaken over a period of time help to build up a more comprehensive picture of a person's circumstances. Reviews of needs should be undertaken proactively and regularly for people who have long-term support needs, or for those identified as at risk of developing needs. There is evidence from assessments of older people that a one-off assessment has little

preventative value, but that a number of follow-up home visits can reduce loss of independence.<sup>22</sup> It is likely that this relates to the timely detection of new problems.<sup>23</sup>

21. Reviews take on a particular significance in an outcome-focused system. Where specific, personalised outcomes have been agreed as part of the assessment and care and support planning process, progress towards these objectives should be assessed at review and the actual outcome recorded.
22. **Carers' assessments.** Adult carers undertaking regular or substantial care are entitled to an assessment of need in their own right,<sup>24</sup> whether or not the person they care for is having an assessment.<sup>25</sup> It is important that, wherever a carer has a potential support need, an assessment is offered to identify whether the carer needs support to continue in their caring role and to maintain their well-being. Consideration also needs to include the appropriateness of caring responsibilities taken on by 'young' carers. So far as possible, the needs of the individual and their carer should be looked at together.

## A person-centred approach

23. Assessments of need incorporating self-assessment and any subsequent care and support planning should be undertaken in line with the key principles of a person-centred approach. In particular, the characteristics of a person-centred approach include:
  - encouraging those who can and wish to undertake an assessment of their own needs – a self-assessment – to do so, with support as necessary, providing the basis for giving individuals the maximum choice, control and power over the care and support they need;
  - where a more formal professional approach is appropriate, involving people fully in the assessment and care and support planning process by listening to their views about how they want to live their lives and the type of care and support that best suits them and helping them to make informed choices;
  - the identification of and agreement on potential risks associated with any care and support plan;<sup>26</sup>
  - involving close family members and carers where appropriate (in terms of considering the impact of a person's needs on them, taking account of their views about the person's needs and recognising the contribution that they can and do make to a person's support and life); family members may have high-level needs themselves that could have an effect on the individual being assessed, so it is important to look holistically at the family;

- focusing on a person's capacities and on the things that are important to them (now and for the future), including their cultural and spiritual needs, and identifying the support they need to make a valued contribution to their community – this should include assessing a person's information requirements, capacity for self-care<sup>27</sup> and the need for support to participate in work or education;
- a shared commitment between members of a multi-disciplinary team which recognises a person's rights and focuses on improving their quality of life; and
- an ongoing, iterative process which involves listening, learning from experience and action.

#### Focusing on individual outcomes

24. A person-centred approach to assessment that encourages self-assessment and self-directed support must focus attention and care and support planning on improving personal client and patient outcomes. There are various articulations and terminology used about how personal outcomes can be drawn together. All cover very similar ground. The CAF and its proposals for information sharing have been based on what people have consistently identified as key personal aspirations in their responses to consultations for key government policy documents: *Independence Well-being and Choice, Our health, our care, our say* and *Strong and Prosperous Communities*. It is from these that much of the current SAP IT software has been developed. The outcomes adults have identified as important are:

- improved health and emotional well-being;
- improved quality of life;
- making a positive contribution;
- choice and control;
- freedom from discrimination;
- economic well-being; and
- personal dignity.

25. In terms of assessment, we need to be clear that these outcomes may be a way to stimulate a person's own consideration of their needs, and what support or care they personally feel would help them achieve these outcomes. The list is also a way in which common information can be structured to give an effective, overall view of a person's circumstances and needs. It is not intended to restrict or confine appropriate client, patient and professional interactions within assessments, nor should it be seen as a rigid structure.

## Identifying the impact of a person's needs on family members and carers

26. It is particularly important that assessment goes beyond identification of a person's specific needs. It must also identify the impact of a person's needs, including the impact of failing to meet those needs, on other people, such as their family and/or carers. Where it is identified that the well-being of a carer, a dependant or another family member is at risk, that person should be offered an assessment or self-assessment of their physical and mental health and social well-being in their own right. Where such an assessment is requested by a carer, it must be provided. Making the right intervention for individuals will need to take account of the wider needs of the family and carers and, where appropriate, a more holistic approach should be taken. Indeed, wider support and community services are increasingly coming together with a focus on the inter-relationship between family members. The Family Pathfinders and Extended Pathfinders for Young Carers project<sup>28</sup> has been set up within a number of areas and will test and inform the development and implementation of the 'think family' approach set out in *Think Family: Improving the life chances of families at risk*.<sup>29</sup> The 'think family' approach encourages adults' and children's services to be more joined up and to support families with complex needs.
27. Adults who have parenting responsibilities for a child under 18 years may require help with these responsibilities. In such cases, councils may also have a duty to provide services under section 47 of the Children Act 1989 to safeguard and promote the welfare of children in their area. Where appropriate, the *Framework for the Assessment of Children in Need and their Families*<sup>30</sup> should be used to explore whether there are any issues relating to children in need and their parenting. Under the Children Act<sup>31</sup> a service may be provided to any member of a child's family, if it is provided with a view to safeguarding or promoting the child's welfare.
28. There has been some perceived confusion about where the responsibility for supporting disabled parents lies.<sup>32</sup> It is important to recognise that adult social care services have an ongoing duty to support parents in carrying out their parenting role, while children's services carry out their responsibilities under the Children Act. Above all, it is crucial that adults' and children's services work together to provide adequate support for parents, children and families.

## Care and support planning

29. In practice, assessment and care and support planning are intrinsic parts of one whole and continuous process. They are intertwined and both need to be based on a person-centred and integrated approach. Care and support planning is essentially a process for delivering care and support that:

- promotes choice and control, placing the individual, their needs and choices at the centre of the process and facilitating better management of risk;
  - focuses on outcomes that people want to achieve, including carers;
  - is planned, anticipatory and proactive, includes emergency/crisis planning and has contingency planning to manage crisis episodes better;
  - ensures that people, especially those with more complex needs, receive coordinated care packages, reducing fragmentation between services;
  - identifies opportunities for re-ablement;
  - provides support and information to help the person self-care/self-manage their condition(s) and prevent deterioration;
  - facilitates joined-up working between different professions and agencies, especially between health and social care; and
  - results in something tangible – an overarching care plan that is owned by the person but can be accessed by those providing direct care/services or other relevant people as agreed by the individual, for example their carer(s).
30. The process requires an effective means of sharing information between members of multi-disciplinary care teams. Detailed information is provided within a range of supporting publications available on the Department of Health website.<sup>33</sup>

#### Care coordination

31. It is established good practice for all adults with long-term support needs to have a named person whom they can contact when needed. For those with more complex longer-term health and social support needs, a specific person should be given the responsibility for coordinating an individual's support. This would include coordinating the assessment or self-assessment processes, where contributions from a number of different people are required, and the development and management of a care and support plan and any identified risks. The use of care coordination is well established within mental health services where the CPA is employed.<sup>34</sup> The proposed care coordinator function would include aspects of the 'care tracker' function developed as part of the Integrated Cancer Care Programme (ICCP).<sup>35</sup>
32. One of the most important aspects of the delivery of personalised care and support for people with long-term conditions is that coordinated services are provided when they are needed. This is particularly important for people with complex needs, who may be assessed as needing care and services from a number of professionals across different organisations. Care and support coordination works best when there is a clearly identified person undertaking it within a multi-disciplinary team, whether it is a professional assuming the role or someone whose job it is exclusively. The name and contact details of the care coordinator should be recorded and everyone in the team

should know who the care coordinator is and understand their role and function (also see Section 5, paragraphs 18 and 19).

33. The person undertaking the care coordination role would need to have a good understanding of the local health and social care sectors, have good communication skills, as well as skills in managing case conferences. In some cases (for example where a person is terminally ill), specific professional skills may be necessary, but we believe that the care coordination role could be undertaken by a range of people with experience in health and social care, including, for example, people from the voluntary and community sectors, or those with experience of using services themselves. Some people might be willing and able to coordinate their own support, with adequate training and assistance.
34. It has also been suggested that a person's carer could act as a care coordinator in some cases, though there are a number of considerations in relation to this suggestion. We believe that it raises a number of complex issues, which would need to be explored further in individual cases. It has the potential to add to the pressures that carers may feel, making some feel duty-bound to take on this additional responsibility, or make them feel more isolated from the support and assistance they may need themselves. If a carer were to act as a formal care coordinator, this could potentially decrease the development of independence and/or increase a person's dependence on their carer and could, under certain circumstances, place people at unacceptable levels of risk. A carer may not always be best placed to navigate the system and may require substantial advice and support in doing this. We believe it should, however, remain an option to be considered in cases where the individual and carer think it will be of benefit to them.
35. It has become apparent from recent initiatives, and from experience abroad, that help given to individuals to take control of their funding, care and support has an important part to play in the overall success of self-directed support.<sup>36</sup> Assisting an individual to decide what they want and need and how to spend their personal budget accordingly is known as support brokerage. Support brokerage, as a term, has been used in some social care services over the last 20 years or so. In the context of self-directed support, it has become fairly commonly used to describe a range of help for people with a personal budget. As self-directed support is still developing, an understanding of the assistance that people need and best practice are continuing to emerge.

#### **Step By Step Living Network (SBS)**

‘The aim of the Living Network is to encourage and support individuals and family members to become their source of their own expertise.’

Member of SBS

The **Living Network** is the development of both a web-based and ‘real’ living network of recipients of personal budgets. It provides the opportunity for people to share experiences both of Step By Step as a brokerage agency, and of issues that personal budget recipients feel would benefit people who are considering self-directed support. This may include tips on creative support plans, good local resources for housing advice, among many other things. The Living Network is supported by family brokers who have experienced personal budgets and are keen to support and share their family’s experiences with others. Although the Network is in its infancy, it is currently being offered as a source of support to people to promote the concept of ‘self-brokerage’ – people and families working through the tasks/activities of brokerage themselves.

#### **The Living Network offers:**

- information, advice and guidance, including recipients’ views;
- signposting to local community resources;
- research on what’s available;
- facilitation;
- advice on planning and devising support plans;
- access to technical advice via Step By Step;
- negotiation and mediation services;
- advocacy; and
- coordination of support and resources – quality assurance.

The longer-term aim for the Living Network will include feedback and quality assurance measurements as an integral part of the website. People will be able to rate the support they receive and consequently advise other individuals and families on good-quality services.

36. Using dedicated resources for brokerage could be more efficient<sup>37</sup> and deliver quality improvements. This model would enable the care broker to work with a person to help them develop creative solutions to needs, without simultaneously needing to consider issues around eligibility and resource allocation. This has the potential to free-up care managers' time to address core assessment tasks.

### Aspects to be developed and tested through the demonstrator sites

37. One of the central aims of the CAF is the development and establishment of streamlined person-centred and proportionate multi-disciplinary assessment processes which promote and utilise self-assessment and which are led by individuals and families to deliver self-directed support through a personalised approach. As the practice of personal budgets takes hold and develops, it is likely to require a different approach to assessment, care planning and review. The CAF demonstrator site programme will provide the evidence on which to base the potential changes to practice and to assess the impact on IT support needs.

#### 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?
- b) will these principles all retain their relevance within the developing context of self-directed support?
- c) what will help ensure that they are sufficiently embedded into practice?

#### 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)?
- b) Should carers be able to act as care coordinators?
- c) Are there specific circumstances in which carers should **not** undertake a care coordinator role?

# 4. Use of shared information from assessment and care and support planning

## Introduction

1. The initial focus of these proposals is to improve the sharing of information that supports multi-disciplinary assessment and support planning. The approach seeks to build on the advances already made in sharing information across health and social care, particularly existing local arrangements and agreements. It also recognises that there are wider elements of support that underpin people's independence and the personal outcomes they want in their lives, and therefore the support available to them. This will often require the relevant information to be shared more widely – to housing services, for example; this means spreading it beyond the statutory sector to voluntary and independent providers. When looked at in the round, the need to connect our approach for adults to the development of support for children and families reinforces that wide context in which information sharing needs to take place.
2. The information that is drawn together on an individual basis to support an individualised care and support plan can have further uses when anonymised and collated. These data can be an essential part of the evidence needed for commissioning, business planning, management and performance. The potential offered by a national approach to sharing outcome-based information across organisational structures rests in the fact that collated data can inform both the personalisation and the community-based agendas.
3. Our proposals provide for an incremental approach to the way in which the practicalities can be worked through, investigated and evaluated. The prospectus inviting expressions of interest in being a demonstrator site sets out a staged approach to this. It establishes core features of the practicalities to be worked through, investigated and evaluated across all demonstrator sites, and adds a number of additional options from which sites may choose in working through the complexities.<sup>38</sup>

## What does information sharing need to deliver and ensure?

4. There are a number of central elements that need to be in place to underpin information sharing:
  - The individual's **consent** to having their personal details shared needs to be explicit in terms of what the information is and with whom it should and should not be shared.
  - Any sharing of an individual's personal information needs to be on the basis that it is **secure** and can only be accessed, with appropriate consent, by professionals who have a legitimate interest in that person's support.

- The mechanism should allow secure patient and user access, and potentially direct control of the information.
- Information sharing should support an individual approach and be clearly set within the context of the personal outcomes that a person wants in their own life.
- There should be a link to and from wider specialist assessments, as well as any other assessments such as web-based self-assessments for equipment.
- It should allow people to frame their own overall assessment and care planning needs, by themselves, with their carers and/or with professional support and advice.
- It should allow the sharing of a limited amount of information that is up to date and correct, in a way that is helpful and useful to the different professionals who may be involved. There should perhaps be different views of the information, detail and background, since different professional groups (such as GPs, community nurses or physiotherapists) are likely to want to see a different initial view or cut of information held.
- The mechanism should provide the basis for recording the information **once**.

### Use of information in assessment and care and support planning

5. Our proposals focus on improving information sharing between health and social care and particularly on supporting improved outcomes and a person-centred approach within multi-disciplinary working.
6. The starting point for the collection, collation and effective use of health and social care information must be the individual. During the assessment and care and support planning process, some individuals might experience frustration and a sense of lack of respect. Having to repeat information already given to other parts of 'the system' can make people feel that their needs are not understood by staff involved in the assessment, planning or delivery of care and support. Deficiencies in information sharing may partly account for this negative perception by service users (and indeed their carers), as well as misunderstandings or differing interpretations by various staff involved in their care and support.
7. It is paramount for the delivery of personalised care that the different professionals involved in the assessment of a person's needs and the formation of an agreed care and support plan are aware of the wider picture. Specialist assessments undertaken as part of multi-disciplinary assessments can involve a number of different professionals and services, for example cancer, diabetes, housing. These assessments should build on a core set of information, where the person is confirming known facts, rather than repeating details they have provided before, and more in-depth, condition-specific information should be requested as needed.

### Extending information sharing more widely

8. The support and care provided through health and social care services do not stand alone. They are part of a much wider set of community support. Particularly with the

growing development of self-assessment and self-directed support, the personalised care and support that people require to increase or maintain their independence or to help them support their life (outcomes) fall outside a traditional service-based solution.

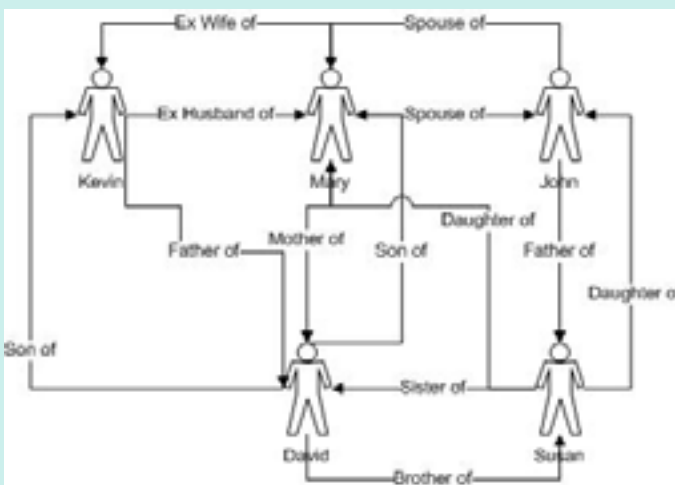
**Information sharing in Stoke-on-Trent based on its Community Support Team**

Stoke-on-Trent has established a locality-based Integrated Community Support Team (ICST), which it has been piloting as part of its local personalisation model. It includes the following professionals:

- social workers;
- community support officers (supporting independent living);
- district nurses;
- occupational therapists;
- physiotherapists; and
- podiatrists.

The team is supported by a local assessment and case-management application – Community Support Information System (COMMSIS), introduced as an operational ‘learning’ model. Information-sharing protocols, signed off at the chief-executive level of all main partners, allow for explicit, informed consent to be discussed, agreed and recorded.

Where the client’s needs are sufficiently complex to require support and intervention from wider partners, a lead worker is appointed to control the input of a person’s information. The system has the ability to link individuals to their wider family group, regardless of their home address, and allows for needs and support to be considered in that wider community context.



With their consent, each individual in the family group shares the same family ID, and the nature of their relationship to others can also be recorded.

Since the introduction of the COMMSIS pilot system, the move from manual paper working to electronic working has enabled

support officers to spend more time with customers. It has also allowed for innovative approaches to support and wider family-based solutions to personal and community issues.

9. The individual may, therefore, want relevant information shared much more widely. Indeed, in some respects there is a growing expectation that the information people give will be shared with a wider range of professionals/organisations. However, this is matched by a competing concern about the security of their personal information.
10. Many communities and areas have addressed this at a local level, establishing local agreements between organisations that share information in a whole variety of ways – through the individual sharing their own care plan; through person-held records; or through some local or stand-alone IT solution. The implications for a national system that would provide similar solutions are alike in their complexity, but are substantially greater in scale and therefore in likely risks and benefits.
11. We have asked authorities and their partners to begin to work through some of these issues as an element of their bids to take part in the CAF demonstrator site programme.

### Wider use of collated data

12. The individual's personal information that is collected during assessment and care and support planning, when anonymised and collated, can be used for a variety of other important functions. These include:
  - joint strategic needs assessment;
  - commissioning of services;
  - local performance monitoring;
  - local and national performance assessment;
  - parliamentary accountability;
  - national policy development; and
  - supporting wider research.
13. The development of a personalised, outcome-focused, shared information set across health and social care (and wider) could, in time, provide the basis for improved coordination across organisational approaches. It will enable a focus on the individual rather than on the 'service' or organisational components. This may be expected to support the community agenda, Local Area Partnership working and Local Area Agreements, as well as the wider community-based performance agenda.
14. The development of the CAF and the practical working through the demonstrator site programme offer the opportunity to begin to address some of the practical realities and complexity. These may involve the wider use of information. Therefore, the CAF needs to fit within and to complement a wider, strategic approach to information and data.

## Issues raised by CAF for the wider information agenda

15. It is clear that the main reason for sharing assessment and care and support planning information is that the different people involved in a person's care and support begin to appreciate, understand and act on the individual's needs, circumstances and wishes. To achieve this and to provide confidence in the information, a number of issues need to be addressed as part of a wider strategy:
- **Consent:** For consent to be given more widely across organisations, those organisations' IT systems need to operate to the same standards of information governance, i.e. they must manage their information so as to ensure that individuals can trust that any information they provide will be treated confidentially by all agencies that have access to it.
  - **Data quality:** Information sharing highlights the need for high-quality data, with all agencies working to similar standards so that professionals can trust the information they receive or access from other agencies.
  - **Data standards:** The same term or information should have the same meaning for different people – whether for professionals or in different areas of the country. While, at a personal and personalised level, text as explanatory information is important, shared standards become vital when information or data is shared across organisations or collated, such as for use as management information.
  - **Workforce and professionals:** There is still a job to do in 'winning hearts and minds'. While there is general agreement that sharing information is vital, for many the past experience of the introduction of IT solutions is that they end up being tied to a computer for longer periods, taking them away from personal interaction with people who need support. There are a number of issues that might drive these views and that need to be avoided, including:
    - duplicating the input of information;
    - IT potentially driving the way in which assessment and care planning are undertaken, rather than the other way round;
    - lack of trust in information collected by others; and
    - lack of initial and continued training.

**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)
- b) wider community support services?  
(such as housing, neighbourhood services and organisations from the voluntary and private sectors providing support)
- c) services providing financial and/or employment support?  
(such as benefits advice or applications, employment, education and training)

# 5. The basis of a shared set of information

## Introduction

1. Our proposals for the development of shared electronic care records (see Section 6) envisage that current electronic information systems and care records will be enabled to interconnect and interface with a range of different types of electronic assessment.
2. As a first step in the development of such shared records, we need to define the scope, content and make-up of a shared Common Assessment Framework (CAF) information set that will meet the aspirations of policy and practice. It is important that this allows for the sharing of text and comment. For it to be usable and transferable, the information needs to be captured in a standardised approach that enables electronic messages to be transmitted between different IT systems; furthermore, the data set must be accessible to all involved in a person's care and support planning and delivery, subject to consent. It is proposed that, where electronic assessment and records are used in future, the IT approach and software will need to allow for interconnectivity between systems based on the proposals for shared information.
3. Drawing on the commonality of information held within different assessment and care planning tools and processes, an initial set of CAF information has been developed. This looks to draw out relevant information held in current systems into an outcome-based format, and is intended to form the basis of the initial information that will be exchanged and be available to those with an appropriate interest.

## The current position

4. Even with large strides being made in the development of the Single Assessment Process (SAP) and IT to support the approach, there is a lack of routine access to holistic information about an individual's assessment and support. Additionally, there remains significant variation in how the SAP has been developed and supported by IT from area to area. A few local areas have worked with partners to provide local systems that share information across health (primary care and acute provision) and social care to housing and other community support services, also involving independent and private providers. Others are a long way from such a comprehensive approach. In either circumstance, when provision of support crosses local area boundaries – for example, when someone attends a regional or national specialist service – information exchange becomes increasingly complex.

5. The central purpose of a CAF information set is to improve the outcomes for people who need multi-disciplinary assessment and support, through improvements in the sharing of information. In developing the information set, we have looked to ensure that it:
  - responds to the framework of principles in Section 3;
  - places the information in the context of outcomes;
  - focuses on the individual and their needs and wishes;
  - provides a holistic view of their needs and the support in place; and
  - links to the needs of carers and families.
6. Within this context we have looked to take a practical and pragmatic approach which:
  - is wide enough to provide a comprehensive picture and to give sufficient background and a holistic picture of assessment, outcomes, wishes and support available;
  - is small enough to be useful in practice and not unwieldy; and
  - allows space for text-based information and capacity for coding information that can be collated across health, social care and wider community support systems.

## Demographic information

7. Demographic information supports verification of a person's identity and also includes their contact details. These items are currently recorded in the NHS Care Records Service Personal Demographics Service (PDS). They may be updated separately at any time in the care process, not only during assessment or care planning. However, as this information may have an impact on the outcome of assessment and/or the types of support required, it will always need to be verified during an assessment.
8. The PDS allows for the initial capture of some extended demographic/biographical information about an individual, which may be needed to inform the assessment. This information may generally be captured during a contact assessment, and includes data on dependants, carer details, employment status, accommodation type and tenure, etc. *(NB Information relating to a person's needs arising from their housing situation, such as the suitability of accommodation or any requirements for adaptations, will be captured as part of the holistic assessment or a specialist occupational therapy assessment.)*
9. Further detailed biographical information requirements beyond the core CAF headings should be captured using a specialist assessment, care plan or other process.

<b>My demographic/biographical information</b>
My NHS Number
My employment status (my work/activities)
My accommodation (where I live)
The people (and pets) who depend on me
People (including my carers) who I depend on
The communication support I need
My GP practice
Consent
My mental capacity

10. A vital aspect of sharing personal and individual information that may be collated from different sources is the assurance that it belongs to that person. We will ensure this by using the NHS Number – an administrative identifier created and owned by the Secretary of State for Health. The NHS Number:
- provides the means for linking records of care and treatment provided to users of health and social care services; and
  - helps to ensure the privacy of service user information.

The NHS Number **must** be used as the primary means of linking and identifying NHS records relating to care and treatment provided to identifiable service users, and **may** be used for these purposes by organisations providing social care services. Other organisations and individuals providing or supporting the provision of (or assessing the need for) NHS and social care services may also process the NHS Number where the purpose is to link, or facilitate the linkage of, records of care and treatment.

11. A person's NHS Number can act as a 'shared systems' identifier for sharing CAF information between health and social care IT systems. Valid NHS Numbers can be obtained from the NHS PDS. Social services care management systems will, therefore, have to link to the NHS PDS to obtain an individual's NHS Number and record it in their systems.

### Reason for referral/contact

12. The CAF information set will need to capture a textual summary identifying a person's presenting needs and recommendations for action (i.e. the reason why they have contacted health or social services, or why a referral has been made). This may indicate the requirement for an overview assessment of needs. It may also capture information about any other actions taken at this stage (for example, referrals to other services to continue assessment/care, or a decision that further assessment at this time is not appropriate), as well as any advice or information given.

13. The contact assessment will normally be completed at the first point when an individual comes into contact with a practitioner who thinks they may need a more in-depth assessment. Specifically, it will need to allow a person to articulate their own reasons for making contact, and will therefore be a starting point for a personalised approach to self-assessment.

My reason for contacting health or social care is:  
*[Explanation of the current reason for contact/referral]*  
*Professional recommendations for actions – specialist assessment*

### Personalised information set within outcomes

14. The proposals for the CAF data set provide for a holistic/overview assessment that will enable a multi-factorial assessment of an individual's physical, mental and social well-being and environmental factors to be held within their care record. It may be possible to use the data set as a prompt for self-assessment or assisted assessment, or at the point of a review or re-assessment of care needs. The information within it is provided in a structured way:
- At its highest level, the information collected is matched to one of the agreed outcomes for adults in the Green Paper *Independence, Well-being and Choice* (for example, 'Improved health').
  - The next level provides domain headings aligned where possible to Fair Access to Care Services (FACS), the national eligibility framework for social services support. Domain headings define the general areas of need – for example, 'My physical well-being', 'Activities of daily living', etc. A commitment to revise the existing guidance has been made in the Department's response to the recent review of FACS by the Commission for Social Care Inspection (CSCI).<sup>39</sup>
  - The sub-domain level (the most detailed level in the information set) provides the headings against which information is actually recorded – for example, 'Using the toilet and continence' or 'Memory, thinking and reasoning'. At this level there is a read-across to the domains of NHS continuing care, which enable information to be recorded that could be used to determine eligibility for NHS continuing care. Each of the sub-domain items also provides guidance about the type of information that is expected to be held against that heading (see Appendix 2 for more detail). This will support toolset developers to deliver consistency when aligning similar information types.

## Levels of information in the proposed CAF data set

High-level outcome	Domain	Sub-domain
Improved health	My physical well-being	My disabilities, impairments and other conditions
		My general physical well-being
		Sensory impairment
		Drug therapies
		Lapses of consciousness
		Skin care/wound management
		Using the toilet and continence
		Breathing
		Swallowing and oral health
		Sleeping
		Pain
	My communication needs	
	My mental, psychological and emotional well-being	My mental health needs
		My behaviour
Memory, thinking and reasoning (cognition)		
Mood		
Misusing substances		
Improved personal dignity and autonomy	Activities of daily living	Dressing/undressing
		Personal hygiene
		Doing housework/my daily tasks
		Eating and drinking
	Mobility	Mobility in my home
		Mobility outside my home
		Falls
Exercise of choice and control	My care preferences	
Freedom from discrimination or harassment	Adult protection	My sense of security
		Abuse/threats
	Equal treatment	

High-level outcome	Domain	Sub-domain
Improved quality of life	My home	My housing support needs
		My current housing
		Managing my home's energy needs
	Keeping healthy	
	Being cared for	
Making a positive contribution	Access to education, training and employment	
	My social well-being	My caring responsibilities
		My relationships
		Involvement in my community
	My religious, cultural and spiritual needs	
Economic well-being	My finances	

### Specialist assessment outcomes

15. Following a contact or overview assessment, specialist assessments may be needed to diagnose a condition or identify a problem more specifically and to plan specialist care and support. Specialist assessments may be service-, discipline- or condition-specific and may use specialist tools and scales as well as tests, investigations and examinations. The intention is to record not the **content** of specialist assessments but only their **outcomes**, which provide the information most relevant to the individual and to other professionals involved.

### Care and support planning information

16. The integrated care plan will provide a single, overarching plan of all the support and care being provided for an individual. Made up of contributions from a range of professionals, it should be accessible to and have the potential to be controlled directly by the individual. The information set provides the facility to capture both a high-level summary of the care plan and a more detailed breakdown of specific care plan components – for example, a wound dressing care plan, a mobility care plan, etc. Local health and social care communities will be able to choose whether to use the more detailed breakdown of specific care plan components or the high-level summary only.

17. Although the integrated care plan will enable a detailed breakdown of information, there is no assumption that local health and social care communities will be required to record this level of detail of information as part of the care planning process. However, providing a detailed breakdown will enable local health and social care communities to take a more comprehensive approach to care planning, should they choose to do so.

### Elements of an integrated care plan captured by the CAF

<b>Care plan summary</b>	Outlines at a high level the areas/issues covered and the principal actions arising from the care plan.
<b>Care plan goals</b>	The overarching goals/purpose of the care plan. May include the individual's life goals and aspirations.
<b>Person coordinating the care plan</b>	Details of the practitioner leading the process and coordinating the care plan – their name and role, the organisation they are part of and their contact details.
<b>Care plan review date</b>	The next planned review date of the whole of the care plan (not just of a single component).
<b>Care plan component details – repeat for each issue</b>  (NB Not all items have to be completed for a care plan component to be created)	Details of which of the seven White Paper high-level outcomes this component of the care plan is linked to, e.g. 'Exercise of choice and control', 'Improved health', etc.
	Details of which of the CAF domains this component of the care plan is linked to, e.g. 'My physical well-being', 'Mobility', 'Keeping healthy', etc.
	Details of which of the CAF sub-domains this component of the care plan is linked to, e.g. 'Sleeping', 'Personal hygiene', 'Involvement in my community', etc.
	Issues, problems or needs identified in the assessment.
	The intended end-point or goals being set at the commencement/ review of this component. Things planned to be achieved/the objectives in this area.
	What is going to be done/is needed to meet the requirements in this area. This includes agreed actions, services, interventions, treatments and support.
	The person(s) responsible for supporting or meeting the needs in this area, e.g. a social worker, a GP, a carer or the individual.
	How the actions, services, etc will be delivered – by which organisation, service, team or person.
	When and how often these actions, services, etc will be needed.
	Information for health needs (which may include an information prescription), including information about staying healthy, specialist services for the individual's condition, choices of services/treatments available, evidence of the benefits and risks of treatments, and contact details for informal patient groups. Information for social care needs (which may include details of social care services, voluntary sector services, equipment and/or financial benefits). Self-care/self-management advice.

	Outcomes or progress actually achieved over the time period just ended, as well as the measure used to evaluate effectiveness.
	Pertinent dates relating to the care plan component, e.g. start date, date of next planned review and actual/expected end date.
<b>Individual care preferences</b>	Information gathered within the 'My care preferences' domain during the overview assessment – further details may be added in relation to specific components, particularly to include end-of-life planning.
<b>Individual strengths</b>	The things the individual can do/their strengths.
<b>Situations that may lead to a deterioration</b>	Situations that may cause a marked deterioration in the individual's condition, e.g. illness of their wife/husband/partner, failure to get enough to drink, failure to take medication as prescribed, etc.
<b>Individual's agreement/ access to the care plan</b>	A record of the individual's agreement to part or all of the care plan, as well as how and when a paper/electronic copy is/was made available to them.
<b>Crisis plan</b>	Details of, for example, who to contact and what to do if the condition breaks down or deteriorates, both in and outside working hours.
<b>Contingency plan</b>	Contingencies that are already in place should they be required, e.g. respite or other support already arranged for the individual and their carer(s), a person or organisation that will step in if the main carer falls ill, etc.

### Importance of the care coordinator's role

18. A care coordinator will need to draw together information from a variety of electronic and manual sources to deliver a fully integrated perspective. They will also need to act as gatekeeper for information that may be sensitive to the individual. There is often sensitivity about records with a mental or sexual health aspect, and other types of information will also need careful management. Local care coordination procedures will need to set out how this will be achieved.
19. It will also be important for someone acting in a care coordination role to define when a CAF assessment or integrated care plan is to be published for sharing with other agencies, as well as when it is due for planned or formal review. As set out in Section 3, paragraphs 31–34, the developments may allow the care coordinator role to be undertaken by a patient/client or a carer. Developments such as NHS HealthSpace, and its extension to the CAF records, may support this by enabling an individual to view and update their own record.

## Aspects to be tested/developed through the demonstrator sites

20. As a central aspect of developments to be tested, we are expecting the CAF demonstrator sites to:
- link local social care systems to the NHS Care Records Service so that relevant information held in local systems can be communicated between care professionals from different agencies and accessed by them through a shared CAF record;
  - use the CAF electronic communications to share information from assessments completed and stored across the partnership, where agreed by individuals, or to propose a replicable alternative; and
  - use electronic messages (or propose a replicable alternative) to share information with named professionals involved in an individual's assessment, care planning or support who need to be aware of it or to take action – for example, around hospital discharge or continuing care assessments.
21. In developing these approaches, there is also an expectation that individual sites will address some of the specific complex issues and practicalities around:
- the inclusion of different primary care organisations, including GP practices or a district nursing service within the partnership;
  - the interests and concerns of specific health populations (for example, those with cancer, long-term conditions, diabetes, stroke, etc) and pathways (such as palliative/end-of-life care) within their community;
  - the establishment of practical approaches to connected arrangements during the transition from children's to adult services;
  - the extension of local care records to the housing authority;
  - the inclusion within the partnership of the voluntary and community sectors, including small organisations and user-led organisations;
  - the use of mobile and other innovative electronic devices and other methods of working to undertake assessments/self-assessments; and
  - procedures for giving service users and their carers access to and ownership of the information about them that is held centrally.

### 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?

# 6. Mechanisms to hold and share care and support records

## Introduction

1. Evidence and reported experience from the implementation of the Single Assessment Process (SAP) is that improvements in information and data sharing need to be based on the appropriate development of IT solutions. Lack of appropriate systems or connectivity between the systems used by different organisations can severely restrict access to shared data and hamper its routine and effective use by care professionals.
2. Throughout the consideration of an appropriate national approach, the central tenet has been that IT solutions should respond directly to the needs of policy and good practice. No IT solution should act to restrict the potential benefits of shared information, nor should it limit future development. The systems should be capable of:
  - supporting the sharing and exchange of information between different areas of England – for example, for people who receive care or treatment in specialist centres or those who are away from their home on holiday;
  - providing or enabling access by and between a wide range of professionals in the different organisations – and allowing for role-based access, ‘first-stop shops’, etc;
  - being developed to allow appropriate access across the voluntary and independent sectors, including by user-led organisations;
  - providing service user access and oversight, and the potential for service user control;
  - addressing current IT realities, namely that different organisations currently use significantly different systems and approaches;
  - addressing expected IT developments – those changes and improvements that are already in the pipeline;
  - responding to changing user needs and outcomes (‘future proofing’);
  - being secure and conforming with arrangements for the governance of information held, in line with current legislation and good practice;
  - restricting access to information to those involved in the care of the individual;
  - tracing and maintaining an audit trail of access;
  - providing for the flagging or signalling of explicit consent to share information and records between organisations or individuals;
  - supporting single entry recording across the system; and
  - being introduced in a cost-effective manner.

### Proposed development

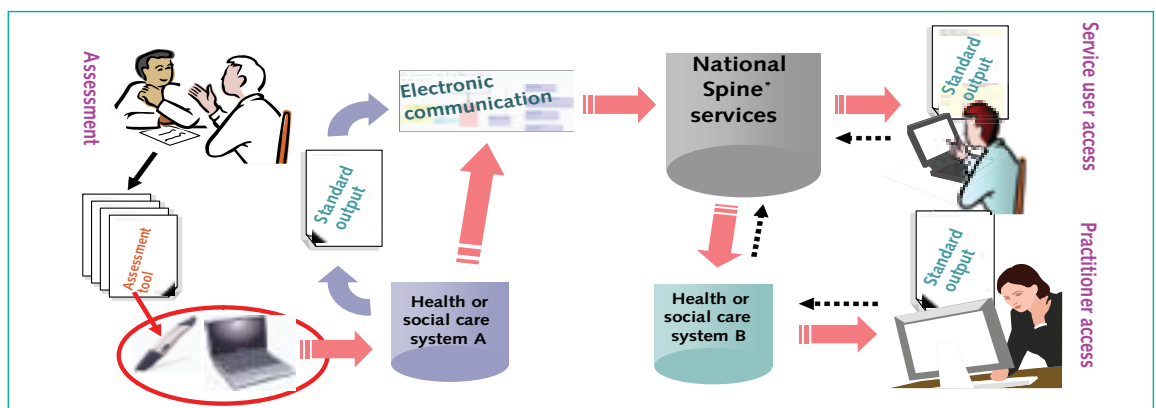
3. The approach we propose looks to respond to these challenges by building on the NHS developments and IT standards and services currently overseen through NHS Connecting for Health (CFH).
4. A project to define and evaluate options for implementing an electronic SAP with integrated electronic care records was commissioned in 2006 by NHS CFH. The project proposed an approach involving connection of social care systems to the NHS Care Records Service using existing national services and making it compliant with existing NHS Care Records information governance standards.<sup>40</sup> This approach will:
  - provide a national/regional facility for holding a shared record;
  - provide a national facility through which to direct information to named professions/organisations through primary and acute care settings including GPs, district nurses, physiotherapists, advocates, etc;
  - be based on experience across complex NHS systems;
  - have developed rules/processes to ensure security; and
  - support an individual's control over the sharing of information by requiring explicit consent.
5. The approach forms the technical basis for the proposed development of the CAF for Adults and sets the context for the CAF demonstrator sites. It does not mean that it is currently clear how the IT can respond, in all respects or to all of the challenges we have posed for it. There are complex issues that need to be addressed and worked through; these will be informed by and developed from the practical experience we expect from the CAF demonstrator sites.
6. We are also aware that this may not be the only mechanism by which the CAF and a national approach to information sharing may be undertaken, and we are keen to seek views and ideas on potential alternatives to the general approach, as well as on the detailed developments we outline. The call for interest in the demonstrator site programme made it clear that we are keen to include and evaluate other potential models that may be nationally replicable.

### Detailed proposals through CFH arrangements

7. The detailed proposals themselves are based on linking existing social services care management systems to the NHS Care Records Service to enable information exchange. They are not intended to replace current systems that are in use. It is proposed that, where electronic assessment and records are used in future, the IT approach and software will need to allow for interconnectivity between systems based on the proposals for shared information.

8. The proposed approach will not deliver fully integrated care records; there will not be a single record system deployed between the NHS and social services. Separate health and social services information systems will continue to exist, but the CAF information set will enable information from assessments and care plans to be shared electronically between existing systems. Staff from NHS organisations, social services and potentially wider community support services will be able to access the same information, and (where appropriate) different views of that information. The information set will:
- provide social care access to the current NHS Personal Demographics Service (PDS), with individual consent;
  - enable storage of and wide access to a CAF shared record, including assessment and care plan history; and
  - enable specific messages to be sent to named professionals involved in an individual’s assessment, care planning or support who need to be aware or to take action – for example, around hospital discharge or continuing care assessments.

### Example of the overarching approach

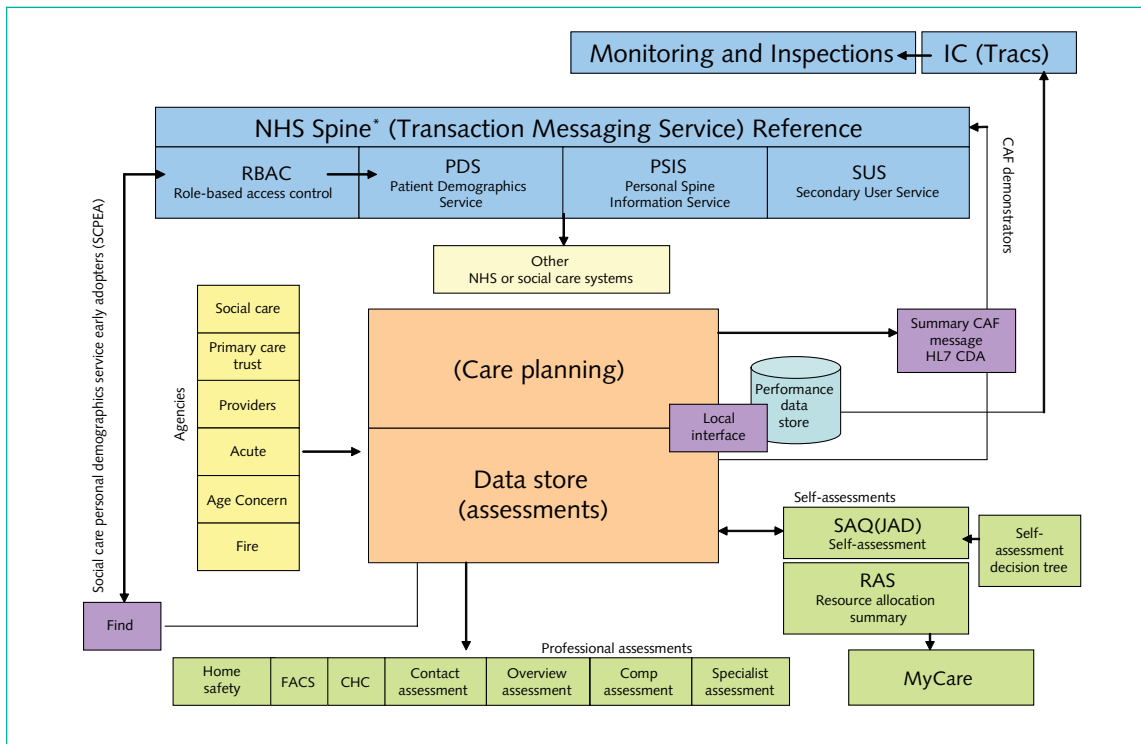


\* For details on the Spine, please refer to endnote 41 on page 59.

9. To date, local councils have made significant progress in the development of electronic social care records, and all have some systems. Most are built around person-centred records. They do, however, vary significantly in their complexity, as well as in how or whether they connect to other systems used inside and outside the council.
10. Where health and social care services have implemented the SAP for Older People, they have often invested in electronic assessment toolkits which guide the assessor through a series of questions to build up a holistic assessment of an individual’s health and social care needs. These toolkits are often incorporated into separate SAP systems which are not fully integrated with other health and social care electronic records systems, nor with social care services back office systems. This means that double entry of data occurs within organisations, as an assessor is subsequently required to enter details of their contact with an individual into their social care system (despite having already recorded the information once on the SAP system).

11. Within the NHS there is increasing use of electronic records across the board, but paper-based records remain the norm in some settings.
12. The first stage in developing the CAF for Adults is to ensure the effectiveness and delivery of a robust system across health and social care. It will also be important to ensure that these initiatives, which cover all adults, link appropriately and can share information with IT developments on children's services (such as the Children's eCAF), particularly across the years of transition from child to adult. But it is intended to expand on this to provide appropriate levels of information sharing across other community support agencies, particularly housing, and to the voluntary and independent sector. We expect the demonstrator sites to begin to work through the challenges that this presents, and to begin to give a more informed view on the potential implications for resources and costs in these areas.
13. Many local councils have undertaken local development in sharing information electronically, and some have done this with a view to being able to take advantage of national links to CFH services. Cheshire County Council, for example, has been developing a strategy looking to take account of current and future developments in personalisation and self-directed support. This will involve information exchange and sharing across the wider community support services. The diagram below shows some of the complex relationships involved.

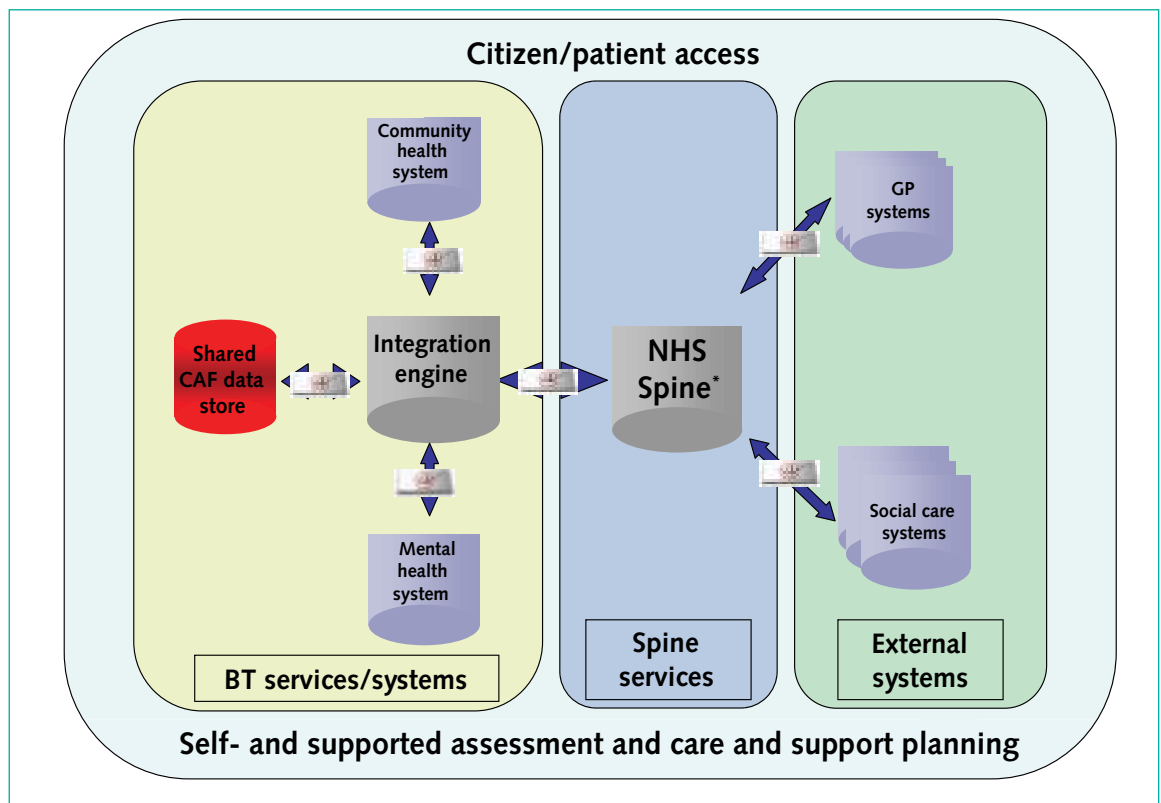
### Cheshire Adult Common Assessment Framework – Connect



\* For details on the Spine, please refer to endnote 41 on page 59.

14. The strategic health authority NHS London has been working on a project with a range of local councils and NHS services across London. The project aims to avoid double data entry and to develop messaging/integration between systems. It has a developing roadmap where health and social care services share information with each other from their own NHS CFH-compliant IT systems, in line with NHS information governance. Information is sent through national CAF messages, including a citizen's integrated care and support plan (available to the citizen on paper and online).

### London interim CAF development roadmap



\* For details on the Spine, please refer to endnote 41 on page 59.

### Personal Demographics Service

15. Linking social care systems to the NHS PDS provides a starting point for essential identification and demographic information, including details of other key contacts such as carers and family members. The PDS is one component in the NHS CFH Spine<sup>41</sup> and does not hold any clinically sensitive information, but it may hold confidential data items such as ethnicity or religion. A full list of current information held on the NHS Spine is shown on the NHS CFH website.<sup>42</sup> Allowing appropriate PDS access to social care services is a first step in enabling the sharing and updating of this basic information, and will enable the safe movement of an individual's records between organisations. This will reduce the number of errors and the time taken in the matching of individuals with their care.

16. With the PDS, individuals will:
  - only need to notify one authorised healthcare organisation of a change of address, and this change will then be available to all organisations as and when their patient records are accessed;
  - eventually be able to check and update their own contact details online via HealthSpace, after which these details will potentially be made available to all healthcare organisations via the PDS; and
  - find that details of their next of kin and carers – two items considered by healthcare workers to be key pieces of information when caring for patients – are held on the PDS.
17. Health and social care professionals will:
  - be confident that they have access to accurate and complete patient demographic information;
  - be able to access the most up-to-date contact details to ensure that mailings are more likely to reach the intended recipient; and
  - more easily be able to find the right record for the right patient, meaning less time spent chasing records and more time spent delivering care and support.
18. The PDS also holds a person's NHS Number as a unique identifier. This is the only National Unique Identifier generally in use in the NHS, and its use across social care IT systems will make it possible to share an individual's information across organisations safely, efficiently and accurately. It therefore also raises issues of information security and access (see Section 5, paragraphs 10–11).
19. Four sites have been selected as social care personal demographics service early adopters (SCPEA project), following the evaluation of proposals submitted in response to a call for expressions of interest. These sites will be the first in the country, along with the Newham Whole Systems demonstrator site, to implement links between their social care systems and the PDS, enabling social services to use their clients' NHS Numbers when sharing information with the NHS.
20. The aim of the early adopter initiative is to link social care systems to the NHS Care Records Service in a controlled way, working with a small number of 'first of type' sites to enable full evaluation prior to wider rollout. The links, once thoroughly tested and evaluated, will be available for other local councils to deploy.
21. Throughout this process the early adopters will need to demonstrate that their security and access arrangements comply with the information governance requirements for the NHS Care Records Service, as set out in the NHS Care Record Guarantee, to implement links between their social care systems and the PDS. They will work with their social care systems supplier and local health partners to implement these links.

The work will be assured by NHS CFH to ensure that the arrangements are compliant with the NHS Care Record Guarantee regarding confidentiality of patient information. The evaluation will include a rigorous assurance process carried out by NHS CFH, which will review all aspects of suppliers' systems from planning and design through to testing and deployment.

### Access to a CAF shared record

22. The proposals for a CAF shared record are detailed in Section 5. The current shared record, giving the overview of an individual's assessment and care/support plan together with the history and appropriate information around any specialist assessment, needs to be accessible (with the appropriate consent) to all the professionals involved and to the individual.
23. We propose an approach to the integration of health and social care information through the development of IT solutions to provide the connection of local social care systems with the NHS CFH Care Records Service. After taking broad soundings from across the field, we have concluded that the existing NHS CFH IT infrastructure, although focused towards health services, could provide the most effective and efficient means of achieving integration. Social care services have already made significant investments in their own IT systems and, although there are a limited number of social care IT software suppliers, there are some significant differences in the systems being employed.
24. We expect to develop a number of 'products' for sharing assessment information, which systems suppliers will then be able to make available to health and social care communities not involved in the demonstrator site programme. The CAF demonstrator sites will help stimulate the implementation of social care systems that conform with NHS information governance standards, and which have successfully shared assessment and care plan information with the NHS Care Records Service using nationally defined messages.
25. With these system connections in place, individuals will:
  - not have to keep providing information they have already given to someone else – they will be able to be confident that the professionals they are working with have a full and complete picture of their needs and the support they have been given in the past, to better inform the choice of support for them in the future;
  - have improved control over who their personal information is shared with, as they will have to give their permission for their information to be used in this way; and
  - have access to their shared information, with the potential – in time – to manage it themselves.

26. Health and social care professionals will:

- have a common set of information that will support the delivery of an integrated person-centred approach to assessing individuals' need for support from health and social care services, and the support needs of their carers;
- be supported to focus on improving individual outcomes for adults by ensuring a person-centred and holistic assessment of need, focused on delivering individual outcomes and taking account of the needs of family members if these have an impact on the individual;
- be able to reduce the bureaucracy that people can face in the health and care system;
- have information-sharing capabilities that support improved joint working between health, social care and wider community services and increase efficiency;
- benefit the people with whom they have contact, so that those individuals will not have to keep providing the same information they have already given someone else; and
- have a system providing clear assurances and the safeguards that need to be in place in terms of the use and security of individuals' personal and confidential information.

### Enabling specific messages to be sent to named professionals

27. The implementation of SAP has shown that there are specific problems with sharing and transferring timely information at key transition points in an individual's care and support. This is particularly true at the points when the individual is moving out of hospital and needs support and care in the community. Methods of information exchange in these two areas are being specifically looked at. Both have important implications for improving the outcomes and experience for adults with complex longer-term health and social care needs.

- **Around hospital discharge:** Discharge messages need to be exchanged between care professionals from acute settings to social care using the NHS CFH Transaction and Messaging Service (TMS). Messages are based on Department of Health guidance regarding the requirement for acute settings to notify social services of discharges potentially requiring social care support at set times prior to the patient discharge using Section 2 and Section 5 of the discharge notifications.
- **Assessment of continuing care:** Information needs to be exchanged between care professionals from all settings (acute, primary, mental health and social care) when taking part in a continuing care assessment. These involve multi-disciplinary assessment with an individual, and provide the information required for a recommendation to be made about whether continuing care should be provided

for that individual (and what form that care should take). Again based on the NHS CFH TMS, these messages will need to be stored on the CFH Spine in the Summary Care Record.

28. The provision of both delayed discharge and continuing care assessment messages supports the requirement to improve integrated working across the NHS and social care. Scoping work has already been started, with work undertaken by NHS CFH and the Newham Whole Systems demonstrator site. Development of both types of message has begun, and these examples of the direct exchange of information are to be piloted in a small number of communities as part of the CAF demonstrators.

**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?

**Question 9:**

Are you aware of any alternative approaches that could be tested?

# Annex A: The consultation questions

## Introduction

### Question 1:

Do you have any general comments about the Common Assessment Framework?

## Section 1: Rationale for developing a Common Assessment Framework for Adults

### 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?

## Section 2: What would a Common Assessment Framework for Adults look like?

### Question 3:

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

## Section 3: Principles of a Common Assessment Framework

### 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?
- b) will these principles all retain their relevance within the developing context of self-directed support?
- c) what will help ensure that they are sufficiently embedded into practice?

**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)?
- b) Should carers be able to act as care coordinators?
- c) Are there specific circumstances in which carers should **not** undertake a care coordinator role?

**Section 4: Use of shared information from assessment and care and support planning**

**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)
- b) wider community support services?  
(such as housing, neighbourhood services and organisations from the voluntary and private sectors providing support)
- c) services providing financial and/or employment support?  
(such as benefits advice or applications, employment, education and training)

**Section 5: The basis of a shared set of information**

**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?

## Section 6: Mechanisms to hold and share care and support records

### **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?

### **Question 9:**

Are you aware of any alternative approaches that could be tested?

# Annex B: References and notes

- 1 *Data Handling Procedures in Government: Final Report*. Cabinet Office, June 2008.  
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# Appendices to Common Assessment Framework for Adults

A consultation on proposals to improve information sharing around  
multi-disciplinary assessment and care planning

# Appendix 1: Evidence relating to the benefits reported from local communities where the Single Assessment Process has been implemented

## Introduction

1. The Single Assessment Process (SAP) was established in 2002 as part of the programme to implement the National Service Framework for Older People.<sup>1</sup> It provided the basis for a single framework to support multi-disciplinary assessments across health and social services for older people. The SAP provided the principles that should underpin and be applied to joint health and social care assessment and set the context for use of IT systems to support the approach.
2. Social services provide support to approximately 1.75 million people. The vast majority of people supported by social services have a disability or general physical frailty due to the effects of ageing. This cohort of people often have complex requirements, including healthcare needs and the need for wider community support.
3. We do not know precisely how many people supported by social services also have a long-term medical condition and come into frequent contact with NHS services. However, anecdotal evidence from local communities where NHS case management of people with long-term medical conditions has been introduced suggests that the people with the highest demand for NHS services are also often the people with the highest demand for social services.

## Information sharing

4. Efficient information sharing between health and social services has been seen as a prerequisite for effective joint working and has historically presented a major obstacle to improving inter-agency working. Traditionally, there has been a lack of coherence about the processes of sharing information between health and social services, with staff telephoning, faxing, or even posting referral information to one another.
5. Following implementation of the SAP for Older People, a number of communities have made progress in using person-held records. This model of information sharing involves leaving a folder containing a person's care record in their home, and having staff refer

<sup>1</sup> *National Service Framework for Older People*, at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003066](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066).

back to it and add to it with each new contact. Although this model can be relatively effective, there are some obvious limitations and risks, for example where a person has cognitive impairment.

6. Electronic care records are being implemented in both the NHS and social services, but this has largely been through separate health and social services systems. A survey of the introduction of Electronic Social Care Records (ESCR) in England was published in 2007.<sup>2</sup> While the survey indicates that progress has been made in implementing ESCR, it reported a number of key themes and issues:
  - There is some way still to go to complete ESCR implementation. Some of the issues raised include staff resistance, lack of a business case and competing priorities.
  - There are problems involving integration with the NHS and other agencies, including cultural and professional barriers, lack of IT solutions, data quality and IT standards.
  - There are skills and resource issues, including general IT literacy and resources available to implement IT systems.
7. A key limitation on the effectiveness of information sharing at present is the lack of integration between health and social care systems. This means that double entry onto both health and social care systems often occurs at the point of referral. For example, an assessment or care plan that is recorded onto a social services system needs to be re-entered onto an NHS system if it is to be available to NHS staff.

## Evaluation of SAP implementation

8. In terms of the Single Assessment Process and the use of IT systems to support it there have been few formal evaluations that provide evidence of costs, efficiencies or cost benefits. Evaluations have tended to focus on implementation, barriers to development and quality.<sup>3, 4, 5, 6</sup> These have been undertaken by different sites and organisations across the country (or else rely on information from them), are not necessarily nationally representative, and have used different methodologies and measures. Additionally, implementation of the SAP has not happened in isolation and has been part of wider

2 *National Electronic Social Care Record survey report – 2006/07*, at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_075529](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075529).

3 A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England, PSSRU, at: [www.pssru.ac.uk/pdf/p060.pdf](http://www.pssru.ac.uk/pdf/p060.pdf).

4 A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England, Research and Policy Update, Issue 1, June 2006, at: [www.pssru.ac.uk/pdf/MCpdfs/SAPupdate1.pdf](http://www.pssru.ac.uk/pdf/MCpdfs/SAPupdate1.pdf).

5 Dickinson A, Cove J, Knopp N, Windle K, *The electronic Single Assessment Process: an evaluation of initial implementation*, University of Hertfordshire, 2005.

6 *Supporting Transformation: National Programme for IT in the NHS – Benefits Statement 2006/07*, at: [www.connectingforhealth.nhs.uk/about/benefits/statement0607.pdf](http://www.connectingforhealth.nhs.uk/about/benefits/statement0607.pdf).

service improvements and efficiencies.<sup>7</sup> It is therefore difficult to determine and specifically attribute cost benefits and system efficiencies from these approaches to evaluation.

9. A number of general areas of benefit have been identified from evidence drawn from the experience of implementing the Single Assessment Process for Older People with IT support in local care communities. There is a general belief, but little fully evaluated evidence, that the SAP makes an important contribution to:
  - reducing length of stay and delayed transfers of care by having earlier and more holistic assessment and care planning prior to discharge;
  - reducing unscheduled admissions through improved coordination of community care and with hospitals having information available on the care being provided in the community;
  - improved management of care for people with long-term conditions and complex care needs by ensuring that all staff involved have up-to-date assessment and care-plan information;
  - improved quality of care for the service user by having a more holistic view of needs, which leads to more appropriate services being put in place, and by not repeatedly asking service users the same questions;
  - resource savings for professional staff by reducing the reassessment of service users and the time spent on associated administration (copying, faxing, phoning);
  - improving the referral process by reducing inappropriate referrals and increasing reliability and efficiency; and
  - improving public health information on the health and care needs of older people by ensuring the availability of aggregate analyses.
10. The benefits of implementing integrated electronic care records will also vary from one local community to another, depending on the local configuration of services and local progress to date in developing electronic care records and implementing the SAP. The full realisation of benefits will also be dependent on delivering cultural change, so that staff across health and social services work in a way that is integrated and genuinely person centred. Members of the Assessment and Care Planning Policy Collaborative felt strongly that delivering joint training for health and social care staff was a key lever in delivering the cultural change necessary to underpin integrated multi-disciplinary working and a person-centred approach to service delivery.

<sup>7</sup> See DH Care Services Efficiency Delivery website, at: [www.csip.org.uk/~csed/solutions/solutions/assessment-care-management.html](http://www.csip.org.uk/~csed/solutions/solutions/assessment-care-management.html).

11. It is believed that electronic care records support efficient delivery in a number of ways:
  - Individual care records are more readily available to care professionals whenever and wherever they are needed, enabling better informed and better coordinated care.
  - There are reduced transaction costs associated with referrals and hand-over.
  - There is less staff time spent on administrative activities.
  - There is less storage of paper.
  - There is improved management information to inform service planning.
  
12. The National Programme for IT's Annual Benefits Statement 2006/07 calculates the annualised recurrent national savings from SAP-based IT technology solutions at £24,000.<sup>8</sup> A number of locally based evaluations have attempted to place a monetary value on potential efficiency savings. These evaluations largely remain unpublished, and aspects of their methodology, practice and outcomes are open to interpretation and question. However, they do indicate potential cost reductions across an average health and social care community in particular aspects of the assessment process. These have been calculated as being in the region of:
  - reduction in subsequent assessment time – avoidance of duplicate assessments: £44,000 per year;
  - reduction in faxing and chasing referrals – with electronic communication of assessments and referrals: £30,000 per year; and
  - reduction in inappropriate referrals – increased ability to see other professionals involved in the care and support plan as well as the outcome of previous care: £6,000 per year.

## Conclusion

13. In relation to the introduction of the SAP and the supporting IT to improve information sharing, there is a shortage of direct evidence of cost efficiencies from peer-reviewed studies or evaluations. However, the experience from practical implementation – that the duplication of information reduces the effectiveness of joint working and its focus on the individual – is more persuasive. It is believed that there are significant quality benefits to be gained from improving information sharing, and that further evaluation is required of the potential efficiencies and cost efficiencies.

8 [www.connectingforhealth.nhs.uk/about/benefits/statement0607.pdf](http://www.connectingforhealth.nhs.uk/about/benefits/statement0607.pdf)

# Appendix 2: Proposals for a Common Assessment Framework Information Set

**This appendix sets out proposals for what assessment and care-planning information should form part of an integrated electronic care record. It contains the core information relating to care management that needs to be shared by multi-disciplinary care teams working across health and social services. It is envisaged that the CAF Information Set will eventually be incorporated into the Summary Care Record and the National Spine.**

My demographics/ biographical information	Details
My NHS Number	NHS Number is recorded here as a unique identifier. <b>NB: No other identifiers would be shared.</b> <b>All electronic exchange of demographic details (such as name, address, date of birth) must come from the NHS Personal Demographic Service (PDS).</b>
My employment status	<i>Status</i> only – not actual occupation. May be, e.g.: full/part/paid/voluntary, etc.
My accommodation	This would be factual information only, not an assessment of suitability. Examples include: type/tenure/access issues, etc.
The people who depend on me (and pets)	
People who I depend on (including my carers)	
The communication support I need	For instance, preferred language, need for an interpreter and advocacy requirements. PDS holds preferred language and interpreter requirements, and other factual details, such as advocacy requirements. This should not cover assessment issues – only factual details.
My GP practice	
Consent	Consent should always be sought before assessment and before information is shared with another organisation. Where consent has been obtained, this should be indicated clearly in a person's care record.
Mental capacity	Documentation should always indicate if a person has the capacity to consent to the assessment and to their record being shared <b>at the time when the assessment is undertaken.</b>

<b>Contact assessment</b>	
My reason for contacting health or social care	Details of the contact assessment. Includes details about why the individual has contacted the statutory sector, NHS or social services and what they are hoping to achieve. Any risks to an individual's ability to carry out their normal daily lives because of their needs or circumstances should be recorded, as should any further action to be taken (e.g. referral for a specialist assessment, or overview assessment). Any detrimental impact on carers* and/or dependants identified during the contact assessment would also be recorded here.

\* See note on page 76.

Holistic/overview assessment				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
Improved health	My physical well-being:	Details of presenting need relating to an individual's physical well-being. Any impact on carers and/or dependants should also be recorded, with their consent.*	My disabilities, impairments and other conditions	Recognised disabilities or conditions perceived/recorded at the time of assessment (may include registered disabilities and learning disabilities). This could include details/impacts of: <ul style="list-style-type: none"> <li>● indicators of condition;</li> <li>● the long- or short-term nature of a condition(s); and</li> <li>● the degenerative nature of a condition(s) (in which case warning signs of onset of deterioration should also be recorded).</li> </ul>
			My general physical well-being	Indicate if general physical frailty, weakness, fatigue or weight loss has occurred.
			Sensory impairment	Indicate impact on independence of any sensory impairment present (e.g. visual impairment, hearing loss, etc. – may include registered impairments).
			Drug therapies	This is not a definitive list of formally prescribed medications (these are available in the clinical record). This is where any drug regimes used and any risks associated with use of non-prescribed medicines (e.g. herbal or alternative treatments/therapies, over-the-counter remedies, private purchase) should be recorded. May also address ability to self-medicate, any aids used to administer medication (e.g. blister packs, spacers), any problems taking medicines and information about medication review, etc. Negative reaction to any treatments should also be included here.
			Lapses of consciousness	Any impact on independence or well-being due to lapses of consciousness – e.g. caused by epilepsy, stroke, diabetes. May also include details of the frequency with which these lapses occur. Emphasis should be placed on the effect on well-being.
	Skin care/wound management			Any impact on independence or well-being due to problems with skin or managing wounds should be recorded – e.g. tissue viability, ulcers, pressure sores, etc. May also include contributory factors which may affect wound/tissue viability and care.

\* See note on page 76

Holistic/overview assessment (continued)				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
			Using the toilet and continence	Any difficulties using the toilet, or continence problems, should be recorded (including aids required – e.g. commode, urinary appliances, stoma care, etc.) and particularly the impact on independence and well-being.
			Breathing	Any impact on independence or well-being because of breathing difficulties/breathlessness should be recorded (e.g. due to COPD, asthma, recurrent chest infections, etc). May also capture monitoring techniques and care processes in place.
			Swallowing and my oral health	Any impact on independence or well-being associated with difficulties in swallowing, chewing, teeth, dental prosthetics and oral hygiene should be recorded.
			Sleeping	Any impact on independence or well-being associated with sleeping patterns/sleeping problems (e.g. sleep apnoea) and details about how they are affecting or being affected by the condition/disability.
			Pain	Presence and impact of any pain. May also capture monitoring techniques and pain-management processes in place.
			My communication needs	Any impact on independence or well-being associated with communication difficulties should be recorded. <b>NB: Factual statements – such as first language or requirement for an interpreter – should be part of the demographic record.</b>

\* See note on page 76

Holistic/overview assessment (continued)				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
	My mental, psychological and emotional well-being:	Details of presenting needs in relation to mental, psychological and emotional well-being. Any impact on carers and/or dependants should also be recorded, with their consent.*	My mental health needs	Any impact on independence or well-being associated with mental health should be recorded (examples include: impacts of dementia, bipolar disorder, phobias, etc.).
			My behaviour	Any impact on independence or well-being due to behaviour should be recorded (e.g. respecting personal space, disruptive behaviour). This may include people's observations about behaviour which may potentially be threatening to others, aggressive behaviour, observed signs of self-harm or self-neglect, etc.). <b>NB: Observations of this nature must trigger a risk assessment</b> , as well as local procedures for capturing risks/warning alerts. It is not envisaged that the output of a full risk assessment would be replicated in a holistic assessment; however, aspects of serious concern should be recorded.
			Memory, thinking and reasoning (cognition)	Any impact on independence or well-being associated with memory loss, level of confidence/disorientation, comprehension, ability to react to emergencies, etc. should be recorded.
			Mood	Details about mood or attitude to life should be recorded here (e.g. depression, anxiety, over-elation, energy levels, lack of motivation/interest, irritability, experience of recent bereavement/loss/unemployment, etc.). Any impact on independence or well-being associated with mood should also be recorded.
			Misusing substances	Any risks associated with heavy smoking (e.g. in conjunction with a respiratory condition), excessive alcohol consumption, drug/substance abuse. May also include abuse of/addiction to prescribed drugs.

\* See note on page 76

Holistic/overview assessment (continued)					
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)	
Improved personal dignity and autonomy	Activities of daily living:	Assessment of ability to manage day-to-day activities. Any impact on carers and/or dependants should also be recorded, with their consent.*	Dressing/undressing	Any impact on independence or well-being due to inability to dress/undress and details of any assistance/aids required.	
			Personal hygiene	Any impact on independence or well-being due to inability to wash hands, shower, use a bath, etc. (including availability of facilities). May also include any difficulties with personal care activities, such as shaving, applying make-up or brushing hair and the impact of these difficulties.	
	Mobility:	Assessment of mobility issues and impacts. Any impact on carers and/or dependants should also be recorded, with their consent.*	Doing housework/my daily tasks	Any impact on independence or well-being due to inability to do things around the home like cleaning, laundry and other support required to keep home clean and tidy.	
			Eating and drinking	Any impact on independence or well-being due to difficulties feeding self, preparing food/drink, shopping/obtaining food, or due to poor diet.	
			Mobility in my home	Any impact on independence or well-being due to inability to access parts of the home, use stairs, etc. Also record if house-bound or bed-bound and use of mobility aids.	
				Mobility outside my home	Any impact on independence or well-being due to mobility issues outside the home, e.g. wheelchair unsuitable for outdoors, or can't make use of public transport.
				Falls	Any history of falls, or perceived risk of falling. Details of falls history, such as frequency, time period, severity, pattern, etc. may also be recorded. <b>NB: Observations of potential risks of falling may be captured, but these should trigger a risk assessment.</b>

\* See note on page 76

Holistic/overview assessment (continued)					
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)	
Exercise of choice and control	My care preferences:	Expressions of personal care preference that are important if well-being is to be maintained during an episode of care. Examples include: gender of home-care assistants, end-of-life care needs, visit from Chaplaincy services while in hospital, therapeutic intervention preferences, etc. Any impact on carers and/or dependants should also be recorded, with their consent.*			
Freedom from discrimination or harassment	Adult protection:	Assessment of issues relating to adult protection. Any impact on/risk to carers and/or dependants should also be recorded, with their consent.*	My sense of security	Any impact on independence or well-being due to perceptions of safety both at home and in general (e.g. ability to summon help in emergency). May also include neighbourhood and environmental considerations.	
	Equal treatment:	Details if person believes that they have not received equal treatment in terms of access to care services or have been discriminated against by providers of care services and there is a risk to the person's well-being as a result (may relate to age, race, ethnicity, gender, sexuality, religion, language, area of residence, poverty, etc.).	Abuse/threats	Details if there is risk of abuse, or if threats have occurred.	

\* See note on page 76

Holistic/overview assessment (continued)					
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)	
Improved quality of life	My home:	Assessment of needs arising from housing situation.	My housing support needs	Any difficulties living alone without support (e.g. need for help in managing accommodation costs, warden call alarms, housing adaptations (ramps, etc.)).	
			My current housing	Any impact on independence or well-being arising from housing situation – i.e. suitability of housing to current situation/needs. Examples include: location, size, state of repair, environmental concerns/infection risks.	
	Keeping healthy:	Details of any health-promotion interventions that could contribute to reducing the risks to a person's independence or well-being. Examples include: opportunities for daily exercise, flu jab, access to active-ageing programme, etc.	Managing my home's energy needs	Any difficulties in maintaining a warm home (e.g. unsuitable heating appliances, unclaimed allowances, financial restrictions, home requires insulation/adaptations, access to grants, etc.).	

\* See note on page 76

Holistic/overview assessment (continued)				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
	Being cared for:	Details about strength of existing caring relationships, including perception of the needs of the carer(s) and their ability to continue caring. (This does not constitute a separate carer's assessment: it is about the person's needs arising from their current caring arrangements, including risks arising to the individual as a result.)		

\* See note on page 76

Holistic/overview assessment (continued)					
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)	
Making a positive contribution	Access to education, training and employment:	Include details if the person's circumstances are such that there is a risk to independence or well-being because the individual is unable to continue to hold an existing job/training course/education place without support; if the person needs support to secure a job (e.g. training, needs help with transport to/from work, etc.); or has voluntary activities that are important to them. Details of support required to continue or access new training or education. Any impact on carers and/or dependants should also be recorded, with their consent.*			

\* See note on page 76

Holistic/overview assessment (continued)				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
	My social well-being:	Details of all areas contributing to an individual's social well-being.	My caring responsibilities	Any difficulties in continuing to undertake caring responsibilities, including caring for other adults and parenting responsibilities.
			My relationships	Any difficulties maintaining existing relationships that are important in order to maintain independence or well-being. Examples include: loss of carer, breakdown of family relations, or level of reliance on support from others, importance of existing support network. Any impact on sexual relationships should also be recorded if this information is important. <b>NB: This should not be a list of people.</b>
			Involvement in my community	Any impact on independence or well-being due to difficulties in maintaining involvement in the community should be recorded (e.g. concerns about maintaining involvement in leisure interests, hobbies, other social activities, or links with existing social networks). <b>NB: May also capture frequency of contact with others.</b>
			My religious, cultural and spiritual needs	Any religious, cultural or spiritual factors that may influence the way that care should be provided (e.g. kosher diet, having someone to pray with), or which could present a risk in current circumstances (e.g. fasting). Details of any support required to access religious or cultural activities that are important.

\* See note on page 76

Holistic/overview assessment (continued)				
High-level outcome	Domain	Domain definition	Sub-domain	Description of impact on independence or well-being (include any perceived impact on carers* and/or dependants within the domain where they have given their consent)
Economic well-being	My finances:	Any impact on independence or well-being due to financial situation or ability to manage finances should be recorded – e.g. impending loss of services due to difficulties managing own finances, need for assistance to manage finances, details of any Lasting Power of Attorney, need for an appointee or independent financial advisor, financial contingency plans (e.g. following admission to hospital, contingency for who pays the bills etc.). May also include issues around maximising income, such as awareness of benefits, access to a benefits review, etc.		

\* Where it is identified that a carer has support needs, they should be offered an assessment of need in their own right, and the outcome of their assessment should be recorded in a separate care record. However, details of the way a person's needs impact on their carer(s) should also be recorded where the carer(s) gives consent. Where information about a third party (including a carer) is recorded on a person's care record, it should be recorded in an anonymised way.

Overview care plan		
Care plan summary	Outlines at a high level what areas/issues are covered and the principal actions arising out of the care plan.	
Care plan goals	The overarching goals/purpose of the care plan. May include the person's life goals and aspirations.	
Person coordinating care plan	Details of the practitioner who is leading the process and coordinating the care plan – their name and role, the organisation they are part of and their contact details.	
Care plan review	Next planned review date of whole of care plan (NB not just of a single component).	
Care plan component – repeats for each issue NB: Not all items need to be completed for a care plan component to be created	White Paper outcome for adults	Defines which of the seven White Paper outcomes this component of the care plan is linked to (e.g. exercise of choice and control, improved physical health, etc.).
	High-level objective (CAF domain)	Defines which of the CAF high-level domains this component of the care plan is linked to (e.g. my physical well-being, mobility, keeping healthy, etc.).
	Lower-level objective (CAF sub-domain)	Defines which of the CAF lower-level sub-domains this component of the care plan is linked to (e.g. sleeping, personal hygiene, involvement in my community, etc.).
	Individual issue (description of issue for individual)	Identified issues, problems or needs from assessment.
	Individual's goal/aims	The intended end-point or goals being set at the commencement/review of this activity. Things planned to be achieved/the objectives in this area.
	Action/intervention	What is actually going to be done/is needed to meet the requirements of this issue. This includes agreed actions, services, interventions, treatments and support.
	Responsibility	Person(s) responsible for supporting or meeting the needs here – e.g. social worker, GP, carer, or the individual.
	Provider/delivered by	How it will be delivered – by which organisation, service, team or person.
	Schedule	When and how often this action is needed.
	Information support	Information for health needs (which may include an information prescription), including staying healthy, specialist services for the person's condition, choices of services/treatments available, evidence of benefits and risks of treatments, informal patient groups. Information for social care needs, including social care services, voluntary sector services, equipment or financial benefits. Self-care/self-management advice.

<b>Overview care plan (continued)</b>	
	Outcome or progress actually achieved over time period, as well as the measure to be used to evaluate effectiveness.
Outcome at review	
Valid dates	Pertinent dates relating to care plan component. Examples include: start date, date of next planned review and/or actual/expected end date.
Individual care preferences	To be reported here from information gathered under 'individual care preferences' item within Holistic/overview assessment above. May add further details in relation to specific component. Should particularly include end-of-life planning.
Individual strengths	The things the person can do – their strengths.
Situations that might lead to a deterioration	Situations that may cause a marked deterioration in the person's condition – e.g. illness of their wife/husband/partner; they don't get enough to drink; they cease to take medication as prescribed, etc.
Individual's agreement/access to care plan	Records individual's agreement to part/all of the care plan, as well as how and when paper/electronic copy is/was made available to them.
Crisis plan	For example whom to contact/what to do in the event that the condition breaks down/deteriorates in working hours or outside of working hours.
Contingency plan	Contingencies already in place should they be required – e.g. respite or other support for individual and their carer(s) already arranged, person or organisation that will step in if main carer falls ill, etc.

# Appendix 3: Recommendations of the Assessment and Care Planning Policy Collaborative in respect of the assessment of adults with longer-term care needs

## Introduction

1. This appendix sets out the recommendations made by the Assessment and Care Planning Policy Collaborative in respect of the assessment of and the care planning for adults with long-term care needs. The Assessment and Care Planning Policy Collaborative was convened by the Department of Health, with support from the Care Services Improvement Partnership (CSIP), and met between October 2006 and March 2007.

## Principles of a Common Assessment Framework for Adults and integrated personalised health and social care plans

2. It was recommended that a Common Assessment Framework (CAF) should **build on existing practice**, in particular the Single Assessment Process (SAP) for Older People and person-centred planning.
3. The overriding principle should be to take a **person-centred approach** to supporting people with longer-term care needs to live their lives in the way that they choose and to maximise the opportunities for them to participate in society by focusing on improving overall quality-of-life outcomes. As 'quality of life' is a relative concept, the approach relies on identifying desired outcomes from episodes of care, as defined by the individuals accessing care services themselves, rather than by professionals. It also relies on a coherent approach to the delivery of care by health and social care workers, so that multi-disciplinary and integrated teams work towards delivering the outcomes that individuals are seeking.
4. A Common Assessment Framework for Adults should be about **sound, efficient processes, not the development of a single national toolkit**. A range of different assessment toolkits should continue to exist.

## Implementation

5. Members of the Policy Collaborative proposed that the implementation of a Common Assessment Framework for Adults should be supported by a number of products:
  - good-practice guidance on integrated and person-centred support planning;
  - national guidance on integrated multi-disciplinary assessment aimed at supporting health and social care staff;
  - a series of leaflets setting out the key points in the guidance aimed at front-line practitioners, GPs and people accessing services (i.e. patients, clients, carers); and
  - a generic business case template aimed at managers in the NHS and social services to support the development of local business cases for implementing integrated electronic health and social care records.

## Good practice in assessment

6. The classification of different types of assessment used in the SAP was helpful:
  - contact;
  - overview;
  - specialist; and
  - review.
7. However, the concept of a ‘comprehensive’ assessment was unclear. Application of the different types or levels of assessment should not be seen as a linear process (e.g. following an emergency response, a person’s first assessment could be a specialist assessment).
8. The principles of the framework should apply to all adults accessing health and social care services, although a more detailed assessment would only be applied where needed (and with the individual’s agreement).
9. Each new contact should build on information that already exists within a person’s care record and should avoid duplicating the collection of information. This requires a culture of trust to develop between professionals. However, it might be appropriate to reassess the situation (i.e. to identify if the information held on a person’s record is still up to date) following key events, such as admission to hospital, or the death of a carer or family member.

## Care coordination

10. A named care coordinator should be appointed to coordinate the assessment and care-planning process and the subsequent provision of any services where more than one person or provider will be involved in assessment or provision of care (i.e. where a

multi-disciplinary response is required). A single person should act as care coordinator throughout the pathway and should coordinate the contribution to assessment and subsequent service provision by any number of people involved during an episode of care.

11. In some cases, the first health or social care worker who comes into contact with a person who has care needs may not be the most appropriate person to undertake an overview assessment and/or to act as care coordinator. For example, if a person with a long-term medical condition has relatively uncomplicated health needs but complex social circumstances, it might make more sense for a social care worker to take the role of lead assessor and/or care coordinator for that person. Decisions would need to be taken on a case-by-case basis, with case conferences convened where appropriate.

### When should an assessment occur

12. Assessment and care planning should be integral to all episodes of care and be conducted at various points along a care pathway. A contact assessment, which could prompt an overview assessment and/or changes to a care plan, should be undertaken:
  - following diagnosis of a long-term medical condition;
  - during routine medical check-ups, where a long-term medical condition is being managed;
  - before and during discharge from hospital (including A&E);
  - on first contact with social services and during subsequent unplanned contacts (e.g. following a crisis);
  - following important life events, where a person already has complex longer-term care needs; and
  - as part of general GP consultations, where a complex situation or impaired functional ability is identified.
13. In some cases, contact assessments might be undertaken by voluntary sector organisations as part of outreach programmes, making referrals to health or social services (with a person's consent) should a potential need be identified. This practice is to be encouraged, as it improves access to services and may be particularly effective in identifying the needs of groups within the community that are less likely to approach statutory service providers.
14. Different levels of assessment are required in different circumstances – not all people with a long-term medical condition will require an overview assessment of need at the point of diagnosis, although a comprehensive assessment of the needs of people with a registered disability is a statutory requirement, and an overview assessment should, therefore, always be offered. At the point of diagnosis, a self-assessment may also be an appropriate way of assessing if a person has wider needs.

### Who can undertake the assessment

15. All front-line staff in primary care, social care, occupational therapy services, A&E, outpatient, inpatient and day-care services may be involved in the assessment process. All front-line staff should, therefore, be familiar with the principles of assessment, be able to identify whether a person may benefit from an overview assessment and understand the action that they personally need to take if a person is having difficulty (or may have difficulty in future if services are not provided) with their normal daily routines (including caring responsibilities).
16. It is not expected that a single health or social care worker will necessarily complete all of the assessment all of the time. They may require input from other health or social care workers in order to identify if there is a need in a particular domain, and the most appropriate way of managing that need, depending on the complexity of the individual's circumstances. In such cases, a specialist assessment would be commissioned.
17. For most people with single, long-term medical conditions, or with a number of conditions that they are self-managing effectively, it is only necessary to identify whether there is any impairment to an individual's ability to manage their normal daily routines (or caring responsibilities) as and when their circumstances change (i.e. an overview assessment would not always be required).
18. During an assessment, consideration should always be given to a person's physical and mental well-being and their ability to carry out activities of daily living (e.g. bathing, housework, etc.). A person's strengths should be identified, as well as their needs.
19. An assessment should identify whether an individual needs support to achieve the agreed outcomes for adults, as set out in *Independence, Well-being and Choice* and *Our health, our care, our say*. An assessment may include assessing risks to that person's independence, in order to determine eligibility for social care services, as part of Fair Access to Care Services (social care eligibility criteria) assessments or assessing eligibility for NHS Continuing Care. Medical and other diagnostic assessments, which are included within the concept of 'specialist assessments', will generally serve a more specific purpose, and a summary of the outcome, including any recommendations about care and clinical management, should be included in the care plan.
20. As part of the subsequent care-planning process, assessors should avoid being unduly risk averse, in line with the principles of *Independence, choice and risk*.<sup>1</sup>

### Contact or screening in assessment

21. It was suggested that, in practice, many local communities have misinterpreted the original aims of the Single Assessment Process in respect of the contact assessment. In some local areas, eight-page contact assessment forms have been developed, which

1 *Independence, choice and risk: a guide to best practice in supported decision making*, Department of Health, 2007.

include large amounts of information that is collected for monitoring purposes, rather than because it is needed to inform decisions about further assessment or onward referral.

22. The purpose of a contact assessment should be to:
- obtain sufficient information to ascertain the impact of any problems on an individual's ability to live independently and on their family or carers, or to prompt an overview assessment;
  - to understand what the individual hopes to achieve by contacting health or social services; and
  - to identify any other service providers that may need to provide support (i.e. to ascertain if a referral is required).
23. A contact assessment should be undertaken whenever a person with an identified longer-term care need self-refers to an NHS service or to social services, or following an emergency intervention. A contact assessment could be the only assessment required, if it is possible to provide a service, to signpost a person to another service, or to provide adequate information on the basis of what is known at this stage.

### Primary demographics and biographical information

24. If a person is already registered with a GP, some demographic information will already exist as part of the Personal Demographic Service. Assessors should check basic personal information in order to enable the individual to be identified accurately. This should include verifying (or, if a health and social care record has not already been created, recording) the following information:
- the person's name;
  - the person's date of birth; and
  - the person's NHS Number (which should be used as a common unique identifier across health and social services).
25. A limited amount of biographical information may be useful to inform the work of other members of a multi-disciplinary care team or other agencies. Where this biographical information is held on a person's record, it may be verified during subsequent assessments, as it may have changed and could influence the type of response required. It is proposed that an assessor may wish to record the following biographical information (which should be entirely factual, rather than subjective information):
- employment status;
  - accommodation;
  - dependencies of others upon this person (including animals, where necessary);

- dependencies on others (including carer support);
- communication support (including any advocacy requirements); and
- National Insurance number (to support information exchange with benefits services – e.g. as part of a single financial assessment initiative).

### Consent

26. Consent should always be sought before a person is assessed and again before information is shared across integrated multi-disciplinary health and social care teams (although there are circumstances where a specialist assessment might be undertaken without explicit consent having been sought – e.g. following an emergency health intervention). The fact that consent has been provided should be indicated clearly in a person's care record. Assessors should be aware that consent to share information could subsequently be withdrawn.

### Mental capacity

27. In line with the requirements of the Mental Capacity Act, it is important to decide on a person's capacity to consent to the assessment and to record this. It should not be assumed by health and social care workers that just because someone lacked capacity at a previous assessment, that person continues to lack capacity, as their circumstances may have changed. For this reason, mental capacity should be reassessed at each new contact.

### Assessing information about presenting needs as part of a contact assessment

28. The purpose of collecting information about a person's presenting needs during a contact assessment is to:
- obtain sufficient information to ascertain the impact of a presenting need (e.g. a disease or a disability) on a person's ability to live their normal daily life (including any caring responsibilities) as independently as possible;
  - identify if there is any detrimental impact on the well-being of carers, family members or other dependants; and
  - understand what the individual hopes to achieve by contacting health or social services (e.g. to alleviate the symptoms of disease, to be able to self-manage a long-term condition, or to have a grab rail fitted outside their home).
29. The Assessment and Care Planning Policy Collaborative recommended that an assessor may find it helpful to focus on the following questions during contact with a person, in order to identify the correct course of action:
- Why has the person contacted health or social services?
  - How long have they been experiencing difficulties?
  - What does the person think would help them?

- Do they need help with anything else?
- Has anything happened recently that has affected the situation?
- What does the person's family or carers think about the issue?

## Holistic/overview assessment

30. A holistic or overview assessment is recommended where a longer-term health or social care need is identified, which may impact on an individual's ability to carry out their normal daily routines (including caring responsibilities), or where their circumstances are having a detrimental impact on their carers, other family members, or other dependants. An overview assessment may also be appropriate in other complex acute situations (e.g. following diagnosis of cancer or end-of-life care needs).
31. The purpose of an overview assessment is to identify if a person has a need for health or social care services, or support from other agencies, and to determine if there are wider health or social care factors, other than those already identified, that could present a risk to independence and/or well-being. By undertaking a holistic/overview assessment, an assessor can be sure that consideration has been given to a range of support that a person may need in order to maximise their independence and well-being, and to reduce lengths of stay in hospital if that person could be appropriately cared for in the community.
32. Undertaking an overview assessment also increases the chance of identifying underlying problems that may be causing (or exacerbating) an existing disease or disability, and of identifying the need to involve partner organisations at an early stage. In this sense, a holistic/overview assessment can be used proactively as a way of case-finding those with complex long-term care needs. In respect of case-finding it has been suggested that assessing activities of daily living (e.g. a person's ability to wash, dress, etc.) is particularly important in both health and social care services.
33. An overview assessment of need may be initiated by a health or social care worker, or by the person themselves (possibly with support from a family member, a carer or another intermediary) as part of a self-directed assessment of need. Consideration should be given as to whether there is potential need across a range of domains (for these purposes the proposed domains of the Common Information Set should provide a guideline). However, it will not always be necessary to assess all the sub-domains in detail. Where the Single Assessment Process is being used, existing toolkits will normally provide a thorough assessment of most of the proposed domains of the Common Information Set and could continue to be used.
34. The assessment should identify any potential risks to independence and well-being associated with each domain, and a summary of the outcome of an overview assessment should be recorded within a person's electronic health and social care record or on a paper-based, person-held record. It has been proposed that the following principles

should inform the way that an overview assessment of health and social care needs is undertaken:

- It should be recognised that some people will not consent to have an overview assessment of need, or for information to be shared more widely following an assessment of need, and this is their right.
- The proposed domains of the holistic/overview assessment should provide a prompt for assessors/people being assessed to consider, rather than a definitive guide.
- It will not always be necessary to assess all domains of need in detail on every occasion.
- Local communities should be able to continue to use existing Single Assessment Process toolkits (and other multi-factorial assessment toolkits) to undertake a holistic/overview assessment.
- The assessment should focus on identifying a person's strengths as well as their needs.

### Support from a carer

35. The support that a person receives from a carer should also be recorded against each domain. For example, if a person struggles to make a meal themselves, but there is no present risk to their well-being because this need is met by a carer, it is important that that is recorded and that contingency arrangements are considered as part of care planning, in case the support from a carer should not be possible in future.

### Specialist assessments

36. It has been proposed that the detailed record of the specialist assessment should be held locally. Where such records are held electronically, they should be held separately from the integrated electronic care record, on the local system.
37. In this context, it is important to note that there is a difference between a person's electronic health **and** electronic social care record (which contains all the information held by the NHS or social services about that person) and their integrated electronic care record (which holds only the information that is shared between health and social services). Therefore, the integrated electronic record is part of a person's health and their social care records, but does not constitute the entirety of either.
38. It is proposed that the following principles should inform a specialist assessment:
  - As with other types of assessment, consent should be sought before an assessment occurs.
  - The detailed results of specialist assessment do not necessarily need to be shared across a multi-disciplinary care team.

- The following details should be recorded within the electronic health and social care record, or person-held record:
    - a summary of the outcome of assessment against the relevant domain of need;
    - the date of assessment, name of the assessor and details of the type of assessment and physical or electronic location of the full record of the specialist assessment; and
    - any interventions, services or changes in existing care arrangements that are recommended as a result.
39. For people with very complex needs, or general physical deterioration, a detailed specialist assessment of several (or all) domains of need may be necessary.

### GPs and the Common Assessment Framework

40. GPs have a particularly important role to play in the management of people with longer-term care needs. As hospital services are reconfigured, health services will increasingly be provided in community settings. Most people with longer-term care needs will be registered with a GP and, for many people who are successfully managing their own conditions or disabilities, a GP may be the only health or social care professional with whom they have contact on a regular basis.
41. Securing the involvement of GPs (and through them other practice and primary care staff) in multi-disciplinary assessment and care planning has been a key obstacle to implementation of the Single Assessment Process in some local areas. It should be recognised that GPs work within significant constraints in terms of the amount of time that they are able to devote to each patient. GPs have also adopted a largely paperless working environment since the turn of the millennium.
42. A framework for assessment has to be consistent with current GP working practices, and GPs should therefore primarily be expected to contribute to the process, rather than to act as care coordinators or to undertake overview assessments of need. The involvement of GPs themselves would normally be at the level of the contact assessment, although in some cases GPs (particularly those with a special interest) could undertake specialist assessments. It will be important for GPs to ensure that an overview assessment is undertaken by practice staff, or that the need for an overview assessment is communicated to other primary care or social care workers.
43. It has been recommended that the CAF Information Set should be incorporated into the IT systems used in general practice, in order to enable GPs to contribute effectively to the process through contact assessments and referrals, as part of their normal working practice.
44. A further recommendation is that GPs should be encouraged to ensure that proactive assessments of people with known long-term health or social care needs are undertaken

in primary care, including assessment of a person's ability to undertake activities of daily living as part of routine, proactive monitoring of people with ongoing long-term medical conditions.

## Carers, families and dependants

45. Members of the Policy Collaborative felt that unpaid carers are people who make an invaluable, but often under-rated, contribution to the work of health and social services. Undertaking caring responsibilities may impact on a person's life opportunities in a number of ways. Where a cared-for person has poor mobility, a carer may be at risk of physical harm through moving and handling that person. Carers are often also at greater risk of social exclusion than the majority of the population, as they may have limited opportunities to undertake social activities, to participate in education, or to work full time. Taking on caring responsibilities can also affect people's lives in more subtle ways, such as changing long-standing relationships between people. The financial burden of funding longer-term care can also impact on the economic well-being of whole families.
46. Throughout the assessment process, consideration should be given to the impact of a person's needs (or failure to meet those needs) on that person's carer(s), family and any other dependants. This should include identifying any impact on carers, family and dependants as part of a screening in assessment and within each domain of an overview assessment, and recording that impact if consent is given by the carer or other family member(s). It is important that the impact of a person's needs on their carers, family and dependants is assessed in order to:
  - identify if that person also needs support from health or social services; and
  - inform contingency planning (e.g. if a lone carer is taken ill).
47. Carers and other people who cohabit with a person are often uniquely well placed to gauge the impact of living with a longer-term care need on that person's quality of life and to identify deterioration or the early onset of illness. The views of a carer or another family member about a person's needs should be considered, as they can often make an important contribution to the assessment process. The assessor should also be aware that a significant degree of mutual interdependence can occur between carers and the people they care for.
48. Carers are entitled to an assessment of needs in their own right, as are other adult family members and children. An assessment of need should be offered wherever a health or social care worker believes that a carer, family member or any other dependant may have a need for community care services. Where such an assessment is undertaken, the same principles and processes should be applied as for other adults with potential longer-term care needs. Where a carer, family member or other dependant is a juvenile, and an assessor believes that they have a care need, a referral to children's social services should be made, or else to that person's GP, if the identified need is primarily health related.

49. In line with the requirements of the Data Protection Act, where it is determined that a carer, family member or other dependant has a need, a separate care record should be produced; this should include a summary of the presenting need and a separate care plan, where a service is to be provided. It is important that different people's needs are recorded in different care records for the purposes of seeking consent to share information (i.e. a cared-for person may be content for a summary of their assessment to be shared between health and social services, but the carer may withhold consent). Local arrangements should be made to ensure that the user's and the carer's plans are considered together.
50. Where it has been identified that a carer has a longer-term health or a social care need, then their need for support should be reassessed as for any other person with an eligible health or social care need. Carers should be entitled to expect at least an annual discussion of the care they provide and the help they receive; of what they feel they need; and of what support is available.
51. Although carers are often at a high risk of developing longer-term care needs themselves, evidence suggests that often they do not perceive themselves as having care needs and are sometimes reluctant to turn to the statutory sector for help. Increasingly, the statutory sector is turning to voluntary sector organisations to provide proactive support services, including making referrals and sometimes participating in information collection as part of a formal health and social care needs-assessment process. The involvement of third parties in this way can increase accessibility to care services and, as such, is to be encouraged.

## Assessment and care planning

52. A holistic assessment may prompt a multi-disciplinary response to meeting a person's needs. Where this occurs, a summary of assessment should be shared within a person's integrated care record. The Department of Health has issued detailed guidance about integrated care planning.

## Review

53. On review, all the domains of the overview assessment should be reassessed (at a high level) in order to identify whether there has been a change in the individual's circumstances. A review should be conducted at least annually for people in long-term need of care; and for people with complex needs, it is considered good practice for assessment to be conducted via a multi-disciplinary review panel or case conference. Depending on the individual's circumstances, a self-assessment may be an appropriate way of initiating a review, with a competent health or social care worker following up the self-assessment to verify the details.

54. Good-practice guidance on care planning makes it clear that objectives related to each aspect of a care package or programme should be included in the care plan. On review, progress against these objectives should also be assessed. It should be recognised that some people's condition will deteriorate and therefore the failure of service providers to meet a desired objective does not necessarily reflect the fact that a prescribed care package or intervention was inappropriate. It is important that progress against objectives is recorded, and that the record is agreed with the person concerned.

### Self-assessment/direct access

55. Self-assessment should be made available wherever possible. Self-assessment could take the form of an individual being asked to complete a self-assessment form. However, councils have an obligation under Section 47 of the NHS and Community Care Act 1990 to assess anyone who appears to them to be in need of their services. Therefore councils must ensure due scrutiny where a person has self-assessed their own social care needs, before any services are provided. As a matter of good practice, organisations will wish to ensure that there are suitable arrangements in place to make sure that individuals completing a self-assessment are neither under-assessing nor over-assessing their need for services.
56. Early learning from 11 self-assessment pilots suggests that self-assessment has a number of benefits in terms of:
  - supporting a cultural shift away from a paternalistic model of care delivery;
  - accessing people who are less likely to contact the statutory sector;
  - improving relationships between service providers and consumers;
  - improving relationships with the voluntary and community sector (where they are involved in the process); and
  - helping service providers to understand the needs and demands of communities.
57. Self-assessment could be applied at a number of points in the care pathway. The different models of self-assessment that were tested through the pilots suggest that self-assessment can be employed:
  - as a way of providing information about local services to people who may wish to arrange their own care;
  - as a way of self-referring into services;
  - as a way of directing people into the most appropriate pathway(s);
  - as a way of collecting basic information to inform an overview assessment of need on which a professional can build, if required; and

- as a way of collecting basic information to inform a specialist assessment (on which a professional can build if necessary) for:
    - sensory impairment services;
    - community equipment services; and
    - housing adaptation services.
58. In addition to those specified above, there may be a range of different types of assessment for which self-assessment is appropriate. Assessors should also be aware that there are circumstances where a self-assessment is not appropriate.
59. Self-assessment cannot replace the role of the professional; but there is clearly scope for self-assessment to be incorporated as *part* of the broader process of assessment.







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