

DOAS SAP Concept Paper - Beginnings and Endings

Traditionally health and social care have had different approaches to beginnings and endings of episodes of support and care. However recent policy documents give an opportunity to re-evaluate these approaches.

These include,

- The 'White Paper, Our health, our care, our say: a new direction for community services - Chapter 5, - Support for people with longer-term needs, January 2006,
- 'A Sure Start to Later Life: Ending Inequalities for Older People', January 2006,
- Living well in later life: A review of progress against the National Service Framework for Older People - produced by the Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection. March 2006

(Please see **Annex 1 - Recent Policy Initiatives** at end of this paper),

It is worth noting the influence that Long Term Conditions and Case Management (with its emphasis on self care/self management) has had in health and, in social care, it is likely that the ethos of self directed support and the growth of resource allocation to people through individualised budgets will have great significance over the next few years (from 'care' to 'support'?).

Beginnings and Endings

An individual may receive health care throughout their life and the information from this may build up into periods of more intensive support/care; not least if an individual has one or more Long Term Condition and complex needs.

Social care involvement is usually only required for set periods or episodes of time – and people do not receive this social care input during these episodes unless they meet eligibility criteria (a legal requirement).

Information technology can support the build up of information during an individual's life, but the transition to more complex multi-professional or multi-agency support/care may need to be clearly defined - in order to identify who we communicate with and who is supporting the individual and coordinating the delivery of this complex support/care (*please see also DOAS SAP Concept Paper – Coordination*).

The proposed Common Assessment Framework (CAF) for Adults building on the Single Assessment Process (SAP) may encompass all levels of need. However, the triggers for identifying the transfer from simpler to more complex support/care, often through a GP (when there is substantial impact on the individual's functional abilities affecting an activity of daily living) are important e.g. to ensure greater co-ordination between services.

This might include the allocation of a responsible professional to support the individual to take control. For people with more complex longer term needs, it might mean a Care Manager/Case Manager/Community Matron, undertaking a formal, proportionate, holistic assessment (overview/comprehensive), creation of a personalised health and social care plan to support the individual, and the creation of effective communication channels (including IT) for sharing information (and dealing with consequent consent issues).

There may be a time when intensive services may reduce or cease. This is marked by no longer needing a responsible professional or a Care Manager/Case Manager/Community Matron although the GP and also those giving lower level support may continue. The personalised integrated care plan may well be replaced by lower level support plans for the remaining service(s). An increase in the individual's level of supported self care/self management should be encouraged as the need for service reduction is determined (in consultation with the individual).

There is a requirement for understanding and rules for these beginnings and endings in health and social care in terms of the greater effort of communication, and the potential sharing of information between agencies.

Triggers for identifying the transfer from simpler to more complex support/care can happen in either health or social services and currently all more limited service material may need to be brought together to inform the formal holistic assessment such as using the domain concept as with the existing Single Assessment Process. This would require all needs to be categorized by a domain, and then assembled under that domain to inform the holistic assessment. This is suggested because of the wide variety of current material that could be assembled, and the different ways of storing it (assessments, questions, codes, text). It may well be easier to agree on headings rather than attempt to rationalise everything.

It seems likely an assessment in line with the proposed Common Assessment Framework for Adults will also cover a number of pre-defined domains in order to take a holistic view of an individual's circumstances. An example as to how the domains and sub-domains of CAF for adults might look follows and linked with domains/dimensions from the CAF for Children.

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Single Assessment Process moving towards a Common Assessment Framework for Adults

Example Domains and Sub-Domains – March 2006

1. Individual's Self Assessment

- Views on their own needs and the support required in the individual's own words
- Expectations, strengths, abilities and preferences
- Ability to participate, self support, self care and self manage.
- Requirement for advocacy, particularly if an adult is lacking capacity (assume capacity)
- Needs and views given by parental/carers representative if a child is too young to input

2. Culture and Identity

- Background History
- Ethnic Identity
- Language
- Religion and Spirituality
- Gender
- Sexuality

3. Carer's Self Assessment

- Views on needs and the support required in carers own words
- Expectations, strengths, abilities and preferences
- Awareness of their legal entitlement to an assessment, not only of their own needs but also outside interests (work, study or leisure)

4. Health - Background

- History of medical conditions and diagnoses
- Past major procedures/surgery
- Family health History
- Allergies and reactions
- The individual's understanding of their condition and planned treatment

5. Health and Well-being

- Immunisation
- Screening and regular monitoring
- Pain management
- Sleeping patterns
- Nutrition, diet and fluids
- Oral health
- Foot-care
- Continence
- Tissue viability
- Mobility
- Substance misuse, drinking and smoking history
- Exercise pattern
- Sexual Health

6. Senses

- Sight
- Hearing
- Touch
- Taste
- Smell

7. Mental Health and Well-being

- Mental Well-being (not just the absence of mental health problems/needs)
- Mental health issues, for example, depression, reactions to loss and events, emotional difficulties or any serious mental illnesses.
- Cognition and dementia, including orientation and memory

8. Medications Management

- Medication used and ability to self-medicate
- Prescribed and non-prescribed
- Past medication history (any significant medication in the past)

9. Activities of Daily Living

- Personal care - getting up and dressed, going to bed, bathing personal hygiene etc
- Managing daily tasks such as correspondence, food preparation, cleaning and shopping
- Mobility inside the house
- Getting out and about

10. Being Cared For (Parenting Capacity) and Development

- Basic care, including physical needs and medical care
- Ensuring safety and protection (see 15)
- Emotional warmth and stability
- Guidance, boundaries and stimulation
- Communication
- Attachment
- Emotional, social and behavioural development
- Identity including self-esteem, self-image and social presentation
- Life events, including trauma, separation and loss and the scale of readjustment required

11. Education, Learning and Employment

- Understanding, reasoning and problem solving
- Education, progress and achievement in learning, aspirations
- Access to employment

12. Relationships and Community Life

- Background history
- Family and social relationships
- Carer support and strength of caring arrangements
- Involvement in the community
- Involvement in leisure and hobbies

13. Housing and Environment

- Housing – location, access, amenities and heating
- State of repair of own home and garden
- Managing tenancy/lease/mortgage
- Managing daily tasks such as correspondence, food preparation, cleaning and shopping
- Access to local facilities and services including transport
- Pets

14. Finances

- Income
- Level and management of finances
- Willingness to manage a direct payment or an individual budget
- Entitlements

15. Protection and Safety

- Abuse (physical, sexual, psychological/emotional, neglect, financial/material, institutional, discriminatory, self neglect)
- Other aspects of personal safety
- Public safety
- Legal status

16. Risk Assessment – Summary

- Risks to self
- Risks to others

17. Summary of Needs

Summary of needs then the basis for Personalised Health and Social Care Plan

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Annex 1: Concept Paper - Beginnings and Endings Recent Policy Initiatives

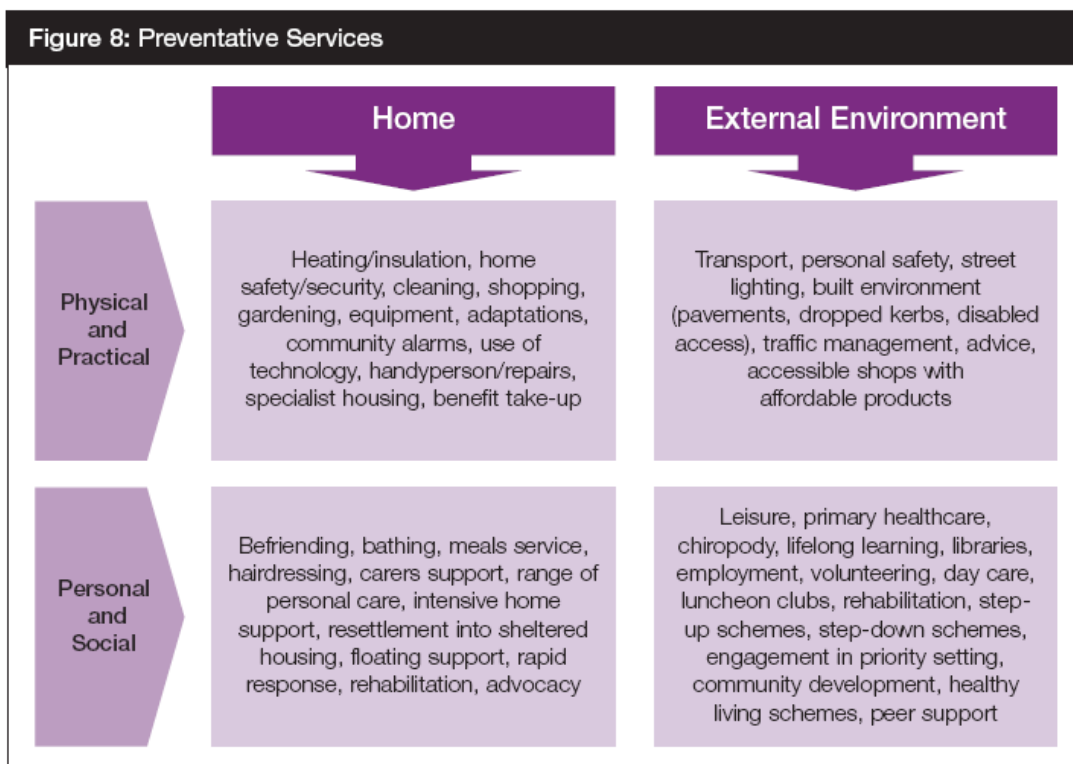
In the White Paper, Our health, our care, our say: a new direction for community services, Chapter 5, P.112 -Support for people with longer-term needs, January 2006, it said,

“We need to move from fragmented to integrated service provision, from an episodic focus to one of continuing relationships – relationships that are flexible enough to respond to changing needs.

People’s needs may fluctuate markedly and health and social care must be able to respond to these.

In ‘A Sure Start to Later Life: Ending Inequalities for Older People’: A Social Exclusion Unit Final Report, Chapter 2, P.28 - preventing a cycle of decline and promoting the cycle of well-being, January 2006, it said,

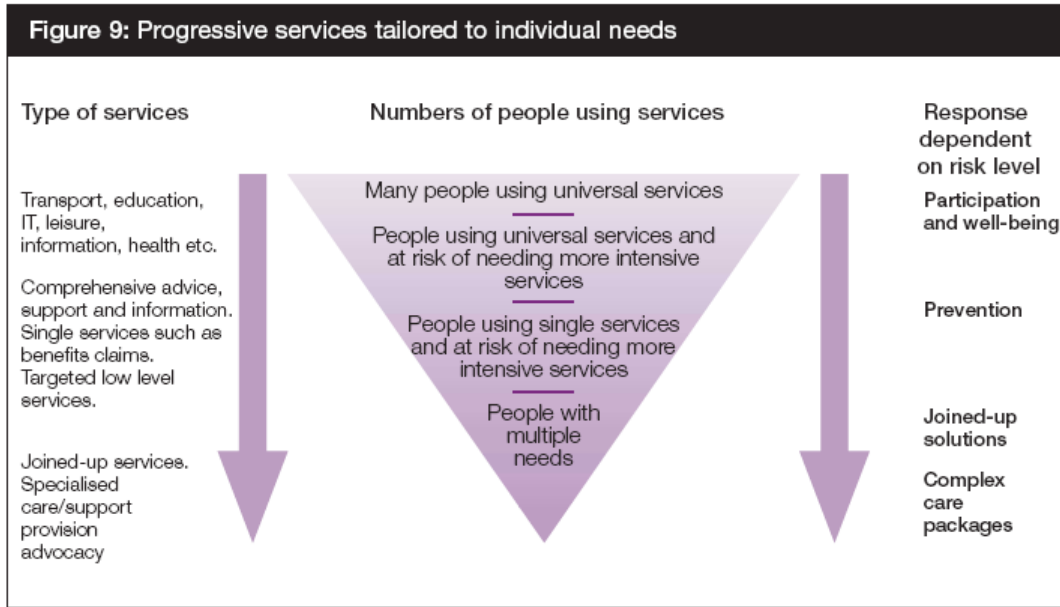
The approach that we are advocating brings together key partners of health, social services, benefits and housing, as well as often overlooked missing links such as transport, leisure, community safety and learning. This is about community capacity building to move the debate on from paternalism to prevention and promotion of well-being. The diagram (Figure 8) (which is a little short on health elements) shows how integrated services could be targeted on people with different levels of risk. For some it will be about active ageing and improving well-being, for others it might be complex packages.



In ‘A Sure Start to Later Life: Ending Inequalities for Older People’: A Social Exclusion Unit Final Report, Chapter 2, P29 - preventing a cycle of decline and promoting the cycle of well-being, January 2006, it said,

“People in the greatest need are the least likely to receive services. For example, our research showed that 34% of people with poor health were excluded from basic services (including some health services), whereas only three per cent of those with excellent health were excluded from basic services. The evidence varies between different services, however our consultation has shown that where there is a pressure on services, tough eligibility criteria or complex operating systems, too often the people with the greatest need lose out.”

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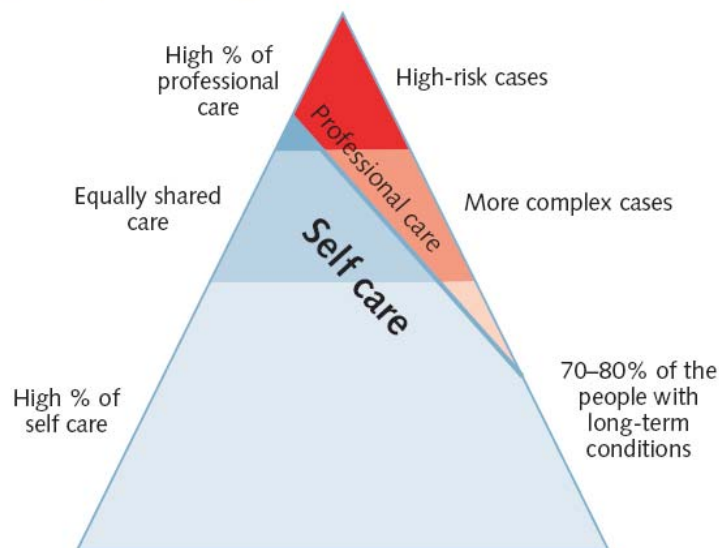


In the White Paper, *Our health, our care, our say: a new direction for community services*, Chapter 5, P.111 - Support for people with longer-term needs, January 2006, it said,

“Our aim for people with longer term needs is the same as our aim for all people who use services. Services should support people to take greater control over their own lives and should allow everyone to enjoy a good quality of life, so that they are able to contribute fully to our communities. They should be seamless, proactive and tailored to individual needs.

People need to be treated sooner, nearer to home and before their condition causes more serious problems. Individuals need information, signposting and support, so that they can take control and make informed choices about their care and treatment. Wherever possible, they should be enabled to use the wide range of services available to the whole community, for example housing, transport and leisure.”

Fig 5.2 Empowering and enabling individuals to take control



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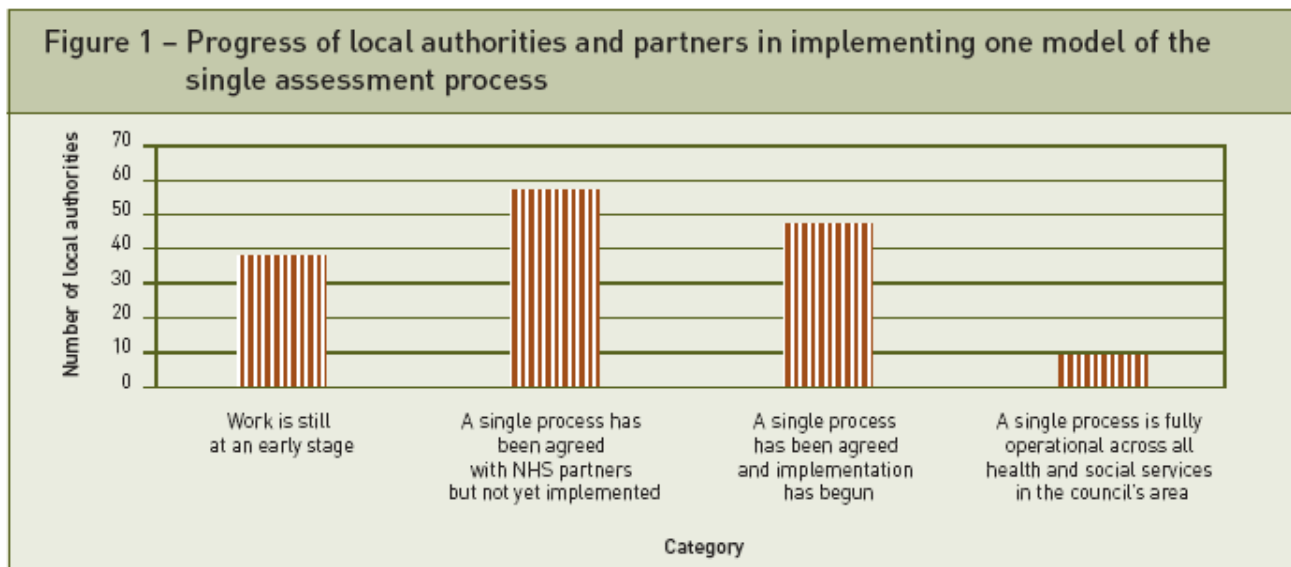
Living well in later life:

A review of progress against the National Service Framework for Older People - produced by the Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection in March 2006.

“NHS trusts and social services need to work together to implement the single assessment process fully and to promote its benefits widely in all organisations that are in contact with older people.”

“NHS trusts and local authorities were implementing plans to introduce a single assessment process and many have been piloting different models to help make an informed decision. However, the timescales in the NSF had not been met for implementing one model of the single assessment process across the community”. “None of the communities that were inspected had introduced one model of single assessment across all partner organisations in the area”.

“This is in line with findings from the Commission for Social Care Inspection’s of services for older people in 2004/2005 that found only 6% of local authorities nationally had a single assessment process for health and social care (see figure 1).”



Source: Padi 2156 Progress on NSF milestones: stage reached in implementing a single assessment process

From the Conclusions, “The National Service Framework for Older People has led to some positive achievements but there is further work to do to meet the standards set out in the NSF. The key issues in need of further action identified as a result of this review are detailed below:

- **The full implementation of the single assessment process across health and local authority partners.**
- Older people should have a copy of their assessment and personalised care plan. A change in culture is required, moving away from services being service-led to being person-centred, so that older people have a central role, not only in designing their care with the combination and type of service that most suits them, but also in planning the range of services that are available .”