Appendix 2 SAP Sub group 1

Do Once and Share SAP Action Team
Sub - Group 1: SAP Vision and Care Pathway
Final Report – March 2006

This report is **twelve** pages long with **six** concept/exploratory papers attached **–**
Annex 1: **Beginnings and Endings**
Annex 2**: Coordination,**
Annex 3**: Medicine and Care,**
Annex 4: **Specialist Assessments,**
Annex 5: **SAP and Two People with Needs,**
Annex 6: **Current Summary Record.**

The high level overall SAP framework is shown in **D. SAP High Level Diagram.** More detailed SAP diagrams can be found on the Centre for Policy on Ageing web site at http://www.cpa.org.uk/sap

A. Introduction to the work

The following were agreed as the main products from the group to handle the allocated deliverables (**see D. Findings).**

- A sub-group, which can make recommendations on issues.
- An overall process, highlighting information flows (especially those across organisations) and the level of detail to which the process has been taken.
- Information Governance implications of the requirements, if they differ from the current CRDB guarantee (this has not been fully handled).

B. Summary of previous work in the field

The group worked on material from the London and Southern cluster – which had already had the following input,

- Started in February 2004. It included the mapping of the high level health and social care process steps that are involved in SAP (not only for older people).
- 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 consulted.
- Social Services were heavily involved in this work alongside health colleagues.
- The Review process produced a total of 777 comments/questions from professionals, many of which were addressed.
- The major product of the work was the SAP Best Practice diagrams with supporting documentation that was produced in March 2005 to drive the development of the Care Records Service IT so that it meets the requirements of the system users.

Comments on the material were previously received from the North West and West Midlands cluster, which had used it as the basis for its own work. Material from the North East cluster was also received.

C. Methodology

- The SAP DOAS project followed up on the London and Southern Best Practice Process Design material, using it as a basis for its work. It was distributed widely through the clusters.
- Comments were received in advance of and during a care pathway workshop. This workshop tested the Care Pathway with real cases, but in parts rather than as a whole (ignoring Information Governance issues, since these are constraints to be added by individuals themselves).
- 70 people at the Care Pathway workshop on the 13.12.05 (including core process group and helpers), raised 337 issues (although a few were duplicates).

Appendix 2 SAP Sub group 1

- A core process group from clusters and centre (but primarily cluster people) was established to make decisions and revise diagrams.
- Core process group brought out the major issues, and wrote concept papers – for approval first in the core process group, and then in the main group.
- The final material will be put on the Centre for Policy on Ageing website for further consultation.

Appendix 2 SAP Sub group 1

D. SAP High Level Diagram

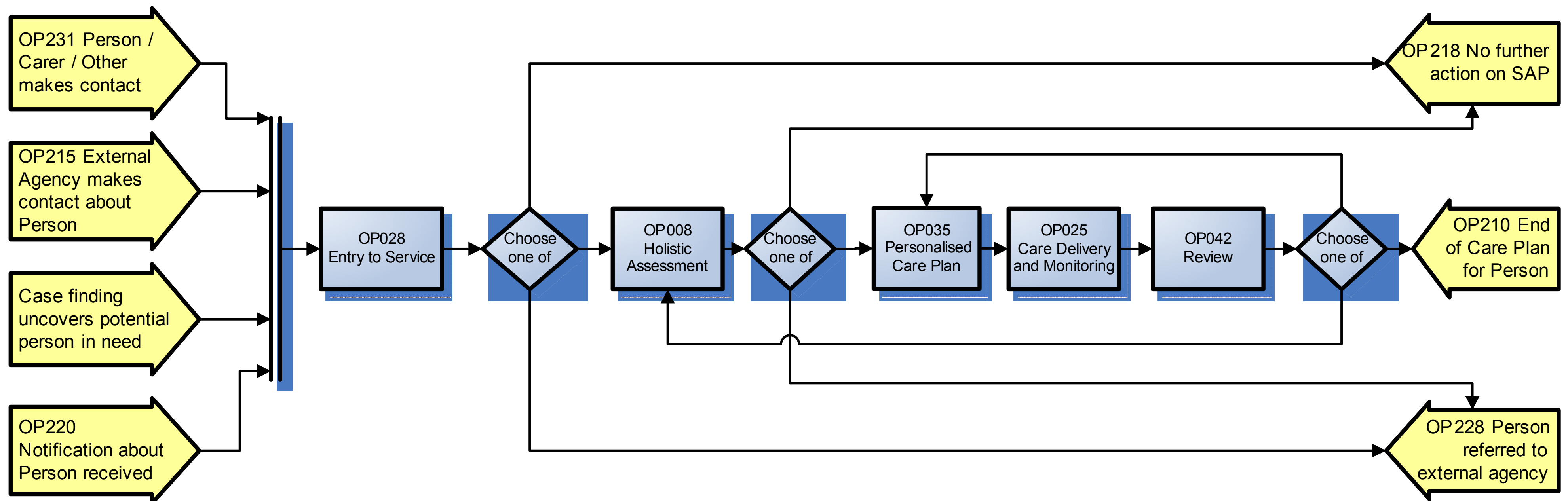
SAP Best Practice Process Design Diagram – High Level

Throughout this process, the emphasis is on supporting the person; encouraging their participation, control and self support/care/management.

The person’s ongoing engagement in assessment (including self assessment), planning and reviewing their own support/care is seen as critical.

The carer is not shown on these documents to avoid multiple lines.

Again, their role is critical, and their needs should be addressed in the same way as the person’s (and separately, if they so desire).



Appendix 2 SAP Sub group 1

E. Findings/Table of results

<table>
<tr><th>Deliverables</th><th>Summary of Key Findings</th></tr>
<tr><td>Deliverable 1
Restate the vision for SAP which will continue to evolve
(Also covered by Sub–Group 4)</td><td>The Single Assessment Process (SAP) 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)
• Monitoring and review”
There have been times over the past 4 years when SAP has been viewed incorrectly as only an assessment tool, or 4 types of assessment, or an electronic system.
However, as we have seen from the original guidance, the Single Assessment Process always was supposed to be a person centred, health and social care framework – entry into service, holistic assessment, personalised care plan, care delivery and review/ending (as outlined by the London/South Best Practice work and confirmed by the SAP DOAS work). Please see D. SAP High Level Diagram.
SAP was timetabled to be fully implemented by March 2004…Although progress was made this did not happen, impetus started to fade in many areas.
SAP has tended to be 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 is already being used for other adult groups as well as older people in many localities. 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.
(please see Deliverable 6)</td></tr>
<tr><td>Deliverable 4
Describe a high level care pathway for SAP that can be agreed as a national standard with localisation areas identified
(Also covered by Sub–Group 4)</td><td>Please see B. Summary of previous work in the field
▪ Discovered just assessment is not enough – have to deal with the complete care process for individuals.
▪ Highlighted 5 main areas: entry into service, assessment, personalised care Plan, the delivery of care and review/ending. Please see D. SAP High Level Diagram.
▪ Person centred, based on holistic assessment and the individual’s integrated personalised care plan (emphasised in the latest White Paper).
▪ There is widespread agreement to a high level process, although documenting the process seems insufficiently person-centred.
Please see revised Care Pathway Diagrams in Visio software (but without textual material) and also the accompanying Spreadsheet with material and answers and questions to the 337 issues http://www.cpa.org.uk/sap
See also papers in
Annex 1: Beginnings and Endings,</td></tr>
</table>

	Annex 2: **Coordination**
Deliverable 5 Identify current information flows between organisations Also covered by Sub–Group 2 and 4)	Informal feedback from health and social care staff is that many areas are still held back by using paper systems. Where there are no computer systems, sharing can be very limited. The fact that many interim electronic solutions are still not fully integrated is also a problem. Contributing factors include the lack of clarity about timescales, social care interfaces, support for assessment tools and migration plans with LSP strategic solutions.
Deliverable 6 Describe a vision for SAP (Also covered by Sub–Group 4)	From 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, "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 for Adults** 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." "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" **(Note:** this should show the underlying commitment to engaging individuals and their carers in their own support/care and the choices around it). "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.**" 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 individual budgets will have great significance over the next few years (from 'care' to 'support'?). Please see **D. SAP High Level Diagram** and papers in Annex 1: **Beginnings and Endings,** Annex 2: **Coordination,** Annex 3: **Medicine and Care,** Annex 4**: Specialist Assessments,** Annex 5: **SAP and Two People with Needs,** Annex 6: **Current Summary Record.**
Deliverable 7 Identify likely information flows between organisations and identify gaps in the current OBS(covered also by Sub–Group 2)	Please see Annex 1: **Beginnings and Endings** An individual may receive health care throughout their life, and the information from this may build up into periods of more complex support/care, not least if an individual has one or more Long Term Conditions. Social Services involvement is usually only required for set periods or episodes of time – and people do not receive this social services input during these episodes unless they meet eligibility criteria (a legal requirement).

	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 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, not least to ensure greater co-ordination between services. This might include the allocation of a responsible professional/contact to support the individual to take control. For people with more complex longer term needs, it might mean a Care Manager/Case Manager, undertaking a formal holistic (overview) assessment, 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/named contact/ or a Care Manager/Case Manager although the GP and also those giving lower level support/care may continue. The personalised integrated care plan may well be replaced by lower level support plans for the remaining individual 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. Note that the 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 will 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. Since the care delivery following a holistic assessment could cover a number of health care services and all of social care, it is unlikely that agreement can be reached on all the data items between the different constituent players. Sharing may best be handled on the documents that naturally form part of the process: the contact assessment, the overview (or comprehensive) assessment (or its summary of risks and needs), any specialist assessment, the care plan, the review document, also any referrals. Alongside this there needs to be mutual updates of changes to demographics or allocated workers.

	See also **Annex 2: Coordination.** Annex 3: **Medicine and Care,** Annex 4: **Specialist Assessments,** Annex 5: **SAP and Two People with Needs,** Annex 6: **Current Summary Record.**
Deliverable 8 Review current use of datasets for SAP, such as the Current Summary Record and consider its usefulness in field (Also covered by Sub–Group 2 and 4)	The Current Summary Record appears to have limited usefulness, and there are some theoretical problems with datasets in elements of SAP. Please see concept paper, Annex 6: **Current Summary Record** for details.
Deliverable 10 Identification of training needs - building on the competencies framework (Covered by all sub-Groups)	Who undertakes coordination can be examined in light of the recent Joint White Paper's recommendation that, "by 2008 it is expected that all PCT's and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs." Attention should be drawn to Competencies Frameworks being developed for Health and Social Care - Skills for Health and Skills for Care and in, particular, the Community Matron and Long Term Conditions Case Managers Competence Framework which is currently (from March 23rd 2006) being evaluated http://www.skillsforhealth.org.uk/viewnews.php?id=43 Please see also Annex 1: **Beginnings and Endings** and Annex 2: **Coordination**
Deliverable 11 Consider areas currently out of scope for further work streams	As a shared process, with joint work, there must be joint electronic methods of sharing information through linking systems effectively.

F. Analysis

- Concept/Exploratory papers – list and conclusions where not documented below – actual papers in Appendices.

G. Interdependencies with other groups/professionals

- Regular contact with other SAP DOAS sub-groups. Particularly with Jan Hoogerwerf and another part of the project – learning from existing e-SAP implementations.
- Visits to other DOAS projects workshops including Keith Strahan attending 'Complex Conditions in Later Life', 'Care Pathway' 'Learning Disabilities' and Mary Riches attending 'Falls'.
- It was noted that at the SAP DOAS Care Pathway conference that the existing London/Southern care pathways maps were fine examples of a care pathway.
- Keith Strahan has since communicated with DOAS projects leads Dee Harrington (Care Pathway) and Dr David Lyon ('Complex Conditions in Later Life'). There are clear links with 'Complex Conditions in Later Life' DOAS project. There is a willingness to work together in future.
- Richard Allen communicating with Learning Disabilities Lead Jacqui Howard.
- Keith Strahan attended 'In-Control' Individualised Budgets conference on the 9.3.06.
- Long Term Conditions – Keith Strahan met with LTC national leads at Richmond House on the 22.12.05.
- Keith Strahan attended DH White Paper meeting on the 3.12.05.

Appendix 2 SAP Sub group 1

- Ian Swanson communicated with colleagues in ADSS.
- All linked to work led by Seamus Bream, Sara Bird and Matthew Fagg.
- Each of the cluster representatives had contact back with cluster groups on SAP.
- Because SAP is a generic process, all areas of complex multi-professional and multi-agency care in the community should potentially use the same process.

Appendix 2 SAP Sub group 1

H. Conclusions and Recommendations

Deliverables	Conclusions - Overall	Recommendations
Deliverable 1 & Deliverable 6 Restate vision for SAP & Describe a vision for SAP	• The Single Assessment Process is the person centred health and social care framework – entry into service, holistic assessment, personalised care plan, care delivery and review/ending. • It provides the foundation of a proposed Common Assessment Framework for Adults. • 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 individual budgets will have great significance over the next few years (from 'care' to 'support'?).	• Revise in line with the White Paper. To provide a foundation for a Common Assessment Framework for Adults. **Ongoing group needed.** • Have a team working with the White Paper implementation team that handles and costs the information technology issues at the same time as the White Paper is turned into policy or legislation. **Recommendation to the DH from CfH.** • Continue to link with other DOAS projects to take forward the work, including the concept of SAP as a core/ generic part of all care pathways and link to the White Paper. A focus of the work should be the development personalised integrated care plans facilitated by NHS Connecting for Health. **Recommendation to be distributed to all adult DOAS projects.** • Ensure that any implementation plans cross health and social services systems, enable future linking to the wider social care arena (both inside and outside statutory agencies). **Recommendation to DH from CfH.**
Deliverable 4 Describe a high level care pathway for SAP	• Highlighted 5 main areas: entry into service, holistic assessment, personalised care plan , the delivery of care and review/ending http://www.cpa.org.uk/sap • Pathway works at a high level, and there is even a fair amount of agreement at the level documented. • There is probably only one basic person centred process for the support of people with complex needs, and any key differences in that process will depend on whether the individual has sole responsibility for co-ordination and management or whether this responsibility is shared / supported by professionals. • The pathway is used separately or jointly in both health and social services and most of the work can be done by either service. The pathway could also transfer from one service to another depending on the focus of care. • A Person centred approach across	• Finalise the diagrams in the light of a further consultation after publication to the external reference group via the CPA web site. **Further work.** • Complete textual material to go with the diagrams. **Further work.** • Create and maintain a continuing inter-agency cross-cluster sub-group to maintain the process and make decisions on variation, given the need for standards across the country. • Enable flexibility in any consequential information system work, since this process is new, as will be sharing between systems and across boundaries. Look for a process of ongoing development. • Create and maintain a continuing inter-agency sub-group to maintain the process and make decisions on variation, given the need for standards across the country. • Enable flexibility in any consequential system work, since this process is new, as will be sharing between systems. Look for a process of ongoing development.

	agencies requires person centred records across agencies, and there will probably be records held on at least two systems – health systems and local government systems. (There may be third systems in the short term that transfer information into both health and social services systems). There may also be a need to link with other agency systems, e.g. voluntary and independent sector. • In an increasingly electronic age, with an increasing variety of care support organisations, this material will need to be transferred between systems, and communicated electronically with the person and we will need standards to enable this. • Centre on communication with the individual, and in particular, the personalised health and social care plan to support individuals (as endorsed in the White Paper). • Critical to engage the individual and their carers in their own support/care (self-management – leads to self respect).	• Embody the main elements of the pathway in standards to be defined nationally, to enable systems to work in approximately the same way for those main elements. **Needs governance and standards work – CRS and ESCR boards.**
Deliverable 5 Identify **current information flows** between organisations.	• Many areas are still constrained by using paper systems and also by interim electronic solutions that are still not fully integrated. • This is obviously compounded by the lack of clarity about timescales, social care interfaces, support for assessment tools and migration plans with LSP strategic solutions.	• Make sure all the SAP DOAS project outcomes are shared with the NHS Connecting for Health project, 'A National Framework for Electronic SAP Implementation'.
Deliverable 7 Identify **likely information flows** between organisations and identify gaps in the current OBS	• Share main items (for definition see the concept paper on the **Current Summary Record),** for which there is a need for agreed naming conventions and minimum data fields. • The **Personalised Integrated Care Plan** is at the centre of sharing, alongside common demographic materials, (including other interested parties, and the home environment) and allocations of staff/teams (to show and contact those involved in care). • Share any assessment, in terms of event details and its conclusions.	• Create an approach based on standards to allow for the variety in the health and social care IT market, and the interconnectivity of many different organisations. • Ensure that workers can communicate electronically and securely through e-mail in advance of and alongside systems. **Create a national owner for secure e-mail.** • Having built agreement on the sharing of documents, consider a domain based method as a way of building up material from different systems, starting the process towards greater integration (see example in Annex 1: **Beginnings and Endings**).

	preferably with access to the whole assessment when more information is required. • There is the need for a medical summary highlighting current conditions and their treatment, and any major matters of history. • Where a professional records in a system outside their normal business system (assumed to be a separate health or social services system), management information needs to be transferred as well (but management information out of context may not be sufficiently meaningful). • In terms of sharing, the transfer of forms/documents would be of value to the transfer of information, especially if any data items took a long time to define and reconcile. • With SAP there needs to be sharing across the social care community which is much wider than health and social services.– maybe done on paper and fax to start with, re-using forms in the system (edited for consent issues). • Enabling staff to communicate electronically (secure e-mail) would be immensely supportive of the process until systems became clearer. • Within support/care elements of holding information, we should concentrate on sharing material around lifestyle in the persons own terms to ensure a full description rather than reducing things to a code, especially since this material should always be communicated back to the individual. This could be coded afterwards for management/research purposes. • It must be remembered that our assessment and support/care material should be routinely shared in a meaningful way with the individual. • The whole record needs to build up over an individual's life, but there will be periods (possibly ongoing and indefinite until death) when health and social care must take a holistic	**Recommendation to consult LSPs and Social Services suppliers about this concept.** • Experiment with methods of engaging individuals in their own care, and research the effects. Consult individuals about the principles in this work. **Further work.** • Consider the principles underlying 'HealthSpace' and use of the national data 'Spine' in the light of differences between medical and care information (please see Annex 3: **Medicine and Care**). Ensure care information does not stigmatise the individual. **HealthSpace to address how it expects to store care information in the light of this material.** • In the current situation, consent to share across the NHS and social care needs to be explicitly gathered at regular intervals, and we may need to trust consent gathering procedures across boundaries. • Consider how common information governance principles can be built into the various health **and social services** systems. **CRS and ESCR boards to develop, approve and mandate common standards. Care Record Guarantee to be reviewed in the light of the White Paper**.

	overview of needs and support/care alongside the individual. At the beginning of such periods material needs to be collated from currently recorded health and social care information. From a health point of view, this is probably a summary of the GP record – detailing current problems and treatments, and major items of history (subject to consent). • Similarly needs generated and summarised within a specialist assessment should be collated together into any holistic assessment (like the SAP overview), and drive the care plan. This assumes consent has been sought and given to move and share the individual's information in this way. • Have methods of ending multi agency and holistic care when appropriate to do so. • During multi agency and holistic care make a nominated worker/team and a review process mandatory in systems. • Make the review process consider outcomes in terms of the predictions in the care plan, and analyse outcomes in terms of the person's realistic expectations of their support/care. Including analysing outcomes in case of death or other exit. • There are two levels of care planning – a holistic level, done in great collaboration with the individual that may prioritise interventions and fit them with an individual's needs and lifestyle, and a service specific level which will provide detailed (and sometimes technical information) methods of carrying out care as guidance for care workers. • All sharing across agencies is subject to consent and material may need to be edited before being shared outside an organisation/service (health or social services). • Mandate the sharing of information when there are triggers to complex needs unless the person has expressly dissented, and make	

	express consent/dissent mandatory on the major stages in the process.	
Deliverable 8 Review current use of datasets for SAP, such as the Current Summary Record	• There is limited use of a common data set: some locally defined common data sets were found. The Current Summary Record - SAP (CSR) is not frequently used unless it is available in electronic form. • There are doubts about the coding of the support/care elements of the current dataset for information sharing purposes • A link between the SAP dataset and other datasets was not explicit. • We need to move from sharing something created artificially, the Current Summary Record, with no clear timing to share (and therefore potentially lacking currency) to sharing items naturally created as they happen, and especially the items (like the personalised care plan) which are shared with the individual (and might typically be found in their person-held record). • These items typically made up the Current Summary Record, but were reduced in it to limited codes in the NHSIA dataset. • Within these items, there is the need for a medical summary highlighting current conditions and their treatment, and any major matters of history.	• Move from the concept of a current summary record to the sharing of the following items between systems, as they happen or as they are compiled, and define the content (which may be free text in some circumstances): ❖ **Medical summary** ❖ **Basic Personal information** ❖ **Event details of all assessments and their conclusions (and potentially access to them)** ❖ **Allocated professional/care team details** ❖ **Integrated Care Plan** ❖ **Referrals** ❖ **Consent:** above to be shared with individual's informed consent.
Deliverable 10 Identification of training needs	• There are still differences across health and social care, especially in terms of vocabularies, joint working attitudes and cultures. • The question as to who can undertake coordination should be examined in light of the recent White Paper's recommendation that, "by 2008 it is expected that all PCTs and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs."	• There is a necessity for clarification about Care Management/Case Management roles in light of the White Paper. **Link to proposed Common Assessment Framework developments.** • There should be a combined Competency Framework (with the acknowledgement of each disciplines specialist area). Attention should be drawn to Competencies Frameworks being developed for Health and Social Care - Skills for Health and Skills for Care and in, particular, the Community Matron and Long Term Conditions Case Managers Competence Framework which is currently (from March 23rd 2006) being evaluated

		23rd 2006) being evaluated http://www.skillsforhealth.org.uk/viewnews.php?id=43 **Link with Skills for Health and Skills for Care.** • Continue to address cultural change towards greater joint working. There must be a properly resourced joint training plan in each 'locality'**. See Above.** • The requirement for a responsible professional / named contact (not necessarily a qualified worker) to support individuals with their lower level needs will also need definition. **Link to proposed Common Assessment Framework developments.** • A shift to 'signposting on' in health and social care rather than 'screening out' is essential, not least when eligibility decisions are made. **Link to proposed Common Assessment Framework developments.** • Examine how IT enables an individual take control of their own life; including coordinating and managing their own health and social care support. **This has implications for HealthSpace.** • What access will individuals have to their electronic 'case' file in the future– not least their integrated care plan? **Part of next phase of DOAS project.**
Deliverable 11 Consider areas currently out of scope	As a shared process, with joint work, there must be joint electronic methods of sharing information through linking systems effectively.	

Keith Strahan – Joint Chair SAP Do Once and Share – March 2006

Sub-Group Membership

Ian Swanson - London Cluster

Keith Strahan – London Cluster

Mary Riches - North East Cluster

Richard Allen – Southern Cluster

Alan Allman – North West and West Midlands Cluster

David Allan–Smith – Eastern Cluster

Jan Hoogerwerf – SAP Consultant to DH

Appendix 2 SAP Sub group 1

Also Circulated To

Jennie Cuthill – Eastern Cluster

Moira McGrath – Eastern Cluster

APPENDICES – Concept and Exploratory Papers

DOAS SAP Concept Paper: Beginnings and Endings – March 2006

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 complex support/care; not least if an individual has one or more Long Term Conditions. Social Services involvement is usually only required for set periods or episodes of time – and people do not receive this social services 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 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/named contact to support the individual to take control. For people with more complex longer term needs, it might mean a Care Manager/Case Manager, undertaking a formal holistic (overview) assessment, 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/named contact or a Care Manager/Case Manager 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 individual 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.

Note that the 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.

Keith Strahan – Joint Chair SAP Do Once and Share – March 2006
Mobile: - 07973-700695 **E-mail address:** Keith.Strahan@cfh.nhs.uk

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

Appendix 2 SAP Sub group 1

Keith Strahan – Joint Chair SAP Do Once and Share – March 2006
Mobile: - 07973-700695 **E-mail address:** Keith.Strahan@cfh.nhs.uk

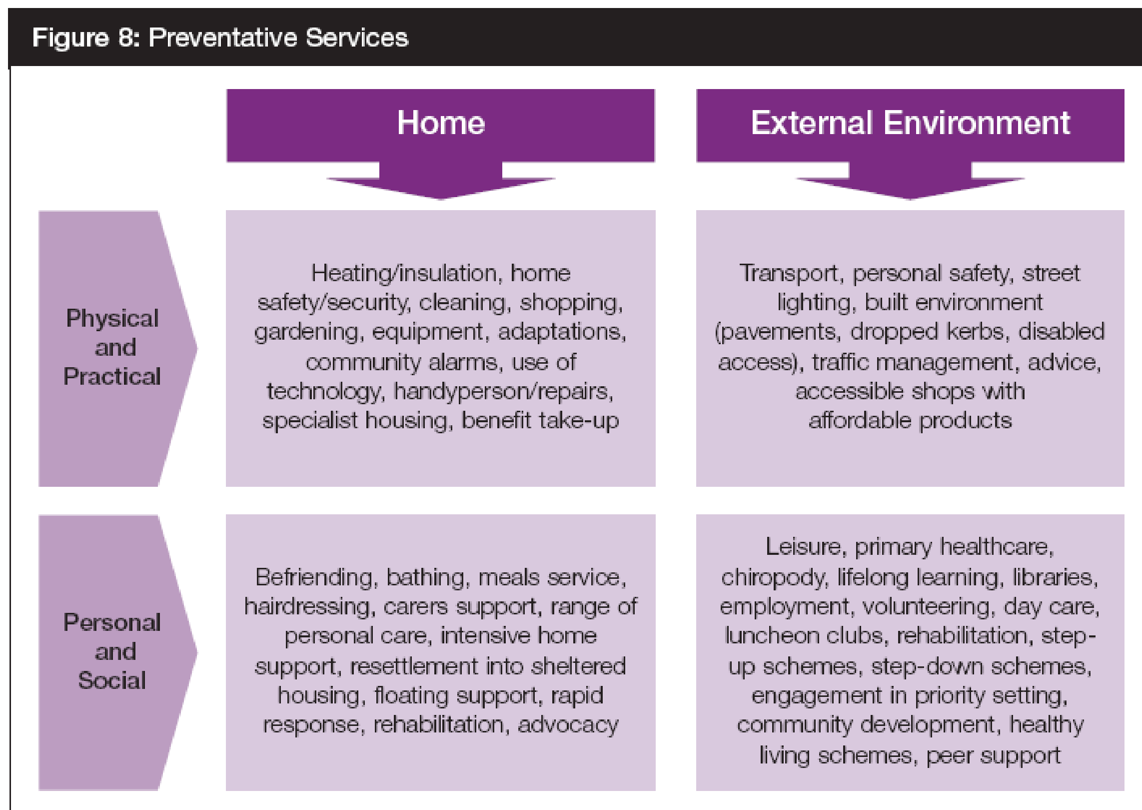
Annex 1: Concept Paper - Beginnings and Endings
Recent Policy Initiatives

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,

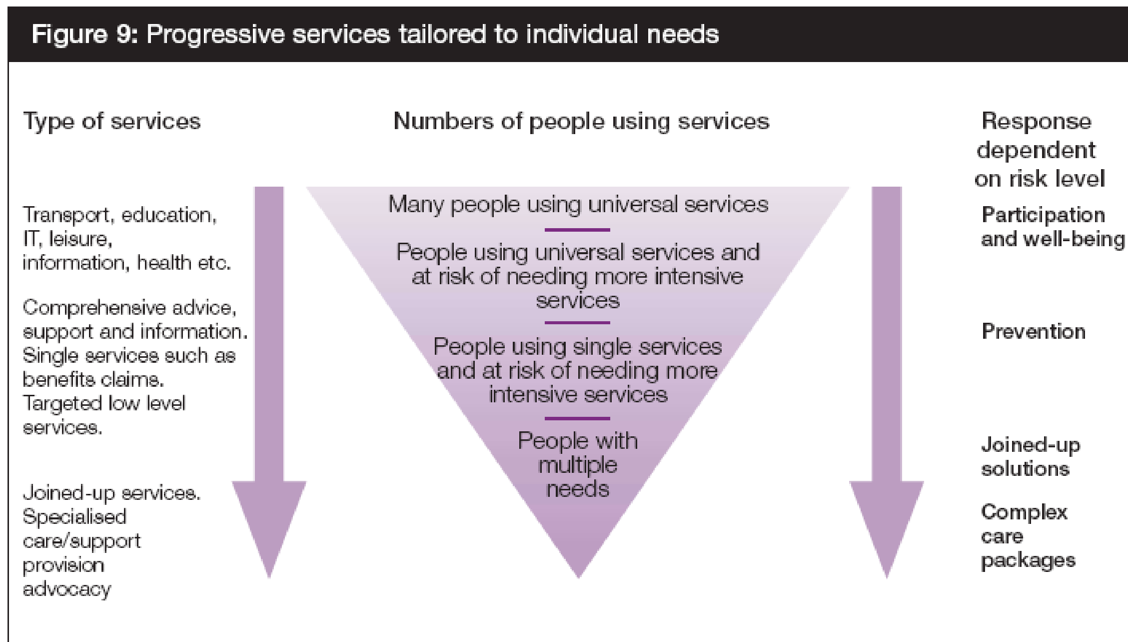
The approach that we are advocating brings together key partners of health, social services, benefits and housing, as well as often overlooked missing links such as transport, leisure, community safety and learning. This is about community capacity building to move the debate on from paternalism to prevention 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.”

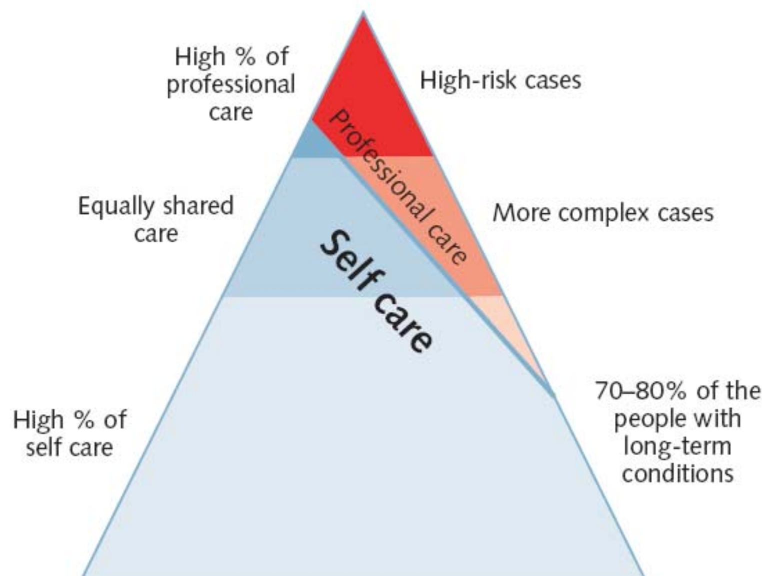
Annex 1: Concept Paper - Beginnings and Endings
Recent Policy Initiatives



In the White Paper, Our health, our care, our say: a new direction for community services, Chapter 5, P.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."



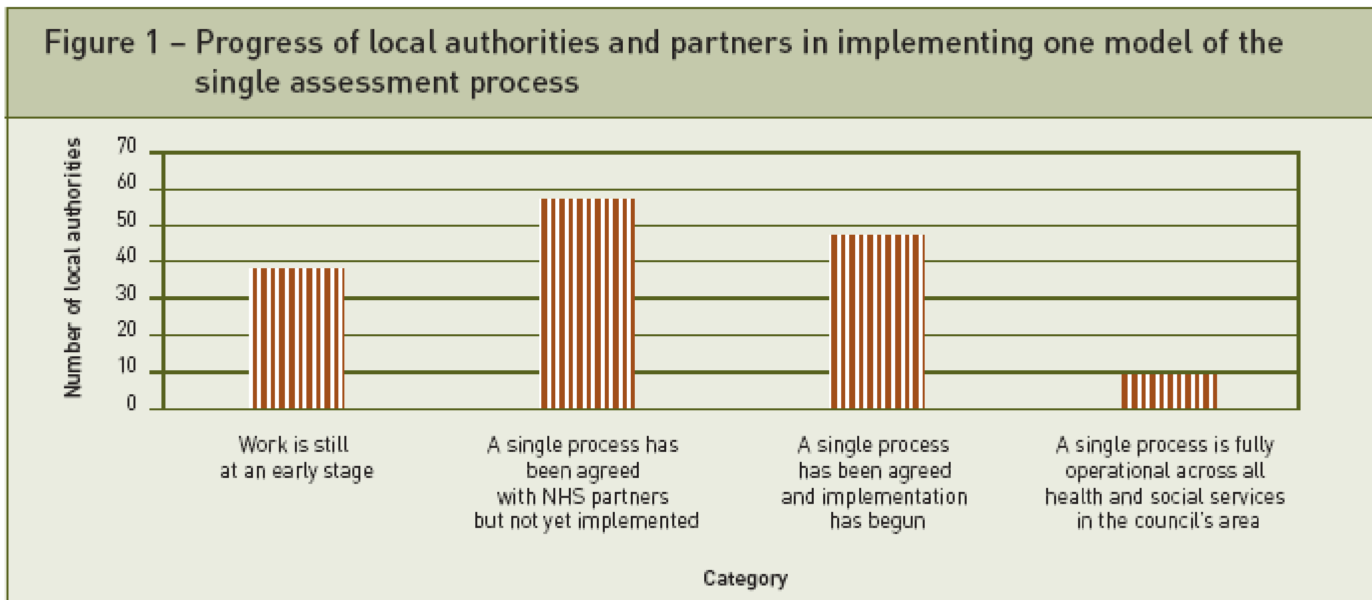
Annex 1: Concept Paper - Beginnings and Endings
Recent Policy Initiatives

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 ."

(Please see **Annex 7** for more details)

Annex 2: Concept Paper: Coordination - From Beginning to End

People with longer term complex needs (with at least one long-term medical condition together with significant social care needs) as mentioned in 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* are likely to be supported by a developing Common Assessment Framework for Adults based on the Single Assessment Process, with close to links to Long Term Conditions, the Care Programme Approach, Supporting People and Valuing People. The emphasis is on empowering individuals with long-term needs to have control and support themselves. Better access to information and integrated health and social care plans will be essential.

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 individual budgets will have great significance over the next few years (from 'care' to 'support'?).

The White Paper calls for more collaboration between health and social care to create multidisciplinary networks to support those people with the most complex needs and states the importance of investment in training and development of skills for staff that care for people with ongoing needs.

With this background, this paper focuses on the crucial area of support and coordination for individuals and their carer(s) from beginning to end **(please see also DOAS SAP Concept: Beginning and Endings).** The emphasis throughout is on working with individuals to enable them to have more control and to support themselves as much as possible.

Coordination

In daily life, many individuals control and coordinate their health care and social care requirements most of the time; for example, resting when not feeling well. They have their own views about their own life and what works for them. The services they receive are universal services e.g. transport, education, etc (although many people are socially excluded even from these). We all get support from others but tend not to think of it in that way. We value our independence, our freedom from others, and we tend to ignore our everyday reliance on others (although for severely disabled people, it is often impossible do so).

There are times when an individual's needs become more complex, when self-support (and the support of their informal carers) becomes more difficult, and many professionals and/or services become involved. When this happens, the individual requires extra assistance so that the services that support them are provided in a coordinated manner.

Individuals have often felt their right to self determination, choice and control over their own lives diminishes if they are not supported appropriately when this stage is reached. This loss of self esteem and dignity just adds to the difficulties they are experiencing. A professional's positive attitude and approach to supporting the individual in this situation can make a significant difference.

Recognising that each individual has their own unique situation, and a desire to have control over their own life, is key. It is the starting point for how support and care should be provided whilst keeping within statutory (and financial) boundaries.

Continuity of Care and Coordination

From entry into service onwards, there should be a responsible professional/named contact who acts as a central point of reference supporting the individual and their carer(s). For many people with single or 'simple' need(s) this will probably be their GP in the first instance. It is when an individual's needs become more complex that a more formal holistic assessment is triggered. These triggers need more definition but for GP's they often happen when there is substantial impact on the individual's functional abilities in daily living.

Care Management or Case Management for people with Long Term Conditions takes place for people with the most complex needs when a proportionate, holistic assessment is indicated and would normally cover all aspects of coordination, including still having a role when the individual is admitted to hospital. Ideally, the same health and/or social care worker should be supporting the individual throughout the process. Where this is not possible, the aim should be to limit the 'hand offs' or handovers between health and social care workers to a minimum.

There are best practice principles underpinning coordination. These include:

- Recognising that individuals value independence, choice and control
- Maintaining a friendly but professional manner that is neither patronising nor threatening in any way
- Using everyday language - never jargon or professional terms/labels which may not easily be understood by a non professional
- Serving as a source of information and advice from the outset for the individual and their carer(s), promoting health and wellbeing and preventing ill health
- Encouraging the participation of the individual and facilitate supported self care/self management so that the individual can have more control, for example, direct payments and individual budgets for social care services
- Being the main point of contact when supporting the individual and their carer(s); also to support the individual to obtain advocacy/agent/broker services as appropriate
- Coordinating the care team to identify and meet the needs of the individual and their carer(s) (if the individual is unable to do). Information should be shared to those with a legitimate relationship with the informed consent of the individual.

Best Practice has shown that Coordination under SAP can usefully be broken down into Assessment Coordination tasks and Care Coordination tasks.

Holistic Assessment

The proportionate holistic assessment (often an overview) should be carried and coordinated by a health or social care professional from the discipline best able to meet the most pressing needs of the individual (as indicated by the information available at that time).

The proportionate holistic assessment would identify risks and needs (physical, mental, social, and developmental, etc). This holistic assessment should also identify abilities, strengths and preferences. The individual's perspective, views and self assessment should be encouraged at all times.

Flexibility is to be encouraged because the circumstances of the individual and their carer(s) might change at any time e.g. emergency care might be required during the assessment stage or further assessment(s) may well be required after the care planning stage.

Assessment coordination tasks include,

- Valuing the experience and expertise of individuals and carers; particularly their understanding of their own requirements
- Working together with the individual and their carer(s) to ensure an appropriate, proportionate holistic assessment takes place and with time given for self assessment
- Making sure specialist assessments are completed as necessary
- Ensuring assessment information is collected, evaluated and linked to the summary of risks and needs

Appendix 2 SAP Sub group 1

- Explaining consent (to share information) to the individual and ensure that her/his wishes are followed within legal guidelines and reviewed

- Ensure that eligibility decisions are made based on the assessed level of need and open, transparent criteria communicated in plain English.

Care Planning – supporting people

The risks and needs identified from the assessment are addressed by joint planning of the care with the individual, their carer(s) and relevant professionals, to achieve agreed outcomes. These can then be used to commission the services to support the individual in the personalised care plan (made accessible to the individual in the most appropriate way).

The personalised care plan needs to specify exactly who is responsible for implementing the different aspects of the plan and by when. Contingencies for deterioration, especially out-of-hours, can be detailed in the plan. Care delivery of the agreed plan occurs with predetermined dates for review established.

If the summary of risks and needs from the assessment indicates a care coordination role, then the most appropriate care coordinator should be identified to facilitate the planning and delivery of care, at least until the first review. There may be times when the care coordinator can be sourced from the voluntary or independent sector or the individual or carer might also fulfil this role with support. The more open the system is and the clearer an individual's entitlements then the easier it should be for individuals to navigate their way through the system by themselves. The views of the individuals and carers concerned; continuity; the level of risk and their best interests, are important factors when the decision is made as to who will be the care coordinator

Regular reviews should take place in consultation with the individual to ensure that the personalised care plan remains relevant, outcomes are being achieved, that changes are not missed and that the individual and their carer(s) are supported appropriately e.g. clear information about their self care/self management if services are no longer required or reduced afterwards.

Care Coordination tasks include,

- Enabling individuals to give informed consent to share their information, and in particular, their personalised care plan, with the rest of their care team
- Working together with the individual and their carer(s) to ensure that the personalised health and social care plan is implemented
- Monitoring services making sure they are delivered effectively, on time and are achieving their objectives
- Facilitating communication between multiple agencies and professionals and oversee discussion/meetings as appropriate in conjunction with the individual
- Maintaining contact with the individual during periods in hospital and involvement in arrangements for discharge
- Ensuring that reviews and re-assessment are undertaken and documentation updated appropriately. The cycle begins again with individuals having increased or decreased inputs as required.

Conclusion

People meet their own lower level health and care needs most of the time; often with the support of carers and their GP. However, there are times when an individual's needs increase, and become more complex. When this happens, the individual often requires extra assistance so that the services that support them are provided in a coordinated manner.

A Care Manager/Case Manager works with individuals with complex, longer term needs to provide support, continuity and security to co-ordinate their assessment(s), and, when appropriate, their care planning and services, encouraging self determination and supported self care/self management.

Individuals and their carers should participate fully in the process and have every opportunity (whatever their age) to take control and make choices about their life. For this to happen, they must

be able to access clear information throughout and have the expectation of honest and understandable answers to any questions.

Recommendations

- Who undertakes coordination can be examined in light of the recent Joint White Paper's recommendation that, "by 2008 it is expected that all PCT's and Local Authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs." There is a necessity for clarification about Care Management/Case Management roles.
- Attention should be drawn to Competencies Frameworks being developed for Health and Social Care - Skills for Health and Skills for Care and in, particular, the Community Matron and Long Term Conditions Case Managers Competence Framework which is currently (from March 23rd 2006) being evaluated http://www.skillsforhealth.org.uk/viewnews.php?id=43
- The requirement for a responsible professional/named contact (not necessarily a qualified worker) to support individuals with their lower level support needs will also need greater definition.
- Another factor will be the Individual Budgets pilots that are taking place for adults. The role of the Support Broker (someone who acts for and is directed by the individual) will influence this debate.
- There is a need to scope how IT enables an individual to take control of their own life; including coordinating and managing their own health and social care support. This has implications for HealthSpace and eSAP solutions. What access will individuals have to their electronic file in the future– not least their integrated care plan?

Keith Strahan – Joint Chair SAP Do Once and Share – March 2006

Annex 3: Concept Paper - Medicine and Care

TWO AMALGAMATED CONCEPTS
A SPECULATION IN THE LIGHT OF INFORMATION TECHNOLOGY IN HEALTH AND SOCIAL SERVICES

Why speculate?
When examining both health and social care recording methods and systems, it becomes increasingly clear that there are two sets of language being talked and two major “themes” involved in the systems.

They appear to distinguish between medical concepts and care concepts.

This paper will look briefly at both themes from the point of view of the person (patient/service user) and from an IT point of view.

The differences need to be carefully handled when creating systems, so that we do not take the assumptions of one theme automatically into another.

Medicine
From a patient’s point of view, the medical profession are the medical experts.

While they expect clinicians to explain treatments and their likely consequences, and to offer alternatives, they will largely be expert guided in what is done **to** them. They will probably accept a fair amount of jargon, especially if they can be pointed to places where they can get translation if they want.

Medicine is a scientific discipline of diagnosis and treatment. It becomes increasingly technical and specialized as people pass on from community to acute services.

It is largely evidence based – by working in research mode; it can discover the best **treatments** (in care pathways) **for conditions** (and also the reason for conditions). To do this having highly coded data for exploitation is really valuable. It also helps in describing things precisely for communication between professionals (but not necessarily with the patient).

As it becomes more technical, information technology can help understand information, and ensure that things like drug conflicts (decision support) can be analysed for the front line.

Systems tend to reflect the ideas above.

Not all medicine is concentrated on this scientific and precise description. In particular, Mental Health treats an individual holistically as a person with needs, and GPs amongst most doctors will be alert to other needs of a person as well as what they may be specifically treating. This may not all get into recording, which is where systems concentrate.

Care (in its support context)
From a person’s point of view, they are personally competent in care and 98-99% of health and social care is done by people themselves every day of their life (resting when not feeling well etc.) – a situation which we need to encourage.

They will have their own views about their needs and what works for them. It is when self-support (and that of carers) no longer works that professions step in. Descriptions in highly formalized language which categorise people can end up being offensive and also insufficiently descriptive of their precise situations, which can cause people to think we do not understand them.

Care is about helping people handle the impacts of disease and other social ills (why health and social care need to work together), so that they can continue to live a (“normal”) life, or sometimes (e.g. in hospital) sustain quite an abnormal life while dealing with medical problems).

However we are all individuals, and the way we care for ourselves, or, have others help us care is actually a matter of personal choice (smoking, diets, exercise, friendships, where we live etc.).
What is recorded about care is about a person's way of living and then professional interactions with that when they need support.

While there is a lot of standardization of **support for needs,** what is actually delivered should fit with (or be negotiated around) a person's own view of their care and their life. Given that support will change according to a person's choices and priorities, it is much more difficult to define the same package of care (in medicine a care pathway) for lots of individuals, and outcomes will vary as well (and need defining from the person's point of view) – so that the simplistic research model loses some of its validity.

A key part of care will be engaging the person (and their relatives etc.) in that care, since we should only be supporting where they have needs that they cannot meet themselves. Communicating with them (including electronically and in our outputs from electronic systems) is probably a crucial part of that engagement, and can be expected to become more important as people develop information technology skills.

(In dealings with a social worker after the introduction of a computerized Electronic Social Care Record System, she affirmed very clearly that a major consequence of the system was that everybody, including the family had a copy of the care plan. This care plan was a negotiated document detailing what everybody did in terms of care. This had led to a clarity, which really helped the process of improving care.)

Example of system problems arising in a care/medical concept

As an example of the difference (which for a third reason causes problems in both camps), both medicine and care may use ethnic description codes.

In medical terms, diseases may be more relevant to populations with specific genetic inheritances – but the coding rarely goes far enough for that – and in any cases actual analysis of the genetic make-up is more important – ethnicity id used as a proxy for this..

In care cultural affinity is much more than just a code, and there are probably almost as many cultural affinities as there are people. And the result of these cultural affinities may be Halal meals, the desire for a certain type of religious representative to comfort me when I am ill, abstention from alcohol or meat or transfusions or photographs

In both cases we have been reduced by a combination of monitoring policy and computer simplification to use a code of ethnic category, which helps neither of the potential uses above, although we do at least allow individuals to self categorise (choose their own label).

The solution to this would be a further two fields – one (coded?) around genuine genetic inheritance, and one (free text) about cultural affinity and its consequences for the individual.

The Care Records Services

From the descriptions above it is probably clear that CRS deals with both medicine and care. In comparison social services systems tends to deal just with care.

There has been a tendency for the CRS to be led by the acute sector – where medicine is at its most dominant in health care.

Coupled with the tradition of computer systems before the web dealing primarily in coded data (often money), this acute led approach has tended to create a CRS dominated by medicine, and less amenable to some of the different concepts of care.

This paper asks whether this is right, and whether some of the professionals involved in holistic care processes, like SAP and CPA in Mental Health, need to require a widening of the Care Records Service, so that the medical assumptions at its heart are broadened to admit care assumptions as well.

The key care assumption, when it comes to information is that its format should be compatible with the individual cared for (consultation with users over the information held and its format becomes crucial)

Conclusions

We need to code medicine but expect to use much more free-text around care (while still categorizing the text for research and management information purposes e.g. aggregating needs)

Medical systems may be more focused on communication between clinicians (care pathways, e-prescribing and decision support), and use technical terminology for precision and system processing. Care systems may need to balance inter professional communication, with the equally important communication with the person. Medical system may be able to move to communication with the person through translation of terminology.

Research assumptions around finding the best evidence based treatment for people may not be as valid in a care context where the person is making many more choices to handle their individual situation.

There needs to be more work on public communication, especially in the care area to see the best way of producing communication that helps engagement.

We noted the difference between the Electronic Social Care Record strategy with its emphasis on documents, and the medical emphasis on data.

Ian Swanson - SAP Do Once and Share project, March 2006

Annex 4: Concept Paper – Specialist Assessments

SPECIALIST ASSESSMENTS IN THE SINGLE ASSESSMENT PROCESS AND HOW INFORMATION TECHNOLOGY COULD SUPPORT THEIR USE

Background

In the original guidance from the DH on SAP, a specialist assessment was defined as 'a way of exploring specific needs, often in detail' and that it should be 'administered and interpreted by the most appropriate qualified professional'.

Some specialist assessments will undoubtedly relate to one professional group whilst others can be carried out by a variety of different disciplines. It is not necessarily the case that only a 'specialist' practitioner can carry out such an assessment.

Additionally, some specialist assessments will be used by only one agency, whilst others will be generic across multiple agencies.

Categorising specialist assessments

SAP provides a flexible, light-touch framework that supports a holistic multi-agency assessment of a person's needs. A specialist assessment is a means of exploring in further detail a person's specific needs and contributes to the development of a care plan.

Often, an overview assessment will precede one or more specialist assessments. In some cases however, a specialist assessment may be the first instance where information is gathered for SAP.

Therefore, to avoid asking the same questions twice, electronic SAP applications should utilise information from specialist assessments to populate the relevant domains of the overview.

'Generic' specialist assessments

It is debatable whether all specialist assessments sit comfortably within the high level plane that SAP occupies. Some specialist assessments do gather information that is relevant and indeed essential for all involved practitioners from acute health, mental health, social care, primary health care and external agencies. Examples of such tools would be a falls assessment, a risk assessment, and a moving and handling assessment. The information gathered would be valuable to all the professionals involved and inform the SAP record and care plan.

This would suggest that some specialist assessments can be carried out by a range of professions / agencies and that the outcomes are of generic value and should be shared in full and inform the high level SAP care plan. For the purposes of this discussion, these could be labelled 'generic specialist assessments'.

'Focused' specialist assessments

Some assessments are highly technical or clinical in their content and in the language used and would not be widely understood, other than by the professional discipline or team that created them. Examples of such tools would include a leg ulcer assessment, a swallowing assessment and a detailed mental health assessment. It is therefore unlikely that the full detail of the information gathered would be useful to others using SAP. However, a high level summary of the specialist assessment findings is certain to be of value to most, if not all, of the practitioners involved, whatever agency they represent.

Such specialist assessments are highly specific to one discipline or agency and could be categorised as 'focused specialist assessments'. The summary of the outcomes should be shared and used to inform the summary care plan and further information may be available through discussion between professionals.

How a single IT solution for SAP could support specialist assessments

There is a view that there should be one electronic solution capable of providing a holistic view of needs and at the same time meeting the requirements of the practitioners carrying out specialist assessments. This would negate the need for SAP and a clinical solution and/or a social care system to interface – all agencies and disciplines would be using the same solution to record the

needs of individuals, refer to other services and plan, monitor and review care. (Integration with back-office and management systems within health and social care would be required.) Importantly, there would be no need for practitioners to access more than one solution.

Practitioners would have access to templates for all specialist assessments and would be able to view the outcomes of completed assessments according to their viewing rights, as dictated by role-based access via a Smartcard. Consent would be required from the person being assessed to the sharing of the information collected in a specialist assessment and 'lock down' functionality would be essential to restrict information being shared beyond the consent given.

Information gathered during a specialist assessment would populate other relevant areas within the solution e.g. the overview; other specialist assessments, in order to avoid repetition of questions as further assessments are undertaken. For example, a leg ulcer assessment will collect information on mobility and nutrition and this should be carried forward to populate the overview and also any subsequent specialist assessments e.g. continence assessment.

This is the ideal model in many ways. However, it does not accurately reflect 'where we are now'. Currently within NPfIT, there is a variety of electronic solutions available and considerable potential for overlap in the functionality provided. In some of the Clusters, there is an LSP application offered for use by community clinicians in the NHS and another for SAP. Integration between the two will be required if the information from the specialist assessments carried out in the NHS Clinical application is to be utilised in the separate SAP application. Also, social care systems will need to integrate with the shared SAP application.

In the absence of a single solution, can integration between applications be effective for SAP?

As described above, the evolution of IT solutions in health and social care has led to a situation in some localities where the SAP solution needs to be integrated with other applications.

Using the integration model, generic specialist assessments need to sit in all SAP applications and the entire findings and outcomes, including the low-level detailed care plan for that specific intervention / service, would therefore be available to all system users who have a legitimate relationship with the person.

Focused specialist assessments could sit in an appropriate application that integrates with all SAP applications and allows a summary of the findings and the outcomes of the specialist assessment to be shared amongst those involved in the care of a person. This could then drive *the SAP Summary Care Plan, populating it where possible,* and still give the opportunity to contact the care professional responsible for carrying out the assessment for further detail if required.

Until all applications handling people with a holistic care plan can handle this integration, system users may need to work in more than one application, which is clumsy, time consuming and likely to lead to disengagement.

The NHS Connecting for Health e-SAP Project due to report in late May 2006 will further examine the issues surrounding electronic implementation of SAP.

Consent

Overriding all of the above suggestions is the need for consent to information sharing by the person taking part in the assessment. By their nature, specialist assessments gather highly personal data and no case can be made for the integration of applications unless there is the functionality to restrict the sharing of information according to the wishes of the person being assessed. This may be particularly significant for the individual being assessed where agencies external to health and social services have access to SAP systems.

Examples of specialist assessments that contain highly personal data include mental health assessments, continence assessments and carer's assessments. In such sensitive fields, it is to be expected that consent to sharing may be withheld in a significant number of cases.

Recommendations

- Generic specialist assessments should be available for all involved care professionals to use and accessible to all of them to view the entire findings and outcomes, including the low-level care plan, assuming that consent is given by the person.

- A summary of the findings and outcomes of focused specialist assessments should be accessible to all involved care professionals having a legitimate relationship with the person. Again, this recommendation is based on the assumption that the person being assessed consents to the sharing of their information.

- Applications designed to record specialist assessments and integrations designed to share the information generated by specialist assessments must have the functionality to restrict the sharing of any part (or all) of that information if the person does not consent.

- Needs generated and summarised within a specialist assessment should populate the SAP overview assessment and any other specialist assessments. This assumes consent has been sought to move and share the person's information in this way.

- The NHS Connecting for Health e-SAP Project due to report in late May 2006 will provide valuable guidance on how the issues discussed here can be addressed.

Mary Riches
North and East Yorkshire and Northern Lincolnshire SHA
March 2006

Acknowledgements: David Allan-Smith and Jan Hoogerwerf

Appendix 5: Exploratory Paper - SAP and Two People with Needs
THE SINGLE ASSESSMENT PROCESS AND THE COMPLEX ENVIRONMENT
EXPLORING THE REQUIREMENT FOR HOLISTIC ASSESSMENT WHERE TWO PEOPLE WITH NEEDS LIVE TOGETHER

Background

The principles of the Single Assessment Process (SAP) have now been established for some time, and in recent weeks reinforced by the new White Paper, “Our health, our care, our say”. One of the key fundamentals has always been that the focus must be ‘person centred’. Whilst this has been evolving as an underlying principle for most localities, it is fair to say that the White Paper has demonstrated that there is still some way to go. One area that as yet has not been formally acknowledged or addressed within the process, is that where more than one person with needs live together. For the purposes of this paper, this is referred to as a ‘complex environment’, which is not to be confused with ‘complex needs’ which refers solely to the needs of one individual. It is of course the case that complex environments may, or may not, also concern people who have complex needs.

What is a ‘complex environment’?

In this context, a complex environment is one where the needs of more than one person have to be taken into consideration. Typically this will be in circumstances where two people live together and have separate individual needs that both require care plans.

Under these circumstances, decisions need to be made regarding what processes can be implemented, to ensure that neither person is disadvantaged and that appropriate support is given that ensures both individual and holistic needs are recognised and supported.

The extension of the process outlined in the White Paper, to other care groups (e.g. Long Term Conditions or Learning Disabilities); will inevitably increase the frequency of complex environments being encountered. It is therefore important that this area is explored and accommodated within the current SAP processes.

There are various options for including complex environments within SAP, and it is to be recognised that none of these will exclusively be the right approach. Each stage of the process will need to be flexible enough to cater for the variations that these circumstances will create.

Entry/Referral Options

- Initial entry or referral may well be as a result of just one of the individuals becoming known to one of the agencies. As a result of an initial assessment it may become clear that there is a need and a desire for another person within the home environment to also be assessed.

- Both people may choose to refer themselves together or be referred as having ‘joint’ needs. Mostly it is likely to be when a couple reach a stage whereby they collectively feel that they can no longer cope with their own needs. They may for some time have been each other’s principal carer, until the stage when this no is longer sufficient to enable them to sustain independence.

- There may have been a significant event within the home environment that has caused a breakdown in the current dynamic, such as a breakdown in relationships, bereavement, or a trauma or sudden deterioration in the health of one or both people.

Assessment Options

- Both individuals may choose to be assessed jointly, stating that their interdependence makes it impossible to separate their needs. This would be a complicated process to respond to, as clearly there would potentially be a need for many professionals and agencies to work closely together in ways that they are not accustomed. A good example of this would be where a mother and child both have significant but very different needs that will change over time, but nevertheless see their interdependence as a significant feature of their environment.

- Both individuals choose to be assessed separately, with the result that separate care plans are developed. In this instance, synchronisation is of paramount importance in the delivery of care, in order to ensure that, where requested, there is an optimisation of the resources being provided. This will avoid the inconvenience and disruption caused by service delivery being staggered through the day at separate times to each other.

- The assessment of each individual needs to be carefully and sensitively appraised in order to attempt to balance the individual's perception of their needs against those of their 'co-service user'.

- Care co-ordination needs to be able to recognise a multiplicity of scenarios to include joint co-ordination by the two service users, co-ordination by just one jointly agreed service user, and of course professional care co-ordination of each individual either separately or jointly.

Review options

- Whether assessment has been carried out jointly or separately, there needs to be the ability to both singly and jointly review at any stage.

- Equally, part of the review process might determine the requirement to separate a joint assessment into two separate ones, or conversely to amalgamate two separate assessments into one joint assessment with associated care plan.

Exit options

- One or other person may improve sufficiently to no longer require services, pass away or require residential care for their needs. What happens at this stage within SAP will be determined by decisions regarding discharge or dormancy at the end of a SAP 'episode'.

- A more general option to be considered is that whereby all care delivery is procured from 3rd party suppliers. It needs to be confirmed how this is to be regarded, monitored and maintained as a record by the SAP process that is administered by the core agencies.

Consent

- Fundamental to all of this is the thorny issue of consent. In the instance of 'joint assessment' then clearly consent is significantly more complicated to determine appropriately.

- Can the consent of one service user ever be taken as consent by both (power of attorney etc)?

- Safeguards need to be introduced to ensure that then needs/requirements of one service user do not override and impair those of the other.

- Processes need to be devised to cater for the scenario where one service user withdraws consent.

Recommendations

The whole issue of the delivery of care holistically is one that, to my knowledge, has never been addressed by SAP in the context of more than one person with needs. As previously mentioned, it is a situation that will occur with increasing frequency as SAP extends into the domains of the other care groups.

It is important to ensure that the process maps allow for 'joint care delivery' in complex environments. However it is to be recognised that the IT requirements that would result are inevitably going to be significant and complex.

When material is filed on an electronic system, joint material needs to file under both individuals, and Legitimate Relationships need to be to both individuals, where they have agreed joint assessment and care planning. During periods where individuals wish to be worked with jointly, an indicator to this effect needs to appear on both records.

The carer aspects within these environments must also be recognised. Assessment must deal with any care-giving needs that the individual has, and should not ignore the possibility of carer support

(e.g. respite) as well as ordinary support for needs and risks. The complexities of how to identify, acknowledge and support the care-giving role of people who themselves also have needs, is one that needs further exploration. It will need to be sensitive to the potential necessity for keeping these elements separate from any jointly held assessments, as well as incorporating them into jointly held documentation if required.

It is recommended that an appendix to the process diagrams is produced that caters specifically for this situation, by a small working group set up for this purpose. Once completed, it will need to be agreed collectively as to how this will then be appropriately incorporated into the evolving core process map.

Richard Allen
Avon, Gloucester & Wiltshire and Thames Valley SHAs
March 2006

Annex 6: Concept Paper - Current Summary Record

CURRENT SUMMARY RECORD
THOUGHTS ABOUT AN ALTERNATIVE FOR USE IN THE INTERCHANGE OF INFORMATION WITHIN SAP

Source

The CSR was a record put together initially by a committee within the Single Assessment Process as a view of the critical information that people needed to see. It has helped concentrate minds on the most important items to share. It is an amalgamation of different parts of the process (information from: demographics, captured at the start of the process; the overview assessment; the care plan; reviews). It is not a document typically created at any point within the process.

It was then taken to the NHSIA to be turned into data items, with seemingly several assumptions (or some of these were made in the NHSIA):

- That a system working on the whole process could produce the CSR automatically, or, that people would produce it additionally for sharing
- That it was key to management information
- That it could provide the basis for sharing between health and social services and other provider systems
- That much of the information could be derived (especially from GP systems)

Because the NHSIA dataset was more management information based, it overemphasized dataset collection rather than sharing (for example the landlord field 1.16 tends to repeat codes around tenure, rather than provide the name and address of the landlord, which is the key matter for adaptations etc.)

Categorisation of an individual

The Single Assessment Process is as much about support around the impact of medical conditions, as opposed to the treatment of those conditions. The conditions impact on a person’s lifestyle (life choices). Such things are very personal, and should not lightly be turned into codes which can be “labelling” (in the experience of social workers – who have written quite a lot of negative comment about tick box assessments). For understanding, it is often best to represent a person in descriptive words (and preferably their own). The Current Summary Record and its dataset tend not to do this. It is one approach to reducing the quantity of material that can potentially be shared.

Consent to share

As is very clear in guidance, sharing material (especially between agencies) is about consent. There can be rules around sealed envelopes, but these may need to be very sensitive to handle information sharing problems. It is doubtful whether any information can be guaranteed to be shared automatically (i.e. there will always be a stage when information sharing is considered before information is sent, and editing considered – although this will only be needed in a small minority of instances). So we may need to build this stage into our sharing of the CSR (except that the CSR is not a naturally occurring document – but something that we hope to have assembled by computer)

Summary and detail

Even if we did share the CSR (as defined in the dataset), there are times when its codifications will not be enough for decisions on care (and where it’s “labelling” may be misleading). Having **access** to the material that lies behind the CSR may always be necessary, and our problem will be to decide how to handle such access (maybe by people communicating)

When to share

The Current Summary Record has a major problem of when it should be shared. Transferring all information, when any element changes, is obviously a difficult overhead. It does have the real benefit of being something that can be sent when a new professional becomes involved.

An alternative approach

Most of the material represented in the CSR obviously has relevance, but it needs to be seen in two contexts – where in the SAP care framework does it get created or changed; and when does it get shared with the person cared for. If the sharing is between two systems, it is best to disassemble the CSR and share material in pieces at different times.

Factual information (person demographics and their physical environment and main contacts)
Changes in a fairly ad-hoc manner, and may be reducible mainly to concrete things – and coded. This should be shared and changed on all systems as the information changes (we may have to document how much needs to be transferred)

Clinical/practice information

What really matters is the care planned to be delivered (its purpose and the reasons for it) and a medical summary of current conditions and major history. With these items anybody working in a partial way will have enough information to do their main work, and if they have to go into more detail, they may need to look at more detailed documents, like the assessments, or talk to other individuals involved like GPs, social workers or consultants. (Mutual access to these items can be important)

Sharing the events and involvements

Knowing that assessments have taken place, and the people responsible for them (so that they can be talked with) is important for multidisciplinary work, and sharing the existence of major events and current involvements seems valuable. This could be extended to items marked by individuals as significant events within their record.

Sharing the Care Plan

Since delivered care is the prime thing that the person wants (assessment is but a step on the way to this), this is the prime thing to share with the individual (and such sharing is prescribed in the SAP guidance, and re-inforced in the White Paper).

It should be written in their terms, and should be a natural product of the process. This will also provide most professionals with the key information they need, and as a natural product of the process, should be available for sharing.

Before the sharing of the care plan, the key thing to share is where somebody is on the SAP process, and who is currently taking responsibility for them on that process. If there was an assessment and no care plan, it might also be worth share the conclusions on needs and risks that had been reached in the assessment process.

Sharing the medical summary

This is a more difficult item. It is not really naturally occurring – but maybe, in essence, it is the GP summary which has started to be discussed in terms of the spine. It can cover the whole of medical care, which may make structuring it into a summary quite difficult, but for people with long term and complex conditions vital. Its content should however obviously consist of all current conditions and treatments/medications and major items of history.

It's sharing with social services needs to be subject to consent to share (and if this was obtained by a social worker, when starting on SAP, would the health service accept their assurance that it did exist, if they were doing an electronic look up?). It may need to contain items like prognosis, although sharing this with the person needs to be handled sensitively.

Moving from an artificial construct, to sharing during the natural process of a case

The alternative suggested in this paper seems to be a move from sharing something created artificially, with no clear moment to share (and therefore potentially lacking currency) to sharing things naturally created as they happen, and especially the items (like the care plan) which are shared with the individual (and might typically be found in their person-held record).

Recommendation

Appendix 2 SAP Sub group 1

That we move from the concept of a current summary record to the sharing of the following items, as they happen or as they are compiled, and define the content (which may be free text in some circumstances):

- **Medical summary**, including problems, medications and major prevention indicators as compiled by the GP? (time of compilation and sharing to be defined). To be shared on initial multi-professional/agency work, and whenever it changes. This needs further CfH work, which should be allied to similar work on planned spine sharing, which also includes events like hospital spells (see Mike Pringle's paper: Clinical development of the NHS Care Record Service),

- **Basic Personal information** – demographics, contacts etc. - mainly coded and textual fields. Shared on initial multi-agency work, and as items change. Again this is information defined and held on the PDS part of the spine – access may be one way of sharing, but with prompts as items are changed.

- **Event details**: Contact assessment, overview assessment, specialist assessment, comprehensive assessment, review. (Current terms which may be revised by CAF) Shared as they happen, with individual details, date of event, type of event, person responsible, their role, team and organization, outcome of event, with a link (URL) to the actual material in the relevant system (or possibly the whole material to be shared as a document). For a specialist assessment, also send the type of assessment (e.g. OT, Physiotherapy, DN pressure sores, Waterlow, etc.). SAP events should be included as part of the general set of events that might happen to a person receiving health and social care, e.g. hospitalisation.

- **Allocated professional/team details:** Details of any allocated professional/team (separate data entities), changed as their allocation changes: Individual details, person allocated (if any), their role, team and organization allocated, contact telephone and e-mail, date of allocation (and when ending, date of end of allocation), care co-ordinator indication, role.

- **Integrated Care plan**: As it is initiated or changed (based on, and maybe as the integrated document shared with the individual): If split down, the following are the most important items: Individual details, date of implementation, need/risk (text, and if necessary for spine sharing, a high level code), service/intervention (text, and if necessary for spine sharing, a high level code), expected outcomes (text, and if necessary for spine sharing, a high level code), {each of these last three together representing a line in an array, and repeatable}, care co-ordinator (or other main responsible professional), their role, team and organization, contact telephone and e-mail, and possibly the timetable of care.

- **Referrals:** The other process that needs supporting is referral for action, which would need to transfer between systems, where care is being delivered across boundaries.

- **Consent:** all of the above to be shared (and edited before sharing if necessary), based on the individual's express consent.

Ian Swanson - SAP Do Once and Share process group, March 2006

Annex 7: 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 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.

From the Chapter**, Designing and delivering services around older people: Single Assessment Process** (Page 38-40)

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 Commission for Social Care Inspection's findings from inspections 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).

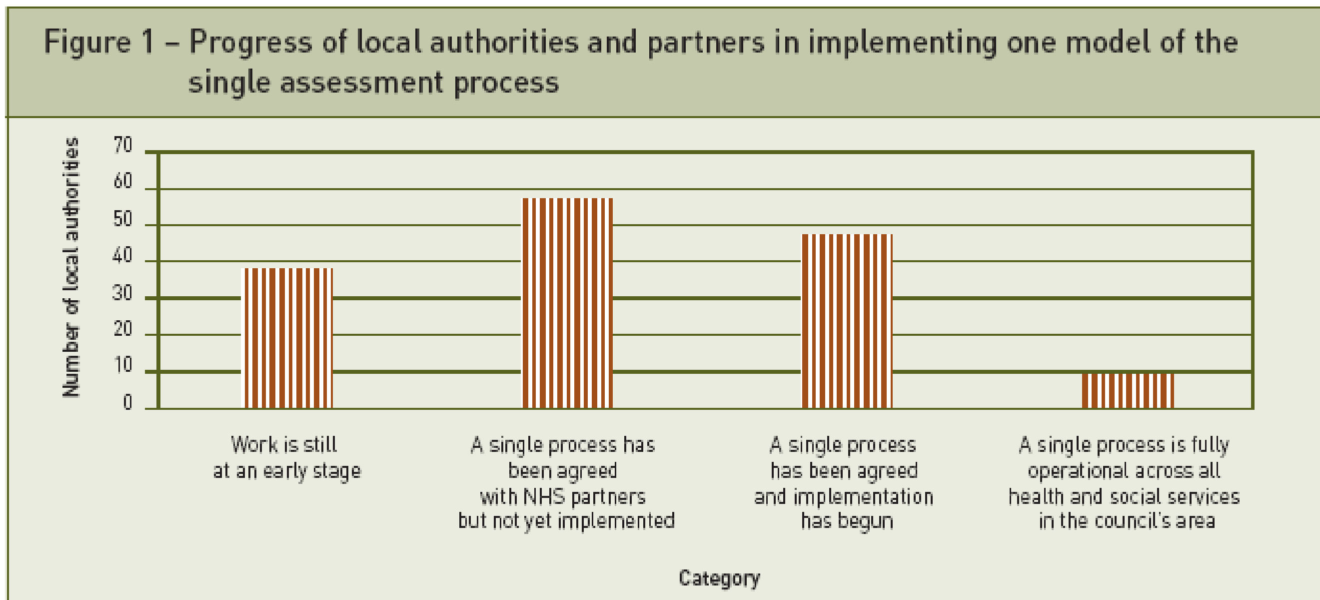


Figure 1 – Progress of local authorities and partners in implementing one model of the single assessment process

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

Two of the inspected communities had introduced single assessment across the area using more than one model, and seven were at varying stages of piloting its implementation. The remaining community that we inspected plans to implement single assessment once IT systems are available in March 2006.

Older people emphasised the importance of receiving services that are well coordinated, or joined up. To achieve this, there should be one coordinated assessment of the needs and aspirations of older people. Multiple assessments mean that older people are likely to be asked the same questions repeatedly, while other important areas remain ignored.

A shared approach reduces the likelihood of confusion and means that critical issues are more likely to be jointly understood and acted on. In addition, older people wanted their unique combination of experiences, aspirations and hopes for the future to be recognised, rather than have uniform solutions imposed on them that focused only on problems.

There was little evidence of an approach to assessment that genuinely placed the older person at the centre, and that focused on the issues that the older person saw as most important. CSCI reached a similar conclusion when it inspected services for older people in 18 councils between March 2004 and March 2005. It found that the views and aspirations of older people were not clearly recorded. But in the one local authority where staff had been trained to use the words of the older person in recording the assessment, this had led to a much more personalised approach, as well as more creative packages of support.

Factors which were affecting implementation of the single assessment process included:

- project management of the introduction of single assessments did not pay enough attention to delivering the requirements of the national service framework (NSF) on time
- the lack of a shared electronic system for keeping records was seen as a major barrier for some although others were using paper-based systems as an interim solution
- testing of single assessments was limited, as most inspected communities were piloting but not yet using this method for all older people in their area
- interagency evaluation of the process was often incomplete and the process for doing so was not always agreed
- the introduction of new approaches to relevant groups of staff was often at an early stage
- multidisciplinary training of staff had started in most areas, although some reported difficulties in getting all partners to attend in sufficient numbers
- staff in hospitals and in GP surgeries were often the least engaged in the process
- there were difficulties and disagreements about what information could be shared between partners

The single assessment process is the foundation for building services around individuals, a key objective of the white paper *Our health, our care, our say*. The limited progress on this was hindering the development of thinking and working with an integrated approach. The understanding by partner organisations of the change in culture, which is needed to make the single assessment process work, was variable.

Without a person centred approach and joined up working, there are poor results for older people, care planning is underdeveloped, the needs and aspirations of older people are ignored and delays are caused by the fragmented nature of the assessment process.

In some communities, the absence of a joint system for information had been used to justify a lack of progress, but in others this had not prevented some progress being made. In these communities at least some older people were benefiting from a joint process, even if it was paper rather than electronically based.

For those older people who had experienced a single assessment there were early indications of the benefits that could be gained. In particular some older people said they liked being able to keep their shared record with them at home.

The inspections of local communities indicated that a single assessment process for older people was also thought to be bringing other benefits, in particular:

- more consistent and regular reviews of care and support
- greater coordination of systems to safeguard older people
- better systems to review prescribed medication

But these benefits are still just aspirations in many areas because of the substantial delays in realising the target of one coordinated assessment and review process.

Four years after the publication of the NSF, the role of strong leadership in 'selling' and promoting the single assessment process at board level and in guiding changes in culture and operational delivery, is more important than ever.

New approaches to delivering public services emphasise the importance of tailoring services to meet the needs and aspirations of individuals. *Our health, our care, our say*, *Independence, wellbeing and choice*, and *Opportunity age*, all set out clear objectives to ensure that older people have more control and choice over the services they receive.

Person centred planning is described as one way to achieve this, building on the experience of using the single assessment process. It is therefore important to implement single assessment, and to increase understanding of the change in approach that this represents. Without this, older people are unlikely to receive a response that genuinely reflects their unique circumstances and preferences.

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: (they include)

- **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".

From Moving Forward,

"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."