

# End Project Report

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## Common Assessment Framework (CAF)

## National Demonstrator Site

## User Involvement Group Report (Phase 1)

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## 1. Management Summary

### 1.1 Purpose

The report refers to Stockport Partnership's Common Assessment Framework Project (CAF) for Adults and work undertaken for Phase 1 of the project with a local User Involvement Group.

Stockport is one of only twelve local authority led partnerships selected as national demonstrator sites for a three year project (April 2009 to March 2012). It is funded by the Department of Health and we are required to periodically report to them, and in addition participate in a national evaluation which will be widely published following closure of all projects.

The demonstrator sites have been chosen to lead the way forward in making a more efficient and transparent system for information sharing, to avoid duplication in assessments and ensure that people receive the best quality care and support.

### 1.2 Outline

Stockport's project covers the Continuing Health Care Team (CHC), and a key priority for Stockport in general is effective delivery of this service. The work is in two phases – Phase 1 is to use current systems and solutions and Phase 2 works towards a link with health service national records.

The partnership is Adult Social Care, NHS Stockport, Age Concern Stockport (Age UK) and system suppliers are OLM and Graphnet. Support has also been given by Stockport NHS Foundation Trust and local GPs.

Background:

- Continuing Health Care is a generic term and can be provided for an extended period of time to adults aged 18 years and over to meet their physical and mental health needs as an outcome from disability, accident or illness. Provision in Stockport can be through Stockport Council (Adult Social Care) or NHS Stockport (Health Care); however care is dependent upon the individuals needs.
- It is a significant area of work since the introduction of the national policy (2007 / revised 2009) and therefore important to devise a whole system model.
- The project will focus upon the assessment and case management in both community and hospital settings.
- Ensuring effective streamlined processes; introduce shared electronic recording with reporting functionality; and respond more appropriately to information sharing.
- Working towards a model framework, virtual views and workflow messaging.
- Developments should also meet the aspirations of the personalisation agenda.

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The partnership recognises that CAF is a good mechanism to address the service as it aims to improve outcomes for complex, longer-term health and social care needs through its unified approach which is especially helpful for people who have had to deal with separate health, social care and support systems.

## 2. User Involvement Group

### 2.1 General

There are numerous work packages for both phases of the CAF Project and people assigned with knowledge and skills in particular topics.

This report comments upon the User Involvement Group and two workshops held late 2009 with outcomes to date from the contributions made. The participation was agreed following a formal request to LINK's and approval was given by the Core Group members. Representation also included professional staff, partnership board members and carers' forum.

The workshops gave an opportunity to re-introduce the project following the brief update at an earlier LINKs event commenting upon the transformation of adult social care.

- The Common Assessment Framework is based upon earlier experience of the Care Programme Approach for Mental Health, Single Assessment Process for Older People and Person Centred Planning for People with Learning Disabilities. The aim being to remove artificial boundaries of older age and to provide continuity of a person centred approach throughout adult life.
- Continuing Health Care follows a national framework (National Framework for NHS Continuing Health Care and NHS Funded Nursing Care) from the Department of Health which contains guidance for determining eligibility, so that people with equal needs have equal opportunity to have their care met free of charge.
- The first part of the project needs to ensure that the Continuing Health Care framework is used appropriately by everyone concerned. Information collected will feed into the Common Assessment Framework to ensure a standard dataset and core details transferred regarding service users to their electronic NHS Care Record.
- Looking at work to date to consider the service pathway from a user / carer perspective.
- A systems approach to understanding how people move through the Continuing Health Care process.
- Feedback from staff about the current processes and the roles undertaken – within the immediate service, service areas making referrals and service areas contributing and supporting assessments and care planning.
- Mapping work has been undertaken referring to the current end to end process:

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- ⇒ Examples of present findings –  
From this review we have noted that some people are over-assessed, there are preventable and predictable elements in current cases, an average of 14 weeks for assessments and care packages to be implemented, not everyone benefits from the multidisciplinary involvement, boundary disputes may impact on quality of delivery.
- ⇒ Examples of what we would like to have –  
Proper conversations with service user's family and carer to explain the process and implications, concise and clear information as not everyone understands the process and why they are going through it, service user / carer to be involved in designing their care package.
- ⇒ Ensure we have a good mechanism in place to seek views from service users / carers about their experience and the decision making process.
- ⇒ Agree how we can evidence and report service user views.
- ⇒ Build into the service design suitable methods for effective engagement.
- ⇒ Take advantage of existing opportunities through carers' assessments, multi-disciplinary sessions, and choices at the support planning stage.

## 2.2 The Workshops

We are very keen to ensure people who may have used the service in some way have an opportunity to voice their opinions about Continuing Health Care and contribute towards real sustainable change. Especially important as service users may already be involved in personal health and social care budgets.

The workshops revolved around interactive pin-board sessions at which we defined and stated problems, considered the main issues in relation to problems, looked towards solutions, noted any obstacles and identified potential actions to move forward. We then prioritised the ideas and looked towards mechanisms for service re-design, which needs to ensure effective engagement and good service delivery.

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## 1. Work Shop 1 highlighted a number of areas:

### (a) Where are we now?

Effectiveness of the current referral / assessment process?	<ul style="list-style-type: none"> <li>➤ Community more dispersed and harder to implement</li> <li>➤ Disparity between hospital process and community</li> <li>➤ A query on referral pathway for self funders</li> <li>➤ Assessment good</li> </ul>
The speed of decision making	<ul style="list-style-type: none"> <li>➤ Issues regarding timing for carers involvement</li> <li>➤ Perhaps slows down due to lack of capacity in service provision</li> <li>➤ Works well following the framework</li> <li>➤ Hospital has a quicker response now</li> </ul>
Seeking the views of users / carers / patients about their experiences	<ul style="list-style-type: none"> <li>➤ Systems is transparent and carers have the choice to be involved – should be within and during the process</li> <li>➤ People need to be well informed to participate effectively</li> </ul>
Evidencing and reporting user views	<ul style="list-style-type: none"> <li>➤ This is a recent inclusion and only just beginning</li> </ul>
How well do Adult Social Care and Health work together to provide Continuing Care?	<ul style="list-style-type: none"> <li>➤ Seen as part of a spectrum</li> <li>➤ Need to identify someone who can explain the process from the start</li> <li>➤ Overall it is the biggest improvement</li> </ul>
How transparent is the process?	<ul style="list-style-type: none"> <li>➤ Although it appears transparent there may not necessarily be good supporting information</li> <li>➤ Still confusion regarding Continuing Health Care and people find it difficult to understand where it actually fits, what processes are involved</li> </ul>

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(b) What needs improving and / or what is missing?

Simple Guide on Common Assessment Framework	<ul style="list-style-type: none"> <li>➤ What makes the framework and why is it different?</li> </ul>
Simple Guide on Continuing Health Care	<ul style="list-style-type: none"> <li>➤ What is the pathway – from referral to assessments?</li> </ul>
Good co-ordination	<ul style="list-style-type: none"> <li>➤ For assessment and service delivery</li> <li>➤ Named nurse to support service user / carer</li> <li>➤ Worker who can cross over from hospital to community after discharge</li> <li>➤ Clearer process for service user / carer as to who is managing the package once Continuing Health Care awarded</li> <li>➤ Update on what to do in an emergency if Continuing Health Care is at home, acceptable resources</li> </ul>
Sharing information between agencies	<ul style="list-style-type: none"> <li>➤ Share the correct information openly about the service user on a need to know basis</li> <li>➤ Regular meetings</li> <li>➤ Have one place to look for details</li> </ul>
Good communications	<ul style="list-style-type: none"> <li>➤ Common language</li> <li>➤ Explanation of the process users are going to go through</li> <li>➤ Liaison service between hospital in-patients and community</li> <li>➤ Make use when required of hospital Mental Health Liaison service</li> <li>➤ Establish lead contacts for specific specialist groups</li> <li>➤ Discussions with family / advocate from an early stage</li> <li>➤ Effective informing and support</li> <li>➤ Peer support for service users /carers</li> <li>➤ Use of IMCA (Independent Mental Capacity Advocate) when the service user lacks capacity and is not befriended</li> <li>➤ Ensure informed user consent</li> </ul>
Good information	<ul style="list-style-type: none"> <li>➤ Co-ordinator for the process from checklist to panel decision</li> <li>➤ Accurate basic details</li> <li>➤ Good training to ensure clarity on requirements from the outset</li> <li>➤ Ask for information once only</li> <li>➤ Do not make assumptions</li> </ul>

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Good information ( <i>continued</i> )	<ul style="list-style-type: none"> <li>➤ Data cleanse and keep details up to date during the service delivery</li> <li>➤ Offer family / carers the opportunity to put views in writing if unable to attend MDT</li> </ul>
Developing a Person Centred System	<ul style="list-style-type: none"> <li>➤ Improve access to the system</li> <li>➤ Process flexible enough for unusual cases – not making the user fit the system</li> <li>➤ Ensuring potential service users who are not eligible do not fall through the gaps</li> </ul>
Need to shape the future	<ul style="list-style-type: none"> <li>➤ Residential / Nursing Home capacity planning</li> <li>➤ Respite Care</li> <li>➤ Address out of area issues</li> </ul>
Funded link	<ul style="list-style-type: none"> <li>➤ Facility to offer expertise</li> <li>➤ Dementia liaison nurse</li> </ul>
Feedback	<ul style="list-style-type: none"> <li>➤ On-line website for service users' and carers / next of kin to browse and feedback on processes, looking for general guidance information to</li> <li>➤ Means to support continuous improvement</li> <li>➤ Mechanism in place to ensure service users comments influence service design</li> </ul>
Professional Education	<ul style="list-style-type: none"> <li>➤ Additional training for hospital ward staff to enable improved understanding of the processes</li> <li>➤ Improved understanding of the national framework</li> </ul>
Make it happen (this time)	

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(c) Votes for key issues – what are the priorities?

1 <sup>st</sup>	Communication and collaboration.
Joint 2 <sup>nd</sup>	Developing a Person Centred System  +  Co-ordinating assessment and service delivery – well resourced.
3 <sup>rd</sup>	Professional Education.
4 <sup>th</sup>	Assessment, good initial information and communication from the beginning.
5 <sup>th</sup>	General feedback, feedback for continuous improvement and re-shaping the future.
6 <sup>th</sup>	Make it happen (this time).
7 <sup>th</sup>	Effective informing and support for service users.

## 2. Work Shop 2 presented the opportunity to visit previous work

(a) Review our priorities

1 <sup>st</sup>	Good co-ordination, assessment and service delivery – well resourced.
2 <sup>nd</sup>	Good communication from the start and good initial information.
3 <sup>rd</sup>	Developing a person centred system.
4 <sup>th</sup>	Funded link, communication and collaboration – sharing information between agencies.
5 <sup>th</sup>	Feedback, shaping the future and continuous improvement.
6 <sup>th</sup>	Consistent support.
7 <sup>th</sup>	Simple Guide.
8 <sup>th</sup>	Effective informing and support for service users.
9 <sup>th</sup>	Professional Education.

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(b) Comments on the top three areas as voted for in the prioritising exercise

<b>Good co-ordination, assessment and service delivery - well resourced</b>	
Solutions	<ul style="list-style-type: none"> <li>➤ Joined-up IT services, clear and effective</li> <li>➤ Carers training awareness</li> <li>➤ Clarity of roles in the process</li> <li>➤ Clear approach to delivery of assessments</li> <li>➤ Appropriate professionals involved</li> <li>➤ Shared policies and procedures</li> <li>➤ Clear charts / written communication between staff</li> <li>➤ More funding</li> </ul>
Barriers	<ul style="list-style-type: none"> <li>➤ Professional boundaries</li> <li>➤ Reluctance of staff – competing priorities</li> <li>➤ No integrated service</li> <li>➤ Joint IT systems with agencies</li> <li>➤ Will IT systems deliver what we need</li> <li>➤ Politics of funding policies</li> <li>➤ Budget led services</li> <li>➤ Market v Welfare Philosophy</li> <li>➤ Resources</li> <li>➤ Partnership working – understanding of Continuing Health Care Assessment</li> </ul>
Recommendations	<ul style="list-style-type: none"> <li>➤ Locally agreed policy / guidance</li> <li>➤ Full Continuing Health Care training and understanding for staff</li> <li>➤ Full training in Common Assessment Framework and data set needs</li> <li>➤ Representative management board</li> <li>➤ Ensure IT system is efficient, understandable and universal</li> </ul>

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<b>Good communication from the start and good initial information</b>	
Solutions	<ul style="list-style-type: none"> <li>➤ Model care plans</li> <li>➤ Single point of entry</li> <li>➤ Carer to be the 'police man'</li> <li>➤ Carer training</li> <li>➤ Common areas for storage – secure communications</li> <li>➤ Invest resources</li> <li>➤ Throw away the 'too hard bin'</li> <li>➤ Prioritise</li> <li>➤ Reduce wait for information</li> <li>➤ Check information</li> <li>➤ Involve carers in service re-design</li> <li>➤ Joint assessment questions – shared information</li> <li>➤ Drugs not used as a first resort</li> <li>➤ Effective management and organisation</li> <li>➤ Making it some one's job to ensure things happen</li> <li>➤ Respect for other professionals integrity</li> <li>➤ Smooth transition through the process</li> <li>➤ Staff training, knowing what to complete</li> <li>➤ Secondary workers name in case of absence</li> <li>➤ Close all the loops</li> <li>➤ Clear guidelines for staff</li> <li>➤ Giving relatives due notice to attend meetings</li> <li>➤ Opportunity for next of kin to provide written support if unable to attend meeting</li> <li>➤ Multi-disciplines to work in same building</li> </ul>
Barriers	<ul style="list-style-type: none"> <li>➤ Lack of communication</li> <li>➤ Security of information</li> <li>➤ 'Ownership' of information</li> <li>➤ Information Sharing</li> <li>➤ Waiting for information</li> <li>➤ Continuity</li> <li>➤ People not picking up work when other staff not available</li> <li>➤ Lack of handover process</li> <li>➤ Multiple health problems</li> <li>➤ Lack of training in specific areas (ie Dementia)</li> <li>➤ Finance</li> <li>➤ Resources</li> </ul>
Recommendations	<ul style="list-style-type: none"> <li>➤ Close all the loops</li> <li>➤ Single point of contact</li> <li>➤ Clear areas of responsibility</li> <li>➤ Reduce administration overheads in assessments</li> <li>➤ Reduce duplication</li> <li>➤ Allocate information from nursing homes to enable process to happen without delay</li> <li>➤ Ensure all processes are time limited</li> </ul>

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<b>Developing a person centred system</b>	
Solutions	<ul style="list-style-type: none"> <li>➤ Single point of contact</li> <li>➤ Sign-posting to services</li> <li>➤ Carers training</li> <li>➤ Make sure that no one falls through the gap</li> <li>➤ Sharing information</li> <li>➤ Better information readily available</li> <li>➤ Health, Social Care and Care Homes share information with Carers</li> <li>➤ Good assessment process</li> <li>➤ Make the system simpler so not intimidating to Service User</li> <li>➤ Provide clear and concise information to Service User at start of process</li> <li>➤ Open forums – obtain people's views at all times</li> <li>➤ Maintain service users involvement in terms of planning and development</li> <li>➤ Adopt a common user friendly language</li> <li>➤ Transparency</li> <li>➤ Provide information in various mediums (ie written, verbal, ensure opportunities for home visits) as part of any process</li> <li>➤ Continuing support / responsibility for people with learning disabilities</li> </ul>
Barriers	<ul style="list-style-type: none"> <li>➤ Lack of forward capacity planning</li> <li>➤ Care Home annual reviews not all complete</li> <li>➤ Plain English, not jargon</li> <li>➤ Budget constraints</li> <li>➤ Poor knowledge</li> <li>➤ Doctors / Care Home staff not referring</li> <li>➤ Competing priorities</li> <li>➤ Inappropriate housing</li> <li>➤ Transport</li> </ul>
Recommendations	<ul style="list-style-type: none"> <li>➤ Service User / Advocate / Carer involvement</li> <li>➤ Education for Service User / Carer / Advocate</li> <li>➤ Improved training for Doctors</li> <li>➤ Improved training for Care Home staff</li> <li>➤ Look at good practice in other areas</li> <li>➤ More stringent contracts for Care Homes – better standards</li> <li>➤ Finding new methods of consultation</li> </ul>

## (c) What's next?

The information gathered is being reviewed and where possible will be used towards the planning of new processes and a model framework. The work identified clear priorities and helps to focus on short, medium and long term objectives.

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### 2.3 Using the information

Real changes are achieved when service users / carers / next of kin are actively involved in determining where the shortfalls appear and participate in problem solving – engaging with professionals delivering the service to jointly comment upon the business processes and look towards innovative ways to improve delivery and quality.

In turn it is important to evidence and highlight the achievements made towards service improvement, plan the practicalities of change, demonstrate how the ideas have been put to work and seek to continue user involvement. Establish a feedback mechanism and measure outcomes for service evaluation to ensure good practice.

The following areas demonstrate how input from the User Involvement Group so far will be incorporated in the next stage of the project work.

- Business Processes
  - Significant work has been undertaken on processes already in place and consideration given to more practical application.
  - Focus has been on the service users' journey looking at the process followed in Stockport when assessing eligibility for Continuing Health Care, (CHC), or Funded Nursing Care, (FNC). The main purposes of this work being:
    - ⇒ to identify touch-points between the different systems used by practitioners (where there is over lap, or information which feeds into each others documentation for the service user / carer)
    - ⇒ to identify the types of practitioner that need access to relevant information at various stages
  - The Continuing Health Care Team has now started to use social care's client management system, responding to the projects need for an electronic recording system. The work will be monitored for the next few months to ensure the team can successfully input and at the same time receive necessary reports – addressing any shortfalls in system set-up.
  - During July and August a pilot is being scoped for a group of health workers to electronically record their assessment information via a health system and work will then be underway to link this into the social care system as a 'view' at this point, and a 'view' back to the health system from the social care system.

There needs to be a number of central elements underpinning information sharing, knowledge of which information would be shared and agreement with the service user to do so. It is recognised that sharing personal information must be on the basis that it is secure and only accessible, with appropriate consent, by professionals with a legitimate interest in a person's support.

It is very important that service users are made aware of this and a proposed mechanism will be shared with the User Involvement Group in due course. Allowing information to be shared which is up to date and correct, in a way that assists the different professionals involved with the person's care. Providing the basis to record information once and then cascade as necessary.

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- An additional area is to understand where the Continuing Health Care / Funded Nursing Care process fits within the social care pathway, in particular requirements of Self Directed Support and as such this is part of work taking place elsewhere but there will be feedback to the CAF Project. However the CAF Project is only dealing with the Continuing Health Care side at this time.
- The Continuing Health Care process must continue to comply with the Department of Health Framework, but intentions are as part of the CAF Project's national evaluation work to provide comments on any improvements identified to hopefully assist professionals and service users / carers through out the Continuing Health Care process.
- Systems Thinking
  - As mentioned at the workshops Stockport Council is working with specialist consultants to look at service changes within the organisation and they are also assisting with the CAF Project – working alongside health and social care professionals involved with Continuing Health Care.
  - The team have been looking into various work areas to understand the demand on the Continuing Health Care service. This has involved visiting service users to gather their views on the process and what their expectations are. Intentions are to review success of the systems and measure outcomes for service users.
  - Time has been set aside for reviewing the User Involvement Group comments for further insight into proposals for operational system changes. Very important in trying to address a person centred system, making sense of information which is gathered to look at the individual's needs and circumstances, helping to make informed choices and any impact upon family members and carers – including the effect of failing to meet needs.
- Benefits Realisation
  - The project has been identifying potential benefits which can be obtained from the investments made, helping us to actively manage such benefits by overcoming obstacles which may prevent them happening.
  - Examples of assumed benefits are:
    - ⇒ A shared care record – how many service users have given consent as part of the project, and how does this compare with the number of recorded consents previously held?
    - ⇒ Shared and integrated view of records across partner organisations when considering previous paper recording – how much data quality amendments, how complete is the information, how much data needs to be added or amended?
    - ⇒ Service User / Carer confidence in the business process and in support of clinical safety.
    - ⇒ Meets the personalisation agenda -
  - Examples of assumed changes are:
    - ⇒ Works towards a Model Framework for Continuing Health Care.
    - ⇒ Encouraging continuing health care to be everybody's business.
    - ⇒ Development of a changed framework.

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- ⇒ Encourage partnership working and strengthen service user involvement.
- ⇒ Consideration of resource streaming for different service groups.
- ⇒ Shared record and good use of information gathered.
- ⇒ Increased participation of service users and carers.
- ⇒ Address commissioning, contracting and case management.

- National Evaluation

The Department of Health has commissioned independent consultants to evaluate the each of the CAF Demonstrator Sites to look at the effectiveness of their initiatives, quality of their user experience, outcomes for individuals and their cost-effectiveness.

This will require the partnership to provide evidence about the quality of outcomes for service users, workforce experience, and usability of the electronic systems for recording information for practitioners and service users, and effectiveness in supporting the business processes. We will be working alongside trained evaluators as they liaise with staff, service users and carers where ever possible.

Learning from the partnerships will be shared widely to encourage the adoption and raise awareness of benefits (already gained, or realised once the evaluation study, or projects themselves are complete) within the social care, health and wider community.

- Co-Production Work

A very recent request from the Department of Health relates to another commissioned piece of work to research and write up good examples of co – production working in practice. Looking for examples of work which shows how “people’s needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done.” References from the User Involvement will be contributed alongside those from the partnership – any feedback from the consultants involved will be relayed to the User Involvement Group via LINKs.

## 3. Conclusion

The project is beginning to make headway and the User Group has proved extremely useful in commenting upon the current service provision, and what an ideal situation for service users and their carers would be. It has provided an opportunity for professionals, carers and service users to come together to share their concerns, note positive work so far, and input towards potential solutions.

Towards the autumn / winter period it is hoped that similar workshops can be held to update on the project, demonstrate the use of a shared record, plans to link with the NHS Care Record Service, comment upon areas of work undertaken and what from the outstanding points can be achieved. In addition we will also be able to provide more details of how the Continuing Health Care categories fit into the nationally developed Common Assessment Framework data set.

Throughout the life of the local project we hope to increase confidence that the effectiveness of the current referrals and assessments are improved, reducing process confusion and maintaining good links with service users and carers.