

Putting **People First**
Transforming Adult Social Care



Common Assessment Framework for Adults Demonstrator Site Programme

Overview of Phase 1 Sites

Common Assessment Framework for Adults Demonstrator Site Programme - Overview of Phase 1 Sites

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Common Assessment Framework for Adults Demonstrator Site Programme

Overview of Phase 1 Sites

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Contents

Contents.....	4
Introduction	5
Barnsley	6
Camden.....	7
Hampshire.....	8
Lincolnshire	9
London Health & Social Care Integration Project.....	10
Rochdale	12
Shropshire.....	13
Stockport.....	14
Warwickshire.....	15
Westminster	16

Introduction

Care Services Minister Phil Hope announced on 9 February 2009 that nine local authority led partnerships have been selected as phase 1 of the Common Assessment Framework for Adults (CAF) Demonstrator Site Programme.

The Demonstrator Site Programme will develop and test improved information sharing across health, social care and wider community support services. They have been chosen to lead the way forward in creating a more efficient and transparent system of information sharing, to avoid duplication in assessments and ensure that people receive the best quality care and support.

This document provides an overview for interested parties of what each site will be addressing and the organisations involved in the partnership. The sites are led by the local adult social services and involve a range of community and acute health services, mental health trusts, housing support services and IT suppliers as well as wider partners in the voluntary and private sector.

In support of the Camden and Westminster Demonstrator Sites, the London Programme for IT (LpFIT) aims to deliver and test solutions on a London-wide basis that support information sharing between health and social care systems. An overview of this work that will also have national implications is included in this document.

All these projects will take into account feedback from the public consultation on the CAF proposals. A further call for interest for a second phase of demonstrator sites is expected in the summer and will be informed by the outcome of the consultation.

The consultation closed on 17 April 2009 and covered:

- How assessment and care planning should be undertaken (the principles)
- What information should be commonly shared
- Who that information might be shared with
- Proposals on the IT approach and solutions that would enable this to happen nationally
- The issues around confidentiality and security arrangements that this entails.

Barnsley

The Barnsley partnership includes the Council, Barnsley PCT, and Voluntary Action Barnsley, providing a link with voluntary sector providers in the area. Software partners are LiquidLogic and TPP SystemOne.

Barnsley's project focuses on the concept of a Virtual Support Team centred around the individual and delivering improved service user experience by facilitating: single provision of information; a social network of all agencies and individuals involved in a person's care. A Virtual Support Team Portal draws strongly on a person-centred model of care. It will enable all agencies and individuals involved in a person's care to share assessment and support planning information and communicate securely. The portal will support:

- self-referral and self-assessment with resource allocation to calculate an indicative personal budget; a centralised diary of interventions
- personal bookmarks to preferred and accredited information sources
- a real-time view of the individual's personal budget
- optional forums to engage with other people with similar conditions (e.g. COPD)
- a personal assistant module, enabling PAs to manage their involvement, including CRB and insurance checks.

The portal allows for control of the support plan to be devolved to the individual, or for a more holistic care coordinator approach, according to the individual's wishes.

Barnsley's approach is strong on co-production, with individual users and carers and voluntary sector partners and user-led organisations involved in every stage of the project. The multi-agency approach of the project will reduce duplication of effort between agencies, as the individual will be able to share information once and make it available to all relevant people and agencies. It is envisaged that the holistic approach to data sharing will help reduce preventable hospital admissions, such as falls, and enable scrutiny and transparency of service delivery by all parties involved, supporting a preventative approach to safeguarding. Information captured from the project will feed into a wider business intelligence framework to feed statutory reporting requirements and will enable a co-productive approach to local and individual commissioning.

Camden

The Camden partnership comprises Camden and Islington Foundation Trust (CIFT), and Camden Adult Social Care working with Corelogic their social care system suppliers, and is focused around the care pathway of people with Mental Health problems. Camden will also be a key partner in the development and delivery of the LSP contracted solution in London for the Common Assessment Framework.

The key objective is to share demographic and assessment data electronically between Camden's social care system and mental health systems using full CAF messaging mediated via the NHS 'Spine' in order to deliver a person-centred, multi-disciplinary assessment process which will improve outcomes for service users and carers, professional practice, effectiveness and cost effectiveness. It will also investigate allowing GPs to message an electronic referral to Camden's Mental Health teams via the EMIS GP system.

The project intends to deliver an online self-assessment facility for citizens and will investigate and implement giving citizens direct access to their care and support plans via a web portal supporting them to self direct their own care. There will be a roll out of CAF messaging to other care management teams such as Mental Health Care for Older People; Substance Misuse Team and Learning Disability Teams.

It links well to the implementation of personalisation in Camden, there is good engagement with frontline staff in the process of change with the development of a network of 'Change Champions' to support the delivery of the programme. Camden has good engagement mechanisms with the voluntary sector and will liaise with key local partnerships - Local Involvement in Health and Social Care Network (LINKs), The Camden Borough User Group (MH service users), Substance Misuse User Group and The Mental Health Liaison Group (Councillor/users). Existing service user groups and carers will be fully engaged with the project and a Service User Reference group will be established.

Hampshire

The Hampshire partnership bid includes alongside the County Council, the Partnership NHS Trust, Primary Care Trust, Carers Together, the Alzheimer's Society, Northgate and Graphnet with a focus on Older Adults, building on their Inquiry into Personalisation Commission. This in turn has resulted in the Hampshire Model, developed jointly with their health partners for transformation and personalisation of services across Hampshire. The Project is user-led, with the Executive being from a voluntary sector carers' organisation.

Patient Held Records and the use of mobile technology including digital pens and web forms is central to the bid, which aims to build upon existing processes such as self-assessment and client held records to help people take control of their own care. This will be achieved through access to HealthSpace, through the Hampshire Health Record (Graphnet message repository).

Solutions are intended to be rolled out incrementally across a two year programme and include for example Mental Health Assessment (CPA), Mental Capacity Assessments, Consent to share and view, Access to health and social care records by individuals and professionals, Out of Hours information gathering and recording, Learning Disability Assessment, Single Assessment Process (SAP) and Health and Social care Passports.

The programme will connect the Hampshire Health Record with the Personal Demographic Service and includes GPs, Health Space, Hampshire Care Self-Service website ('CareChoice'), primary (community) and secondary health care systems, Mental Health systems and the system for social care teams.

This project also intends to provide uniquely a citizen support desk to support those accessing their records, to ensure corrections can be made and records hidden as requested.

Benefits anticipated include reduced hospital admissions, accuracy of records increasing, improved quality and quantity of information available, increased accessibility across multi disciplinary teams and professionals, and increased engagement of citizens in the planning of their support and services.

Lincolnshire

The Lincolnshire CAF partnership includes Lincolnshire County Council, NHS Lincolnshire, Lincolnshire Partnership Foundation NHS Trust and United Lincolnshire Hospitals Trust. The key system suppliers involved in the project are Northgate Public Sector (AIS), and (via the National Programme for IT) TPP (Systemone), Maracis and, in the future, Lorenzo. The project will include strong service user engagement and co-production through existing forums set up for the Adult Social Care Transformation programme.

Lincolnshire County Council, NHS Lincolnshire and Lincolnshire Partnership NHS Trust have jointly set an 'aggressive agenda' to deliver Putting People First, focusing particularly on prevention, reablement and ongoing maintenance. This is underpinned by the council's experience and learning acquired by being an Individual Budget pilot site. The aim of the CAF Demonstrator project is to use technology to support this agenda through effective information sharing and streamlined business processes. The focus is on the delivery of assessment and support planning for all adult client groups and young people moving through transition to adult services.

The project will give secure access for health professionals including GPs and hospital discharge teams, to the social care system, enabling referrals and assessments to be generated. Functionality will be developed to support a Resource Allocation System calculation and self-assessment by citizens. Connection with the Spine will offer the facility to share agreed information between health and social care professionals.

This project utilises technology to support Lincolnshire's robust Putting People First Programme through an incremental approach in which planned deployments of CFH solutions and the Summary Care Record are linked to social care systems. By exploiting technology the project will deliver benefits for all adult clients and young people moving through transition including fewer repeat assessments, the facility to self assess and equality of access to exercise choice and control in support planning.

London Health & Social Care Integration Project

Supporting the London CAF Demonstrators

The LPfIT Health & Social Care Integration Project is part of a long term strategy to share information across Health & Social Care Organisations within London.

The scope of this project applies to the London Common Assessment Framework Demonstrators (Camden and Westminster) with potential to roll-out the solution to Communities across London.

The key outcome of the project is to implement within Camden and Westminster, a truly interoperable solution through the collaborative development of NHS Spine compliant health and social care systems (in turn, to provide a usable and accepted solution for clinicians and to improve health and social care support for citizens in London). This will be met through the delivery of 3 key objectives:

1. To develop a solution to enable point to point messaging between:
 - Mental Health and Community applications (RiO)
 - e-SAP application
 - PDS compliant applications outside of BT LSP, e.g. social care systems and GP systems currently being enhanced as part of the NHS CfH Health & Social Care Programme.
2. To develop a solution to send and retrieve messages sent point to point between applications to a central data repository.
3. The deployment of the solution to the two London CAF Demonstrators.

The wider objectives are as follows and will be tracked through the individual CAF Demonstrator Projects.

1. To facilitate practitioners in sharing assessment (Contact, Overview and Specialist Assessment Outcome) and care planning information electronically in the form of an Integrated Care & Support Plan across health and social care.
2. To facilitate practitioners in using their core systems to query data in a central repository and render it in the system user's core system.
3. To provide a person-centred record of care, support needs and services provided to a citizen.
4. To support the evaluation of the feasibility, benefits and costs of electronic sharing of assessment and care planning information to inform other communities in deciding their own way forward with integrated work.

5. To validate the Information Governance model for information sharing between NHS and social care systems.

Anticipated Benefits

With the ability to share information across organisational boundaries, health and social care professionals will have ready access to up-to-date assessment and care plan information about citizens and carers on their caseload.

Meetings with citizens will become more efficient, with professionals having a current and holistic view of the individual's needs, enabling them to focus on the next stage of the individuals' journey rather than gathering data which has already been collected.

Health and social care professionals will also spend less time and resources on administration (entering information and checking up on whether referrals have been received).

As well as the obvious benefits to the health and social care organisations and professionals, the key beneficiary will be the citizen as the recipient of personalised, efficient, effective and coordinated care.

The need for explicit consent from the citizen for their information to be shared is central and this enhances personalisation within this project.

Rochdale

The Rochdale partnership includes Rochdale Metropolitan Borough Council Adult Care and Supporting People Services, Pennine Care NHS Foundation Trust, a group of voluntary agencies selected for their involvement with individuals with mental health needs (Age Concern Metro Rochdale, Making Space and Rochdale & District MIND). Pennine Care PALS and the Patients Council will be representing individual users and carers of services. The Software partners are Liquidlogic and CSC, who will deploy Lorenzo.

The project will develop and trial CAF messaging between Rochdale MBC Adult Care and Supporting People and Pennine Care NHS Foundation Trust. It also seeks to develop a secure web-based shared assessment tool to be used by third sector partners and integrated with the social care IT system.

A unique aspect of the Rochdale project is the addition of a proposal to incorporate a multi agency risk management tool, PROTOCOL 360, which will identify risk factors in real time across multiple IT systems and alert relevant staff.

The project sets out to enable service users and carers to tell their stories only once and achieve improved outcomes. For healthcare and social care practitioners, organisations and third sector partners, the benefits will include reduce duplication of assessment effort, enhanced multi-agency communication and improved risk management in a multi-agency setting. Rochdale's bid focuses on a person-centred multidisciplinary approach and is strong on co-production with service users and carers and has a sound approach to business change, training and benefits management within the wider context of the transformation of adult social care.

The pilot will be specifically focusing on members of the population who use mental health services. Allowing information to be shared from acute and community mental health services (Pennine Care) to adult social care services (RMBC Adult Care).

Information sharing will be improved through a combination of technological development and organisational change management. The focus of this Demonstrator Project is on developing the cultural, organisational and workforce developments necessary to achieve gains in service user outcomes and new information sharing technologies will be developed and systematically trialled to support new ways of working.

Shropshire

The Shropshire partnership includes the Joint Community Learning Disability Team, (nursing and social work staff and allied health professionals) Oswestry and Shropshire Citizen Advocacy (OSCA), Taking Part (Advocacy Service), Shropshire Community Council, Shropshire Police and GP practices, and will be working with their social care system suppliers OLM.

The CAF project is strongly connected to a number of initiatives but has transformation, personalisation and self-directed supported at the centre. This project aims to address the inadequacy of co-ordinated communication for adults with learning difficulties, including young people in transition and their family carers.

It will demonstrate more effective safeguarding, deliver a broader more personalized range of services, shaped by individuals and their family carers increasing customer satisfaction. This will be achieved partly through the development of a single person centered support plan with increasing roles played by user led and advocacy groups supporting a citizen led process, including housing, employment and benefits, and transport. This proposal will also demonstrate improved outcomes and quality of life through better uptake of preventative services and faster identification of needs and issues. It includes providing people with learning difficulties and their family carers with access / ownership to the information held about them through a Citizens Portal. Also the development of a Virtual Record providing a view of a persons Support Plan and Emergency Action Plan will be made available for professionals who have a legitimate link established with the person and will connect to the Personal Demographic Service.

This proposal offers a particular focus on adults with learning difficulties and their family carers, and young people in transition, as well as having the objective of improved emergency planning. In addition the integral focus on co-production including accessible communication for sharing information throughout the delivery of the project is critical.

Stockport

Stockport's project focuses on Continuing Care, so covers people with a wide range of significant physical and mental health needs who require assistance from health, social care and third sector agencies, including GPs, in a variety of settings, including at home, in hospital and in hospices. The project partners are Stockport MBC, NHS Stockport and Age Concern Stockport. Software partners are OLM and Graphnet.

The project will implement learning from recent business process mapping exercises to deliver an effective model identifying appropriate use of shared records, virtual views, information exchange and workflow messaging. It will implement this in two stages: the first linking via existing infrastructure and the second integrating the NHS Spine Personal Demographics Service and CAF messaging. Information sharing and governance arrangements will be created in partnership. Additional intentions are to address issues arising from the use of professional language and terminology used in case recording, and address how language and terminology is used to inform individual service users. The project will explore a range of contact channels, including links to a 'Citizen's Portal'. Access for professionals will be via clearly defined roles, and the virtual record will be accessed only where there is a legitimate link established between the service user and practitioner.

Stockport's approach focuses on outcomes for service users ensuring that the project meets the aspirations of the personalisation agenda, including personal health budgets which are being trialled in Stockport as part of the 'Staying in Control' national pilot, and exploring the use of shared information for reporting and modelling unit costs. The project will continue to draw on a long history of co-production with service users and carers and build on existing excellent working relationships with third sector organisation within the wider context of transforming adult social care.

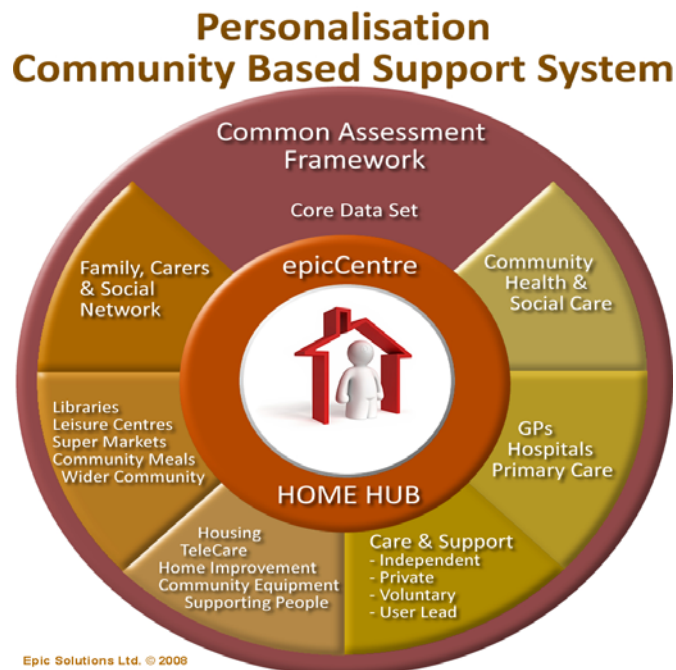
Warwickshire

The Warwickshire CAF proposals are underpinned by innovative technical solutions that are based on internet technology to enable the customer to retain ownership of their information and for customers to drive governance arrangements for implementation of protocols that allow information to be shared across the multiple agencies providing support.

Using an in-depth understanding of the joint customer / patient pathways and business processes across the Health and Social Care sector, the Warwickshire CAF partnership will develop new operational systems for use by customers, as well as health and social care staff.

The innovative web based systems will create a 'home-hub' between customers at home and in other care and support settings, health, social care, their family and wider community. The solution will build on Warwickshire's strategic direction for ICT architecture and conform to standards required by the NHS National programme for IT.

Using measures deployed in an operational setting, opportunities for delivering wider scale benefits will be assessed using a business case approach.



Additionally, the project will identify and evaluate the financial savings and human resource efficiencies achieved through this whole system redesign in Leamington, Rugby and Alcester Health and Social Care sites.

Ultimately, the Warwickshire CAF project aims to produce an industrial scale IT blueprint of an integrated NHS and local authority personalised care and support model, within a detailed business case to enable national scale implementation of the model.

Westminster

The Westminster project has a focus around Re-ablement and Long Term Conditions (LTC) and seeks to deliver improved and streamlined information sharing processes. There is a long history of constructive joint working with NHS Westminster and the partnership includes the Inner North West London Care Community representing three local authorities and their primary, secondary care and Mental Health Trusts. The London Programme for IT (LPfIT) and Northgate Information Systems are the project's principle technology partners. Service users, Carers and User Led organisations, particularly Westminster Action Network on Disability (WAND), will be fully involved in the design and development of a citizen web portal and will participate in the transformation work around personalisation.

The key objective of the project is the development of electronic CAF messaging to share information from an individual's assessment and care plan between the social care and health systems, including the Community RiO system and the EMIS GP system, and connecting the SWIFT social care system to the Personal Demographics Service on the NHS 'Spine'. Westminster will also be a key partner in the development and delivery of the LSP contracted solution in London for the Common Assessment Framework.

The project intends to deliver a citizen self-assessment web portal to allow service users/carers to direct their own support needs and both service users and carers to view their assessment and care planning. It will look to engage with community based practitioners including district nursing and GP practices.

The project is looking to interface with other Care Community projects such as a Chronic Disease Management System for both diabetes and COPD, the Healthcare for London Stroke project, and an Out of Hours Emergency Services project to develop IT and operational links between acute services, primary care, mental health services, London Ambulance Service and community pharmacy. Westminster has also submitted an expression of interest, jointly with Kensington & Chelsea and Hammersmith & Fulham, to undertake a Personal Health Budgets pilot.

The project will also investigate the potential to store assessments for people who do not yet meet the threshold for services to facilitate the provision of information and advice and access to preventative services.