# Do Once and Share
# Single Assessment Process

## Vision and Care Pathway

3rd February 2006

## Vision in White Paper

NHS Connecting for Health

- “We have already developed a Single Assessment Process for older people’s services. Work is underway to build on this to develop a Common Assessment Framework to ensure less duplication across different agencies and allow people to self assess where possible.”
- “An integrated health and social care information system for shared care is planned as part of the NHS Connecting for Health strategy. It is an essential requirement for effective care co-ordination.”

## Vision in White Paper

NHS Connecting for Health

- "An integrated health and social care information system will enable a shared health and social care plan to follow a person as they move through the care system".
- **"We will ensure that, ultimately, everyone who requires and wants one has a personal health and social care plan as part of an integrated health and social care record.** Initially we will focus on offering integrated care plans to those individuals who have complex health and social care needs."
- **"By 2008 we would expect everyone with both long-term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long-term condition to be offered a care plan.** We will issue good practice guidance early in 2007."

## From SAP to CAF?

## Start of SAP…..

NHS Connecting for Health

The Single Assessment Process was first mentioned in Standard 2: **Person Centred Care** in the NSF for Older People.

Then came the SAP guidelines in January 2002….

**"The DH stages of the single assessment process are :**

- Publishing information about services
- Case finding (optional)
- Completing assessment – the four types
- Evaluating assessment information
- Deciding what help should be offered, including eligibility decisions
- Care planning (leading to service delivery)

## From SAP to CAF?
## SAP Developing…..

- SAP has always been a ‘bottom up’ approach, with the commitment of staff within health and social care (in the widest sense) in localities the greatest positive driving the integrated working agenda.
- SAP was timetabled to be implemented by April 2004….did not happen, impetus started to fade…
- There have been times when SAP has been viewed as only an assessment tool, or 4 types of assessment, or an electronic system**.**
- However, as just we have seen, the Single Assessment Process always was supposed to be a **person centred, health and social care framework.**
- SAP is already being **used for other adult groups** as well as older people. It links, complements and is enhanced by other key areas of policy.
- For example, **Long term Conditions**, with its emphasis on supported self care / self management, **personalised care plans** and using case management to provide care for individuals with complex needs.

## Vision and Care Pathway

Connecting for Health

- Based on previous London/Southern SAP Best Practice work.
- Done to drive the development of the Care Records Service IT so that it meets the requirements of the system users.
- Included the mapping of the high level **health and social care** process steps that are involved in SAP.
- Discovered just assessment is not enough – have to deal with the **complete care process** for individuals with **many/complex needs.**
- Highlighted 5 main areas: gateway/entry into service, assessment, planning care, the delivery of care and review.
- **Person centred,** based around **holistic assessment** and the **individual’s integrated personalised care plan.**

## SAP Best Practice Process Design Group

- In total, there were **24** Single Assessment Process workshops (8 Joint with Southern Cluster)**.** The workshops involved **70** staff from health and social care agencies across London and the South and an older person from Tower Hamlets.
- A series of **12** field visits were also undertaken – to social services, GP surgeries, clinics, acute sector - another **20-30** staff were consulted.
- Social Services were heavily involved in this work alongside health colleagues.
- The Review process produced a total of **777** comments/questions from clinicians/practitioners.
- The major product of the work was the SAP Best Practice documentation (high level diagrams and document with more detail).

## These Workshops Covered..

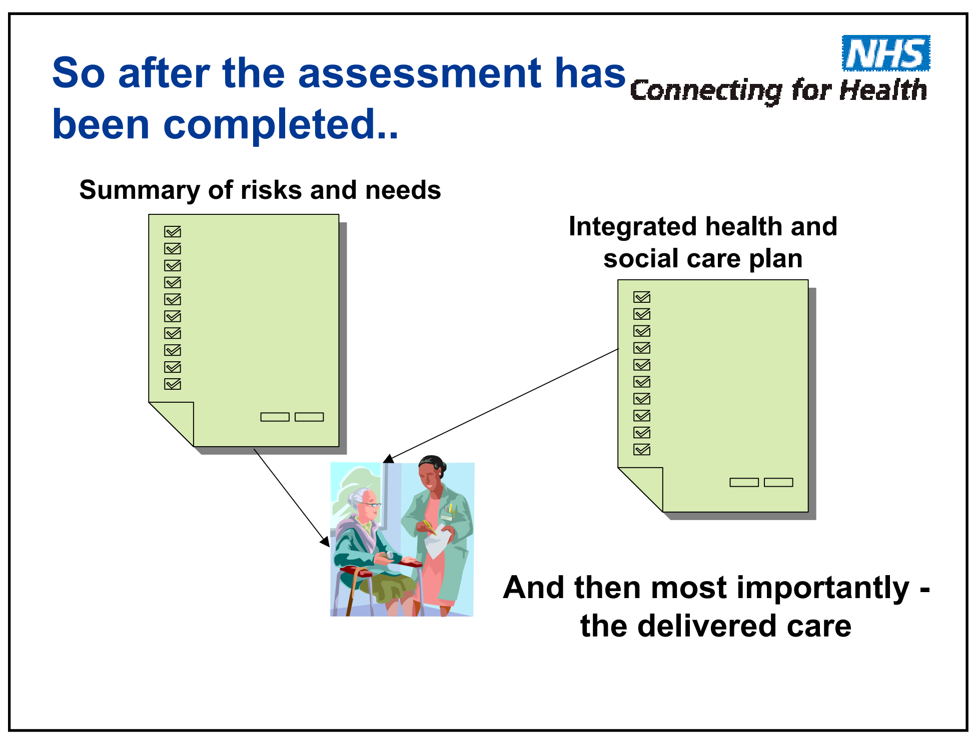
NHS
Connecting for Health

- Contact Assessment
- Holistic Assessment
- Specialist Assessment
- Carer’s Assessment
- Care Planning and Care Plans
- Monitoring and Reviews
- Current Summary Record
- Care Coordination
- Consent and Information Sharing
- Social Services Integration
- SAP Assessment Tools
- Links with Mental Health, Acute sector
- Long Term Conditions / Case Management

## Personalised Care Plan

### Integrated Health and Social Care Plan

- **Risks and needs** are common to all SAP overview tools and drive the integrated care plan.
- **Shared Care Plan**, including conclusions on risks/needs puts the individual at the centre of the approach – enabling their participation and that of their carer(s). Also looks at **services** and **planned outcomes**.
- Need to **share with the individual -** write in their terms, no jargon.
- Service or treatment specific plans can provide the detail afterwards.
- Highlights Self Care / Self Management which links with recent initiatives around Long Term Conditions.
- **Best for communication** - the care plan as the basis for sharing information and the Person Held Record (paper or electronic).
- Best practice care pathway and care planning work included in document "Good Care Planning for People with Long Term Conditions" - June 2005.



## Coordination Principles

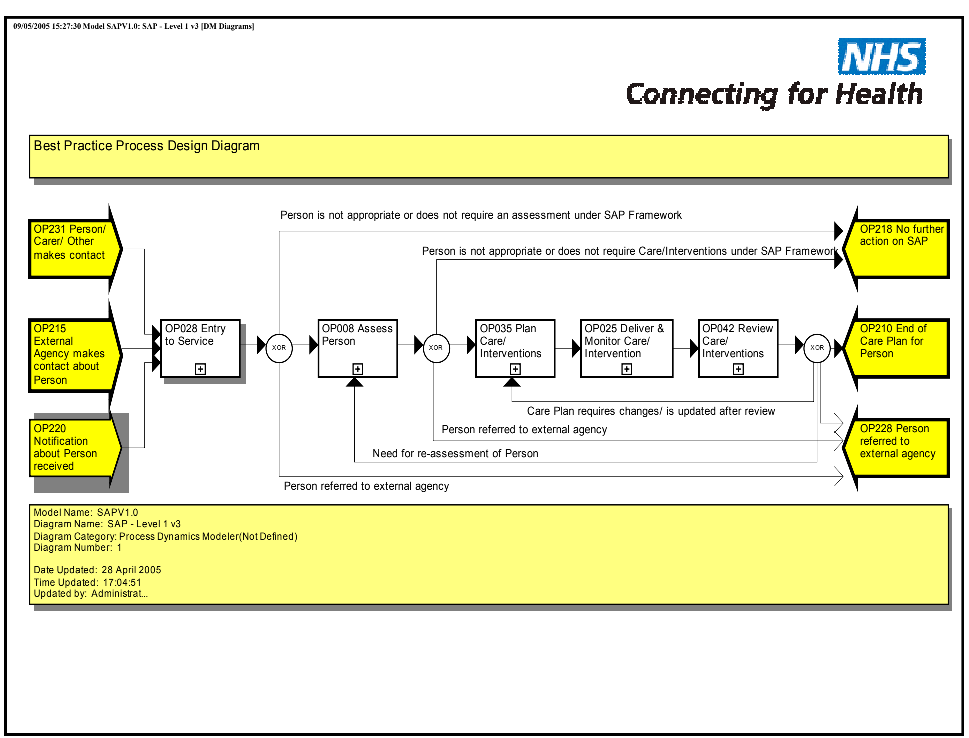
### Coordination Principles - based on Continuity of Care

- Principles of Coordination included in the Best Practice output.
- Importance of Continuity and at least a Named Contact.
- Assessment Coordination and Care Coordination **tasks** as required.
- Named in simple language for the individual to understand the role (e.g. Coordinator or Case Manager)
- Builds on the work undertaken by Mental Health - already has a definition of Care Coordination.
- **Case Management** would take place for individuals with complex needs when comprehensive assessment is indicated, covering all aspects of coordination, not least when the individual is hospitalised.
- Published on the CD accompanying the Community Matron/Case Manager competencies in 2005.

## Other benefits from the SAP Best Practice work

NHS
Connecting for Health

- Showed **joint participation** of health and social services, **linking** with external social care has been stressed throughout the work.
- Gateway requirement on the way to holistic assessment.
- The process is common with other holistic care workstreams.
- Link made Single Assessment Process and Long Term Conditions – help towards bringing Health and Social Care together?
- Sharing of information, whether paper or electronic, built around the personalised care plan with the individual fully participating.
- Glossary of Health, Social Care & Information Technology (incorporating Long Term Conditions and Case Management). Now used on CPA National SAP website **http://www.cpa.org.uk/sap**




# DOAS SAP Care Pathway Workshop

NHS Connecting for Health

- DOAS SAP National Care Pathway workshop held on the 13.12.05.
- Representatives from each cluster.
- Used best practice process design material from London and Southern clusters in order to establish the basis for agreement around a **common pathway for SAP** across the country.
- Considered issues/differences in practice across the country.
- Did not speculate about future systems, but looking for the processes that lie at their heart. Taking our current system hats off and looking at the processes.
- Finished product can help other national initiatives look at system options and how they are tied together in the future.

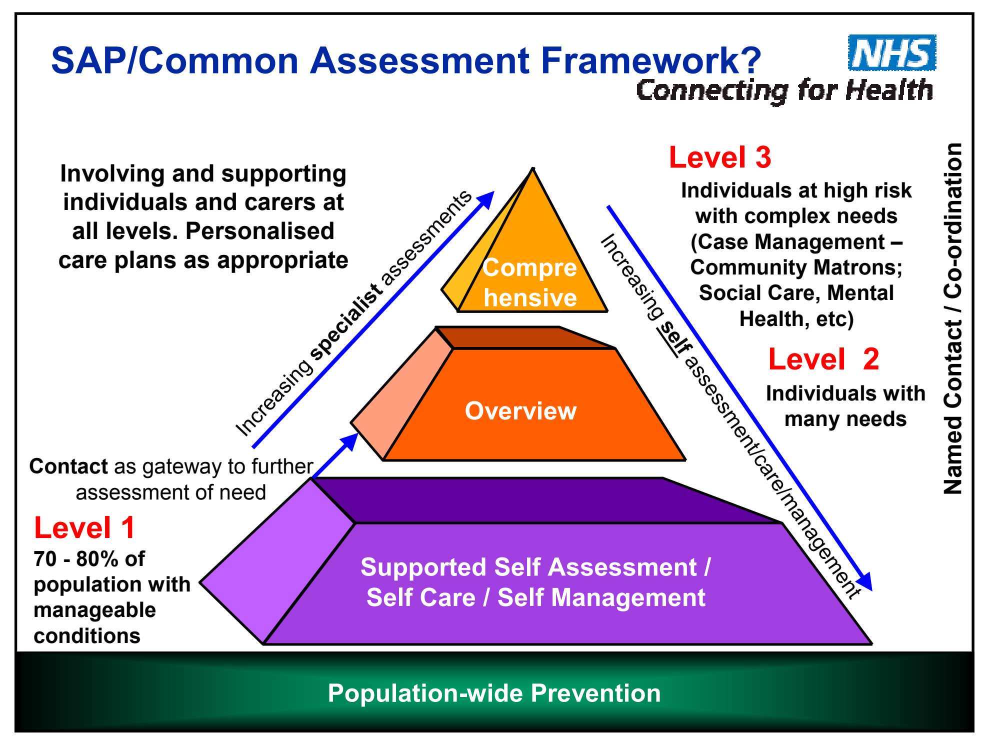
## DOAS SAP Care Pathway

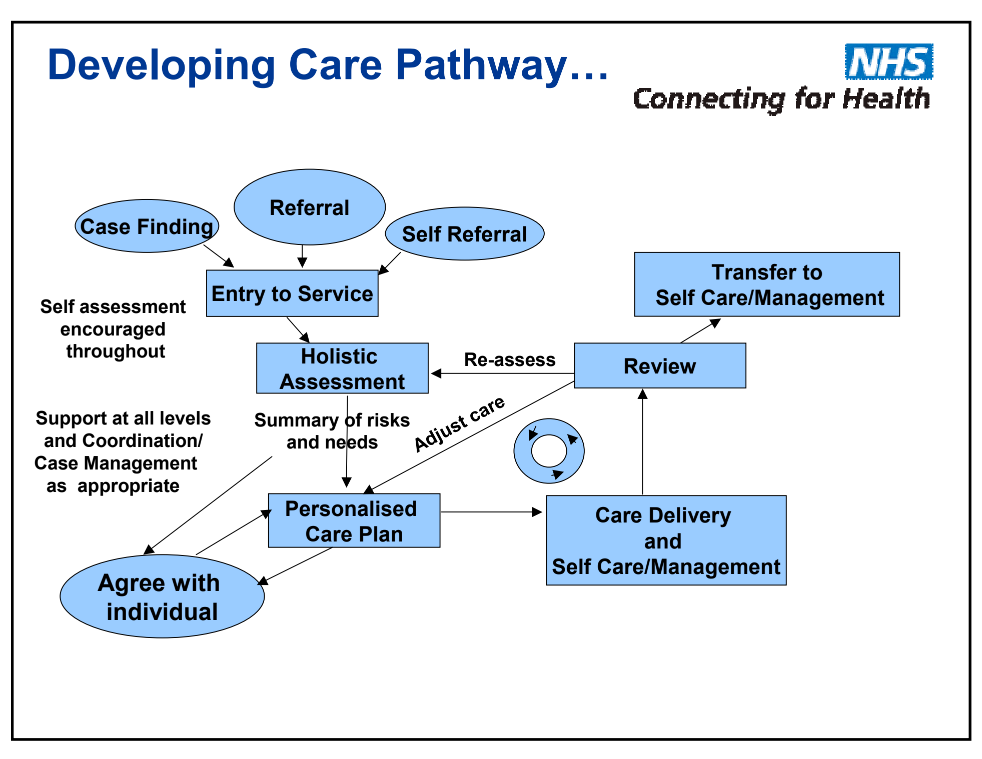
- Consensus on the overall pathway, but can be more person-centred.
- Workshop raised 335 issues comments/questions.
- Many of these have now been tackled by representatives from each cluster, and will be fed back as further consultation.
- Consideration needs to be taken of White Paper direction.
- SAP Best Practice Documentation amended by March 2006.
- Some key unresolved issues will be discussed at in the Care Pathway workshops this afternoon.

## Some Issues to be resolved

Connecting for Health

- Who actually gets SAP/CAF? Those people with more than minimum needs or is everybody in?
- Who is the Care Coordinator (is there always a responsible person?) and what power do they have?
- How does self assessment and self management fit with the model?
- How does the model handle two people with needs who live together?
- How do specialist assessments fit into the model?
- Are there differences between medicine and care?
- What is the role of the Current Summary Record?


SAP/Common Assessment Framework?
NHS
Connecting for Health
Involving and supporting individuals and carers at all levels. Personalised care plans as appropriate
Increasing specialist assessments
Compre hensive
Overview
Level 3
Individuals at high risk with complex needs (Case Management – Community Matrons; Social Care, Mental Health, etc)
Level 2
Individuals with many needs
Increasing self assessment/care/management
Named Contact / Co-ordination
Contact as gateway to further assessment of need
Level 1
70 - 80% of population with manageable conditions
Supported Self Assessment / Self Care / Self Management
Population-wide Prevention


Developing Care Pathway…
NHS
Connecting for Health
Case Finding
Referral
Self Referral
Entry to Service
Transfer to Self Care/Management
Self assessment encouraged throughout
Holistic Assessment
Re-assess
Review
Support at all levels and Coordination/ Case Management as appropriate
Summary of risks and needs
Adjust care
Personalised Care Plan
Care Delivery and Self Care/Management
Agree with individual