

## **DOaS SAP Action Team Sub-group 4 – SAP and Complex Assessments**

This is an 18 page report with attached Annexes.

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**Note:** (C) = input during discussion at the conference.

### **AN INTRODUCTION TO THE WORK OF SUB-GROUP 4**

The project identified a key output as progressing understanding on ‘triggering into complex assessments’. There is at present little co-ordinated information on what is currently in use. In addition the use of datasets, nature of the intervention to ‘trigger’ the movement from one type of assessment to another and role of IT as ‘enabler’ within the Single Assessment Process (SAP) is currently unclear. A key aim was therefore to capture examples of ‘triggers’ into complex/comprehensive assessment.

The work of this sub-group included:

- utilising a structured template designed to focus on the project deliverables allocated to this sub-group. Members would access a small number of sites where SAP is used and discuss current practice in detail with named contacts.

- analysis of results for presentation at Conference.
- discussion of findings in Conference breakout session and identification of 'next steps'.
- synthesis of material for inclusion in the project report.

## **1. SUMMARY OF PREVIOUS WORK IN THE FIELD**

An objective of this project was to build on work already done nationally within the Best Practice groups on Single Assessment Process - London and Southern Clusters (December 2004) and Long Term Conditions - London Cluster (May 2005), CRDB SAP Action Team and pilot projects, such as the OPDM funded Framework for Multi-agency Environments - FAME projects.

The purpose of SAP is to "ensure that older people receive appropriate, effective and timely responses to their health and social care needs and that professional resources are used effectively" - (NSF Older People and DH Guidelines). 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'. This in turn suggests that processes are in place, which 'trigger' the movement between different types of assessments but there appears to be limited information available about what is used.

The Current Summary Record already has a dataset devised by a multi-agency group of professionals working with the NHSIA in 2003 to standardise the format. This is now being reviewed to ensure it is compliant with the CfH SPINE. There is also a need to determine how useful this particular dataset is in meeting the needs of those in the field as well as the 'joining up' which may be helpful with associated datasets (eg those relating to depression/dementia, stroke, falls and continence).

The complexity of the pathway of delivery and the need to coordinate the assessment and care delivery for older people who are suffering from multiple long term conditions has long been recognised.

It was felt that greater understanding of the 'triggers' currently in place would enable progress to be made on achieving greater consensus on the requirements for undertaking assessments, sharing information, summarising information and how IT could enable this process both in the short and longer term.

## 2. APPROACH / METHODOLOGY

The **approach / methodology** adopted fell into two stages. In summary these were:

- Initial fieldwork using a structured template, high-level analysis for presentation at the conference on 3<sup>rd</sup> February, and discussion of findings during the breakout session.
- Refinement of key findings emerging using material from conference breakout session (on 'triggers' in particular) and the responses received from the additional e-mail fieldwork using the nurse consultant network.

The findings linked to deliverables are summarised in **Section 3** below and the conclusions and recommendations are in **Section 6**.

The **aims informing the design** of the template for use in the field were:

- primarily - to capture examples of 'triggers' into complex/comprehensive assessment
- secondarily - to see how in depth assessments for people with chronic conditions (or in need of continuing care) linked to the Single Assessment (SAP) process.

The intended output/deliverables were linked to the DOaS SAP project deliverables and project task coverage as outlined in the draft interim report – Dec 2005.

The **project deliverables** earmarked for this sub-group were:

- Restate a vision of SAP which will continue to evolve (**deliverable 1**)
- Identify current information flows between organisations (**deliverable 5**)
- Describe a vision for SAP (**deliverable 6**)
- Review current use of datasets for SAP, such as the current summary record and consider its usefulness in the field (**deliverable 8**).
- Identify training needs – building on the competencies framework (**deliverable 10**).

The **core tasks/activities** identified for this sub-group were:

- Through the core group identify and contact other key people including those from other DOAS groups and encourage the spread of the SAP method of working for complex care.
- From other case studies and reports of implementations identify what triggers comprehensive assessments (perhaps arriving at a clearer definition with long term conditions) and the role of IT in this area.

Guidance notes and a short glossary and reference to the CPA website was also included within the template. (See **Annex 5.2** for details of how the deliverables/tasks linked to the template questions and **Annex 5.3** for a copy of the template).

The fieldwork sites/contacts were selected via sub-group members' personal networks. There was a desire to also link with other DOaS projects – notably those related to long term/complex conditions.

The fieldwork was scheduled to take place during January 2006. It was to be undertaken by sub-group members. In practice (due to availability constraints), it proved to be problematic to access all the initial contacts identified and two additional approaches were adopted to increase site coverage. These approaches included e-mail circulation of the template to the

SAP lead network London – 32 leads via Keith Strahan and e-mail circulation to the Nurse Consultant’s network (over 60) via Deborah Sturdy for return to a tight deadline.

It was initially agreed that the template be used to guide the discussion with those at the contact sites. The sub-group member would thus aid the completion of the template for analysis of the results prior to the conference. In practice this happened with only a few sites. The usual response (for both the initial fieldwork and accessing the two networks) was for the template to be circulated by members of the sub-group team for completion and return to tight deadlines. With the benefit of hindsight it is acknowledged that whilst providing diversity this ‘mixed’ approach added complexity. It could also have impacted on interpretation of the questions and might have affected the responses and therefore the ‘robustness’ of analysis and the core findings.

The **fieldwork responses** feeding into the analysis were as follows:

- From the initially identified fieldwork sites: Glenys Jones and team (Sunderland), Aileen Fraser (North Bristol PCT), Ian Donald (Gloucestershire), Clive Bowman (BUPA – Care Homes) and Beverley Waddell (East Lancashire SAP group – response duplicated in Nurse Consultant fieldwork returned).
- From the SAP leads: 11 returned – London area.
- DOaS related projects – Colin Gordan (Heart Failure) and Sue Roberts (Diabetes) were interviewed.
- From the Nurse Consultant network – a targeted scan of the 7 received as at 10<sup>th</sup> February to see if responses were at variance with those above in relation to deliverables only. (6 responses only used as 1 of the 7 was a duplicate of the response received from the initial fieldwork).

The main constraint in undertaking this work was the tight timetable for the initial fieldwork (January 3<sup>rd</sup>-19<sup>th</sup>) and the lack of resource to undertake the fieldwork in the manner originally intended and to analyse the findings. The pressure was compounded by the need for the fieldwork material to be presented at the Conference. However the benefit of this was that the Conference enabled a wider group to be engaged and to comment on the initial findings – thereby providing evidence of more ‘**national stakeholder sign off**’.

Invitees and attendees of the conference are listed elsewhere in the project report - **Appendix 6.3**. A particular effort was made to include members of related DOaS groups. A representative from DOaS Complex Conditions (David Lyon, clinical lead) joined the break-out session for this sub-group and Colin Gordan (Heart Failure) was also able to join part of the conference. The break-out session at the conference considered:

- The presentation of initial findings given at the conference
- Specific responses to the topic of ‘triggers’ and particularly
  - How that might strengthen the links between Health and Social Care
  - If different SAP models might imply different approaches to ‘triggers’.
- Views on unresolved issues
- Suggested next steps.

(See **Annex 5.4** for a summary of the discussion at the breakout session).

### **3. FINDINGS RELATED TO THE DELIVERABLES, TASKS AND ACTIVITIES INCLUDING ANALYSIS**

This section will focus on synthesising findings from the fieldwork as presented at the Conference on 3<sup>rd</sup> February. It will also refer to material from the breakout sessions and material returned from the Nurse Consultants network initiative. It is structured to show the findings by deliverable allocated to sub-group 4 followed by the findings related to triggers and the material obtained on the link between SAP and Long Term Conditions/Case Management and Continuing Care. The final part of the section lists areas highlighted as 'out of scope' or for further work.

**A summary of the findings feeds into the conclusions and recommendations emerging. These are brought together in section 6 below.**

#### **3.1 Restate the Vision for Single Assessment Process (SAP) which continues to evolve (deliverable 1) 'Describe a Vision of SAP' (deliverable 6) - Sub-groups 1 & 4**

**Status:** Complete (Both deliverables).

##### **Summary of key findings:**

- Almost all of those responding to both fieldwork areas (21 of 22) indicated that the assessments being undertaken were contributing to the development of a personalised care plan.
- Practically almost everyone that replied used SAP for contact and overview assessments, most used SAP for referral and some did specialist and/or comprehensive assessments.
- While over 50% of those responding to the initial fieldwork indicated that comprehensive/complex assessments were defined in their locality, it was noticeable that the higher proportion of 'Yes' was from the Nurse Consultant fieldwork responses. (Over 80%).
- Some of the actual definitions were relatively 'vague'
- There was a wide range of definitions for Comprehensive/Complex Assessments being used including (from the two pieces of fieldwork):
  - Contact and specialist (1)
  - Overview and specialist (2)
  - Collection of specialist assessments (1)
  - Involvement of 2 or more services where there are 'complex' needs (3)
  - Assessments done with multi-disciplinary teams leading to longer term/continuing care. (3)
  - Where Case Manager/co-ordination is required (3)
  - 'No hard and fast definition' (3)
  - Local practices/arrangements are in place (1)
- The feedback from the Nurse Consultants network tended to have more explicit definitions eg:
  - "A comprehensive assessment is multi-disciplinary and includes the completion of contact, overview and two or more specialist assessments". (Leeds)
  - "Case management by Community Matrons where there are multi social and health needs". (Crawley).

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- There was some evidence that the terms comprehensive and complex were frequently inter-linked or used interchangeably.
- SAP is the process when two or more professional are involved, the person has complex needs and co-ordinated care for older persons is required.
- There is currently the potential for confusion between the process of assessment, tools to collect material and the outcome of assessment. (C)
- The fieldwork responses showed different conceptual and definitional starting points.

### **3.2 Identify current information flows between organisations (deliverable 5) - Sub-groups 1 & 2**

**Status:** Complete.

#### **Summary of key findings:**

- Different places share different information in different ways.
- Generally Overview and Contact Assessments are shared. Some share referrals, Care Plans or Specialist Assessments. One example of sharing action plans between care team members was given.
- Currently there is no consensus on what information needs to flow between statutory organisations and for what purpose.
- Whilst there may have been progress with assessments in community settings and associated information flow within statutory organisations, currently SAP related information tends not to flow between the statutory and independent sectors. A specific challenge relates to discharge summaries which typically go to the patients last registered GP. This can be problematic if the patient is discharged to another non-statutory institution eg a Care/Nursing Home which may have other GP arrangements.
- An electronic notebook is used for assessments – but there is no clear way forward on electronic transfer. (Barking and Dagenham).
- Some responses highlighted the intention for the flow of information – and the opportunity that IT could provide eg:
  - “Any information that with consent supports the individual care needs of the patient/service user”. (East Yorkshire).
  - “This hasn’t worked on paper – we are about to start the process with IT and then all information would flow over’ (Lambeth)
- Mechanisms used to facilitate timely information flow include phone, FAX, e-mail/secure e-mail (East Yorks), the web and increasingly tailored IT. Some trends to greater use of IT as ‘enabler’ can be observed.
  - Examples included:
    - On-line web-based SAP assessment e-forms plus attachments (Islington)
    - Use of word template on tablet PC (Enfield)
    - User held record as a ‘shared tool’ (Richmond)
    - Electronic referrals are routinely made through Liquid Logic (Sunderland)
    - Move from paper contact assessment to electronic contact, overview and Care Plan (as part of pilot – East Lancs)
    - IT version of overview assessment is starting soon (Gloucestershire)

### **3.3 Review current use of datasets for SAP, such as the current summary record and consider its usefulness in the field (deliverable 8) - Sub-groups 1,2 & 4**

**Status:** Complete.

#### **Summary of key findings:**

- The Current Summary Record (CSR) is in limited use. Where the CSR is used this is usually where there are electronic systems in place (eg Kingston Protocol SAP, East Yorks and East Surrey when 'go live'). In contrast, Redbridge use CSR with paper-based CAT).
- There is a local CSR linked to the web based initiative (Hampshire and Isle of Wight).
- A User Held Record which is 'fairly close' to SAP is highlighted (Richmond).
- The use of the summary record for REACH (which also acts as a discharge letter to GPs etc is also mentioned). (Camden).
- It would appear that there is limited use of a common data set currently. In addition, usefulness of the CSR and other datasets seems to depend on the availability of IT systems. This may have implications for core requirements for a hand held record.
- While there were some local datasets mentioned there was no specific reference to disease registers or other existing national datasets within the responses.
- Information Technology is seen as integral to all SAP solutions, and those with pilot or e-support stressed the potential for IT overall. However there is a lack of clarity about how IT systems will help.
- There may be implications in these findings for developing datasets for SAP which are usable in the field.

(See also 3.2 above for material on information flows and associated mechanisms).

### **3.4 Identification of training needs – building on the competencies frameworks (deliverable 10) - Sub-groups 1-4**

**Status:** Complete.

#### **Summary of key findings:**

- While the initial fieldwork showed some have done training, some are planning it and some have no plans, the responses from the nurse consultants tended to highlight relatively more initiatives on awareness raising and on-going training.
- Training focused at locality or team level is usually highlighted as required.
- Good, well-resourced awareness raising and associated joint training is critical to implementing SAP in general and electronic SAP in particular.
- Any plan to implement SAP must include training: on SAP and on joint awareness to deal with and manage the multi-party nature of SAP (primary and secondary NHS care, social services and social care) and for e-solutions – IT related training.
- The case example from Castlefields PCT where joint assessments have been gradually introduced with health and social services working together initially and then gradually moving towards providing assessments which all the team used, took about a year and was outlined during the breakout session at the conference (C).

### 3.5 'Triggers'

**Identification from the case studies and reports of implementation what triggers comprehensive assessments, perhaps arriving at a clearer definition with Long Term Conditions and the role of IT in this area.**

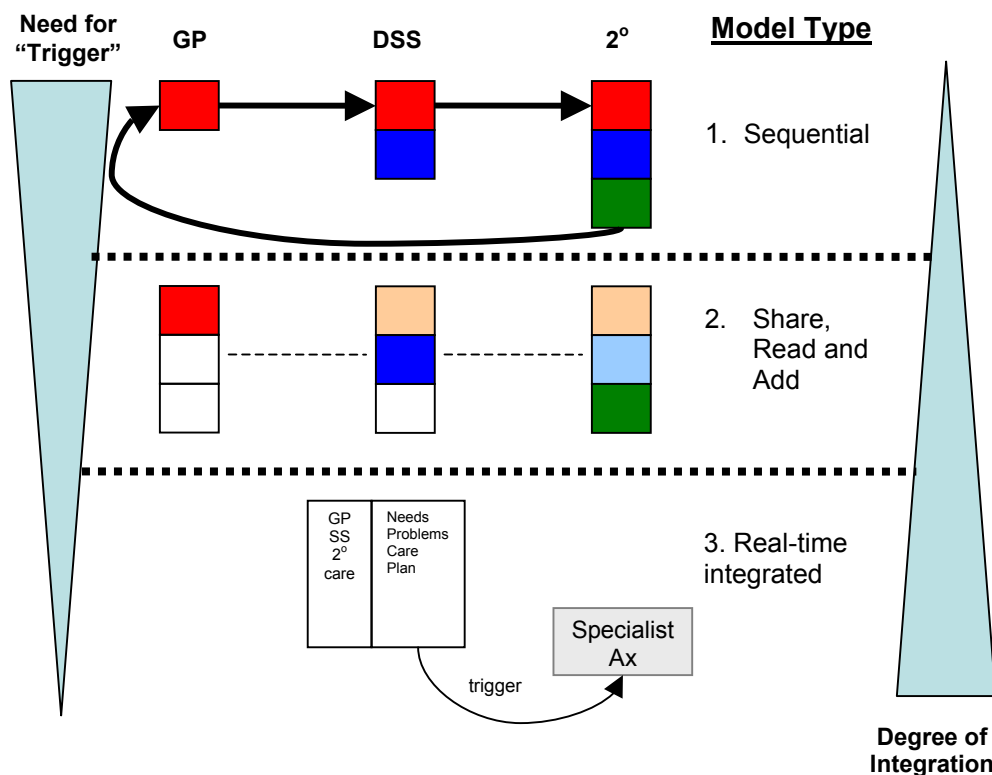
**Status:** Complete.

#### **Summary of key fieldwork findings:**

- Practically all those that responded to the fieldwork used SAP for contact and overview assessments, most used SAP for referral and some did specialist and/or comprehensive assessments – with the suggestion that in due course comprehensive and when appropriate specialist assessments would become the 'norm'. BUPA Care Homes were working on standards of assessment for individuals already placed in Nursing Homes.
- The responses to the fieldwork indicated that usually no formal mechanisms (i.e. policy/procedures) are in place to 'trigger' from overview assessments to comprehensive assessments or to go direct to comprehensive assessments without the need to do the overview.
- 'Triggers' are not usually explicit or defined but part of the emergent local working arrangements between teams. Local working arrangements mentioned included:
  - Practitioner judgement based on findings (Newham, Hackney, Richmond NF/ETVS)
  - "...can be the result of indications in other assessments or may be made independently at any time ... the question is difficult to answer" ...(Kingston).
  - local arrangements in teams and between Social Workers and District Nurses (Enfield).
  - issues or risks highlighted in the assessment will trigger further assessment (East Yorks PCT).
- Sunderland regarded triggers as not being necessary as 'professionals have always completed comprehensive assessment of needs when required'. A Continuing Health Care (CHC) matrix includes a complex geriatric assessment. Sunderland use the contact assessment for referrals and share information electronically. However the care plans are not joint care plans because of the legal implications around responsibility for delivery.
- It was noticeable that more of the Nurse Consultants than those in the original fieldwork (SAP lead responses in particular) highlighted that triggers were in place. The triggers mentioned implied a key role for professional 'judgement' eg follow-up of issues/risks highlighted, if patients had 'complex needs'.
- The responses from the field indicated that at present 'triggers' used were usually independent of IT systems - the role of IT in this area was not clear.
- The fieldwork responses suggested that there is a diversity of interpretation of 'triggers'. It suggested to the fieldworkers that this showed different starting points/conceptual models. The diagram below shows how comprehensive assessments can be built up and has implications for the nature of and need for 'triggers'.



**POSSIBLE SAP MODELS:**



**Summary of key findings from the Conference:**

- Discussion during the Conference breakout session on 'triggers' in general and the diagram in particular highlighted:
  - The process for SAP/Joint assessments and triggers needs to be sufficiently robust to enable colleagues familiar and unfamiliar with the system to use material
  - Recognition of need for 'link' person/key worker.
  - The term 'triggers' could imply either anticipatory or reactive response – and associated 'cultural' shift. It could also be either 'positive' or negative'.
  - There was the potential for both standard and client specific triggers
  - There is a difference between signposts and triggers
  - There was a need for 'alerts' and for practitioner engagement to define these.
  - Case examples – Castlefields, Evercare tool.
  - There is currently no common understanding of 'comprehensive assessment' or agreement what triggers are in place or need to be in place – it is essential to have common definitions to enable team working.

### **3.6 Identification of and contacts made (including those from other DOaS projects) to spread the SAP method of working for complex care**

#### **3.6.1 Links between Long Term Conditions/Case Management development and SAP – and examples of good practice**

**Status:** Complete.

##### **Key findings from the fieldwork:**

- Long Term Conditions/Case Management links either exist or are in development in the sites surveyed.
- They often:
  - entail Advanced Care Practitioners/Community Matrons/District Nurses using contact and overview assessments when moving to Case Management (Gloucester, Crawley, Enfield).
  - form 'the basis of assessment(s)/referrals' (Greenwich, Sunderland).
- Responses from the Nurse Consultant network in particular highlighted the linkage between SAP and Long Term Conditions for care co-ordination and management of Long Term Conditions
- Examples of good practice include:
  - Advanced Primary Care Practitioners/Community Matrons are seen as a key player/anchor point – building on the work of others eg District Nurses (Islington).
  - Nurse Consultants mentioned PARR tool (Leeds/Lambeth) and Web based initiative in Hampshire/IOW. (New Forest/ETVS/Hants Alliance).
  - SAP protocol (web system) linked to SWIFT (Islington/Kingston).
  - Integration projects include long term conditions (East Lancs).

#### **3.6.2 Links between Continuing Care developments and SAP – and examples of good practice**

**Status:** Complete.

##### **Key findings from the fieldwork:**

- Continuing Care links are relatively less developed – though there were notable exceptions to this eg Sunderland (CHC matrix) and Redbridge.
  - It is recognised that information collected in contact, overview and specialist assessments within SAP can be built on to meet the requirements for continuing care assessments – though much of this is still 'work in progress'.
  - BUPA are seeking to develop more programme related 'managed care' and highlighted dementia care as a particular candidate for cross organisational initiatives.
- Examples of good practice included:
  - The web based initiative (Hampshire/IOW) which enables rehabilitation teams to use similar documentation.
  - Gloucestershire initiative, which includes assessment for CHC and banding for assessment by RNCC.

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- Ribble (East Lancashire) where if District Nurses are using SAP IT the information required for a continuing care assessment will be contained in a specialist document (locally developed tool).

### 3.6.3 Contacts made (including those from other DOaS projects) to encourage the utilisation of the SAP method of working for complex care

See **Annex 5.8**.

In discussion with Colin Gordan (DOaS Heart Failure) an indication of their fieldwork findings was obtained and access to the pathway work being undertaken by DOaS SAP sub-group1 was given to him.

“The core problem is passing information along the patient pathway and developing the mechanism to handle different disease processes along that pathway”. (Colin Gordan).

Links made by this group to other DOaS groups during the course of this project included Falls, Complex Conditions, Cancer, Children’s Mental Health, Learning Disabilities, Diabetes and Heart Failure.

Colleagues from the Information Centre who had been working on datasets related to SAP implementation and the NSF for Older People were contacted. They became involved in the workshops and attended the conferences.

### 3.7 Areas currently out of scope for further work streams

During the course of the work, areas identified for further work streams were identified:-

- Despite best intentions it was not possible to analyse all the fieldwork material. Responses relating to the deliverables and core task/activities were prioritised. (See **Annex 5.7** for list of material which has not been included in the analysis to date).
- Unresolved issues highlighted at DOaS conference within ‘triggering’ breakout session were:
  - Clarification if topic is triggering into complex assessments or comprehensive assessments.
  - Clarification of how continuing care fits into SAP.
  - Further work on alerts/signposts/triggers – for current SAP and future e-SAP and the move to common assessment
  - Education/training – to reflect the cultural shifts that may be required.
  - Sharing of good practice examples more widely so others can adopt/tailor to specific local circumstances.
  - User access to both information and resources may be problematic eg downloading resources from CPA site for individual older people/carers/relatives needing service information and how can this be enabled.

There is a need to research the usefulness of tools currently being developed to move from contact and overview assessments to comprehensive assessments. More work is required on refining models that show how the assessments are related and capturing ways of ensuring that people with multiple long term conditions are linked into the system.

Definition of these key triggers would help ensure consistency in process and in outcomes for individuals.

#### 4. OUTPUTS

##### **Local initiatives highlighted:**

- Sunderland – CHC matrix... this and other paperwork available.
- St Mary's' assessment and Royal Brompton assessment initiatives (and awareness that SAP has been selected as local ISIP change programme for 2006/7).
- LHC/Care Community selection of SAP as integrated change programme – London PCT
- Leeds North East PCT (and LGI) – working group in place considering development of robust system for comprehensive assessments. Analysis of 85 referrals currently underway – contact Dagmar Long and Sally Mayfield.
- Essex – examples of the use of SAP in long term conditions and some areas have developed patient held records. Contact Pippa Sage.
- SW Hants Alliance (Eastleigh and Test Valley South PCT – and associated standardised processes (and shared copy of admissions/referral and transfer form and multi-professional assessment form) plus referred to Hampshire and Isle of Wight secure SAP web-based data collection. Material was shared with e-SAP group.
- East Lancashire SAP working group/Ribble locality (Waddell) : Shared access to care pilot has commenced. This is a team of health and social care staff who have been trained to be able to access low level services utilising the single assessment to prevent hospital admission. Associated 'integration' projects (including Long Term Conditions) are also underway.
- Mentioned in discussion on Long Term Conditions:
  - PARR tool (Leeds/Lambeth)
  - Web based initiative in Hampshire/IOW. (New Forest/ETVS/Hants Alliance).
  - SAP protocol (web system) linked to SWIFT (Islington/Kingston).
- Mentioned in discussion on Continuing Care:
  - Web based initiative in Hampshire/IOW. (New Forest/ETVS/Hants Alliance).
  - Assessment for CHC banding for assessment by RNCC. (Gloucestershire)
  - Continuing Care Assessments as specialist document within IT solution. (Ribble/East Lancashire – locally developed tool).

##### **Influence on National initiatives:**

- Framework for implementing electronic SAP project - DOaS SAP Action Team's work will be used to provide the basis for this project recently initiated by NHS Connecting for Health.
- Desire to share information across the patient pathway between other conditions, eg heart failure and SAP.
- Research proposal – CRDB member Penny Hill on 'person centred intelligence: a model to investigate the processes underpinning the assessment of need'.
- Highlighting of BUPA's current pilots and plans to develop a corporate standard for assessment across their Care Homes. BUPA wish to share their work so far and wish to discuss the opportunity to align DH's policy on assessment and assessment across Care Homes within and beyond BUPA's portfolio at an early date.

**Project outputs:**

- Fieldwork Template
  - Summary of material from DOaS SAP conference – presentation and topics/themes and attendees – breakout session
  - Analysis of fieldwork (1) and scan of fieldwork (2) nurse consultants
  - List of additional material collected but not presented in this analysis
  - Additional contacts made – with a view to spreading the SAP method of working
- (See **Annexes** for details).

**5. INTERDEPENDENCIES WITH OTHER GROUPS**

This project as a whole notably:

- e-SAP – links through questionnaire design – to avoid overlap – plus passing on of information relating to e-SAP received.
- Concept and discussion papers – eg Thoughts about the current summary record and its use in the interchange of information within SAP, medicine and care – two amalgamated concepts – a speculation in the light of information technology in health and social services, SAP and the complex environment – exploring the requirement for holistic assessment where two people with needs live together, specialist assessments in the single assessment process and how information technology could support their use and discussion papers single assessment process moving to common assessment process – beginnings and endings and co-ordination.

**6. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS**

**6.1 Restate the Vision for Single Assessment Process (SAP) which continues to evolve (Deliverable 1) ‘Describe a Vision of SAP’ (deliverable 6)**

<b>Conclusions</b>	<b>Recommendations</b>
<ul style="list-style-type: none"> <li>• Whilst there is awareness of the SAP Vision in the field there is some confusion between the terms ‘complex’ and comprehensive assessments and much locally based interpretation.</li> <li>• Practically almost all those that replied used SAP for contact and overview assessments, most used SAP for referral and some did specialist and/or comprehensive assessments – with the suggestion that in due course comprehensive and when appropriate specialist assessments would become the ‘norm’</li> </ul>	<ul style="list-style-type: none"> <li>• That work continue (which takes into account the White Paper) to encourage greater consensus about the definitions and thus the content of SAP assessments and how they relate to care processes and the care pathway.</li> <li>• That Comprehensive Assessment explicitly includes Medical Assessment.</li> <li>• That “Vision” needs to be informed by how processes currently work.</li> </ul>

<ul style="list-style-type: none"> <li>• Three possible models evolved, showing how a comprehensive assessment can be built up.</li> <li>• A phased approach could be appropriate for a transition from paper-based systems to ‘electronic’ – tailored to the different starting points and end points envisaged in the models.</li> </ul>	<ul style="list-style-type: none"> <li>• The suggested models need to be defined in detail including the underpinning assumptions on the nature of integration and triggers as well as how alerts and signposts may be distinguished.</li> </ul>
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## 6.2 Identify current information flows between organisations (deliverable 5)

<b>Conclusions</b>	<b>Recommendations</b>
<ul style="list-style-type: none"> <li>• Currently there is no consensus on what information needs to flow between statutory organizations and for what purpose.</li> <li>• SAP and other related information tends not to flow between the statutory and independent sectors.</li> <li>• The link between disease registers and other related data islands and SAP was not explicit.</li> </ul>	<ul style="list-style-type: none"> <li>• That, given the white paper and mixed economy emerging, consideration needs to be given for opportunities for improvements in information flow (including use of regulatory and other levers) – and thus CFH needs to ensure that mechanisms and associated infrastructure are in place to enable that flow to happen</li> <li>• That consensus be obtained on what the information flow needs are - including those for personalised care plans.</li> <li>• That clarification be sought on what the Spine will and won't do to support SAP processes.</li> <li>• That the date when the Spine will be available in support of SAP be made clear. (If this is more than 2 years, then there must be interim IT solutions to facilitate the information flows required for SAP and the proposed Common Assessment Framework).</li> <li>• That the links between Disease Registers and other related data islands and SAP be clarified and strengthened.</li> </ul>

**6.3 Review current use of datasets for SAP, such as the current summary record and consider its usefulness in the field (deliverable 8)**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>• There is limited use of a common dataset.</li> <li>• Some locally defined common datasets were found.</li> <li>• The Current Summary Record - SAP (CSR) is not frequently used unless it is available in electronic form.</li> <li>• A link between the SAP CSR dataset and other datasets was not explicit.</li> </ul>	<ul style="list-style-type: none"> <li>• That with the current limited use of the CSR (SAP dataset) in the field there is a need to revisit its content and to clarify its fitness for future purpose.</li> <li>• That there is a need to re-visit the SAP dataset to see if there is sufficient flexibility within it to meet referral and associated purposes.</li> <li>• That a link between SAP datasets, findings from other associated DOaS groups, proposals for common assessment arising from the white paper and proposals for the CSR for the Spine and associated messaging needs to be made.</li> </ul>

**6.4 Identification of training needs – building on the competencies frameworks. (deliverable 10)**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>• Good, well-resourced awareness raising and associated joint training is critical to implementing SAP in general and electronic SAP in particular.</li> </ul>	<ul style="list-style-type: none"> <li>• That there must be a properly resourced joint training plan in each 'locality'.</li> <li>• That 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) being evaluated <a href="http://www.skillsforhealth.org.uk/viewnews.php?id=43">http://www.skillsforhealth.org.uk/viewnews.php?id=43</a></li> <li>• The outcomes of this could provide the basis for a combined Competency Framework for Health &amp; Social Care (as per White Paper) as we move towards joint teams to support people with complex longer term needs.</li> </ul>

**6.5 'Triggers'**

**Identification from the case studies and reports of implementation what triggers comprehensive assessments, perhaps arriving at a clearer definition with Long Term Conditions and the role of IT in this area.**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>• Triggers are not usually explicit or defined but part of emergent local working arrangements between teams.</li> <li>• There is currently no common understanding of 'comprehensive assessment' or agreement about what triggers are in place or need to be in place to enable movement into either comprehensive or complex assessment.</li> <li>• The role of IT in this area was not clear.</li> </ul>	<ul style="list-style-type: none"> <li>• That there is a need to be clear how SAP will work (including the nature of 'triggers'), which all parties (clinicians, users, carers, etc) need to be happy with.</li> <li>• That models of working need to be devised, and clear definitions of assessments and other terms are needed (eg. comprehensive, complex, specialist (generic and focussed) etc) which show their inter-relationships and implications etc.</li> <li>• That such models for SAP need to be integrated with other associated long term conditions.</li> <li>• That the models developed - and the 'triggers' in particular need to be tested to confirm 'fitness for purpose', their impact on the users journey along appropriate pathways and the implications for 'joint care delivery'.</li> <li>• That the models developed need to be clearer about the role of IT in facilitating the process.</li> </ul>

**6.6 Identification of and contacts made (including those from other DOaS projects) to spread the SAP method of working for complex care.**

**6.6.1 Links between Long Term Conditions/Case Management development and SAP – and examples of good practice.**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>• Long term conditions/case management links with SAP either exist or are in development.</li> <li>• Community Matron and Long Term Conditions Case Managers Competency Framework stated that Community Matrons and Case Managers should be using SAP.</li> </ul>	<ul style="list-style-type: none"> <li>• That further work be undertaken in line with the policy signaled in the White Paper.</li> <li>• That attention should be drawn to the Community Matron and Long Term Conditions Case Managers Competency Framework evaluation which is currently taking place. <a href="http://www.skillsforhealth.org.uk/viewnews.php?id=43">http://www.skillsforhealth.org.uk/viewnews.php?id=43</a></li> </ul>



DOAS SAP Sub group 4 - SAP and Complex Assessments

<ul style="list-style-type: none"> <li>DH Film 'Listen to What I'm Saying' links a Person Centred Approach, SAP and Long Term Conditions with real case studies (available free from the CPA website) of people with complex needs.</li> </ul>	<ul style="list-style-type: none"> <li>Distribute film.</li> </ul>
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**6.6.2 Links between Continuing Care developments and SAP.**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>Continuing care links with SAP are currently relatively less developed than those for Long Term Conditions/Case Management.</li> </ul>	<ul style="list-style-type: none"> <li>That further work be undertaken to ensure the standards of assessment for Continuing Health Care entitlement are fully integrated into the SAP process.</li> </ul>

**6.6.3 Contacts made (including those from other DOaS projects) to spread the SAP method of working for complex care.**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>Initial contact was made with associated DOaS groups notably complex conditions, falls, cancer, children's mental health services, learning disabilities and heart failure.</li> <li>Contact has been made on datasets developments with colleagues from the Information Centre.</li> </ul>	<ul style="list-style-type: none"> <li>That further work take place with those working on related datasets at the Information Centre and other DOaS projects.</li> </ul>

**6.7 Areas currently out of scope – for future work streams.**

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>• SAP offers the opportunity for generic assessments to be undertaken as a basis for referral either for specialist assessments and/or other assessments for long term conditions.</li> <li>• There are signs that SAP momentum is building up – Community Matrons and pilot initiatives are assisting this.</li> </ul>	<ul style="list-style-type: none"> <li>• That common assessment as proposed in the White Paper should build on SAP work done so far – and extend to include complex conditions, other client groups and care home residents – i.e. to cover all care settings.</li> <li>• That further work be undertaken on how the Community Matron/Case Manager can be further enabled to facilitate more integrated assessments and better team working.</li> </ul>
<ul style="list-style-type: none"> <li>• The analysis of the fieldwork was not completed and may contain additional material of ‘value’</li> </ul>	<ul style="list-style-type: none"> <li>• That the analysis from fieldwork, which is currently outstanding, be undertaken (See <b>Annex 5.7</b>).</li> </ul>
<ul style="list-style-type: none"> <li>• The unresolved questions identified at the conference could be addressed</li> </ul>	<ul style="list-style-type: none"> <li>• Consider the unresolved questions identified at the conference – see section 3.7.</li> </ul>
<ul style="list-style-type: none"> <li>• Additional fieldwork including contacts with tool user groups could be timely.</li> </ul>	<ul style="list-style-type: none"> <li>• Obtain additional information from more extensive fieldwork, including tool user groups on current developments in the field being piloted:                         <ul style="list-style-type: none"> <li>○ on models that show how the assessments are related.</li> <li>○ on ways of ensuring that people with longer term needs have also been taken into account.</li> </ul> </li> </ul>

**ANNEXES:**

- 5.1 Members of sub-group 4 – and involvement in the fieldwork
- 5.2 List of deliverables addressed through this work and link to fieldwork template.
- 5.3 Template for fieldwork
- 5.4 Summary of material from DOaS SAP conference 3<sup>rd</sup> February 2006
  - Presentations
  - Topics/themes and attendees – breakout session
- 5.5 Working paper – analysis of fieldwork (1) – and list of those involved
- 5.6 Working paper – scan of fieldwork (2) – nurse consultants.
- 5.7 List of additional material collected but not presented in this analysis.
- 5.8 Additional contacts.

**5.1 Members of sub-group 4 – and involvement in the fieldwork**

<b>Name</b>	<b>Involvement in fieldwork</b>
Dr Beverly Castleton	Interviewer
Deborah Sturdy	Initiator of circulation to Nurse Consultants network
Keith Strahan	Initiator of circulation to SAP leads network plus interviewer
Richard Carthew	Initial analysis for development of presentation at conference
Sally Bassett	Interviewer
Judith Whittam	Interviewer
Jenny Stephany (Project support)	Interviewer and analysis

Material was also routinely copied for information to Ian Donald and John Gladman, Joint Chairmen of the British Geriatric Society Special Interest Group - Community and Primary Care, Dick Curry, DOaS SAP Project Manager and Ann McIntosh, CfH Project Manager.

## 5.2 DOaS outputs/deliverables and link with the template used for the fieldwork of sub-group 4.

### Output 4: Triggering into comprehensive assessments – sub-group 4

“A small number of sites where SAP and other assessments are used concurrently will be studied in detail through a questionnaire and personal contact. The results will be analysed and presented at the February conference”.

Deliverable	Link with template/ questionnaire – sub-group 4	Comments
Restate the vision for SAP which will continue to evolve (1)	Q7,8,9.	Link to output 4
Identify current information flows between organisations (5)	Q14 – collection of information and flows between organisations Q15 – mechanisms to facilitate flow	
Describe a vision for SAP (6).	Q7,8,9 – definitions and mechanisms for triggering..	Link to output 4 – and different types of assessments in place.
Review current use of datasets for SAP, such as the Current Summary Record and consider its usefulness in field. (8)	Q16 – use of current summary record (CSR). (Q12, 13 – use of SAP tools).	
Identification of training needs - building on the competencies framework (10)	Q17 – what joint training has occurred	
Consider areas currently out of scope for further work streams (11)	Q20 – other comments	Discussion at conference.

Task/activities list.	Link with template/ questionnaire – sub-group 4	Comments
Through the core group identify and contact other key people including from the other DOAS groups and spread the SAP method of working for complex care (3)		Through both contacts for fieldwork and invitees to conference plus???
From the case studies and reports of implementations identify what triggers comprehensive assessments (perhaps arriving at a clearer definition with Long term Conditions) and the role of IT in this area. (7)	Q4 Q5 Q6 – other generic assessments being used. Q10 – triggers, Q11 – eligibility under FACS Q12.13 – use of SAP tools	This links back to output 4  For comparison but ltd as potential for overlap with e-sap sub-gp
Other questions included but not directly linked to deliverables/tasks/activities	Q1,2,3 use of SAP on locality including client gp Q11 – eligibility under FACS  Q18 and 19 –work and barriers to be overcome Q20 – other comments	Other questions being asked – for context etc. Plus to give opportunity for other comments to be made.

**Annex 5.3**

**Single Assessment Process and Complex/Comprehensive Assessments**

Name:	Sub-group member who interviewed:
Name of initiative/locality:	Total population coverage:
Date of interview:	Date material synthesised and by whom:

**Suggested Questions**

1. **Is Single Assessment Process (SAP) used in your health/social care locality? – Yes/No**

2. **If SAP is used in your locality, please confirm what it is used for**

Case finding	Yes/No
Referral	Yes/No
Contact	Yes/No
Overview	Yes/No
Specialist (in-depth) assessment	Yes/No
Comprehensive Assessment	Yes/No
Care Planning	Yes/No

3. **If SAP is used in your locality, please confirm which of the following client groups are covered**

Elderly over 65	Yes/No
Younger disabled	Yes/No
Those with Learning Disabilities	Yes/No
All adults	Yes/No

4. **How are Long Term Conditions/Case Management developments being linked to SAP in your area? Please highlight examples of good practice (including contact details)**

**5. How are Continuing Care developments being linked to SAP in your area? Please highlight examples of good practice (including contact details)**

**6. What other generic assessments (rather than specialist) are still being used (e.g. nursing, community care, care programme approach (CPA) and what 'joining up' is in place and/or required?**

**7. Are the assessments undertaken contributing to the development of a personalised care plan that is appropriate to needs? Yes/No**

**8. Are comprehensive/complex assessments defined in your locality? Yes/No**

**9. If Yes, could you please outline the definition being used? (See also Glossary)**

**10. Is there a mechanism in place to 'trigger' from overview assessments to comprehensive assessments or to go direct to comprehensive assessments without the need to do the overview? Yes/No**

**If Yes, please give details**

**11. What assessments inform eligibility under Fair Access to Care Services (FACS) in your locality and are these the integrated with your local SAP assessment tools? (See Glossary)**

**12. Are you using SAP assessment tools in your locality? Yes/No**

**13. If yes, please indicate the SAP tool(s) in use and if this is being applied electronically or using paper**

<u>Tool</u>	<u>In use Yes/No</u>	<u>Electronic/Paper/both</u>
EasyCare	Yes/No	Electronic/Paper/both
FACE	Yes/No	Electronic/Paper/both
CAT	Yes/No	Electronic/Paper/both
MDS RAI	Yes/No	Electronic/Paper/both
STEP	Yes/No	Electronic/Paper/both
NOAT	Yes/No	Electronic/Paper/both
Locally developed tool	Yes/No	Electronic/Paper/both
Combination tool	Yes/No	Electronic/Paper/both

**14. What information is collected which then flows between organisations/clinicians? (e.g. contact assessments, referrals, overview assessments (whole or in part), care plans, list of the care team involved, identified datasets, others - please specify).**

**15. What mechanisms are used to enable this information to flow between organisations/clinicians (e.g. phone, fax, e-mail, post, paper based forms, etc)**

**16. Are you using the Current Summary Record? Yes/No**

**17. Within your initiative/locality what joint training (to enable the appropriate utilisation of Comprehensive Assessment) has occurred?**

**18. In summary, what has made things work in your locality? What has been critical to success?**

**19. In summary, what are the main barriers that have been overcome? What barriers still exist?**

**20. Is there anything else you wish to add?**

**Thank you for your time**



## **Accompanying Notes**

### **Assumptions informing suggested design:**

#### **Aims:**

- Primarily to capture examples of 'triggers' into complex/comprehensive assessment.
- Secondly to see how in depth assessments for people with chronic conditions (or in need of continuing care) links to the Single Assessment (SAP) process.

#### **Intended output/deliverables:**

- of assessments: a personalised care plan appropriate to need
- relating to the DOaS SAP project deliverables: (Source draft interim report circulated Friday 9<sup>th</sup> December).
  - describe/restate the vision of SAP which will continue to evolve
  - identify current information flows between organisations
  - review datasets, such as the current summary record and consider its usefulness in the field. Link to other pieces of work – falls/stroke etc.
  - consider tactical interim solutions and integrated approach across health and social care for determining the future IT requirements
  - identification of training needs – building on the competencies framework.
- relating to the DOaS SAP project task coverage: (Source draft interim report circulated Friday 9<sup>th</sup> December).
  - Through the core group identify and contact other key people including from the other DOaS groups and spread the SAP method of working for complex care
  - Identify what triggers comprehensive assessments (perhaps arriving at a clearer definition with long term conditions) and the role of IT.
  - Describe what information is being collected and collated and link with other work in this area. (Time precluded links with David Challis' on-going research on SAP implementation in England).
  - Highlight approaches to implementation using accredited tools/local tools and barriers overcome/still in place. (Time precluded links with David Challis' on-going research on SAP implementation in England).
- Material is to be presented at the February conference and will feed into the DOaS SAP output

## **Glossary:**

### **Comprehensive Assessment (Extract from original SAP Guidelines – Annex E – Stages of Assessment).**

#### ***Purpose***

A comprehensive assessment may arise in several ways. For example, from the outset, it may be obvious to a doctor or other qualified professional that, based on their professional judgement, the needs and circumstances of an older person are such that a comprehensive assessment involving specialist assessments of all or most of the domains of the single assessment process should be commenced. In this situation, conducting an overview assessment would be unnecessary and could delay getting the right help to the older person.

Alternatively at initial contact there could be less certainty, and an overview assessment may be carried out to explore areas of concern. When all the domains of an overview assessment have been surveyed, and specialist assessments carried out in most or all of them, the result is also a comprehensive assessment.

In addition, comprehensive assessments should be completed for people where the level of support and treatment likely to be offered is intensive or prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home.

For further guidance on assessment for people entering care homes - see Annex H.

However, no decisions on where people are best supported should be made before all information from a comprehensive assessment has been evaluated, including information from medical assessments and a thorough exploration of rehabilitation potential.

#### ***A note on terminology***

This guidance uses the term comprehensive assessment. However, in some localities and sites the equivalent terms of “comprehensive geriatric assessment” and “comprehensive old age assessment” are traditionally used and well understood. Within localities, agencies should agree their preferred term, in consultation with older people and other stakeholders, and ensure its common usage.

#### ***Who undertakes comprehensive assessment?***

Comprehensive assessment will involve a range of different professionals or specialist teams, with the relevant skills and knowledge. Geriatricians and old age psychiatrists, and their teams, should usually play the leading or a prominent role in comprehensive assessment. This involvement is crucial for accurate and timely diagnoses of treatable and other health conditions, without which wider assessment and subsequent care planning is likely to be flawed. It will be important for the various specialist assessments to be co-ordinated and drawn together and interpreted. Annex G gives further details on care co-ordination.

#### ***Tools***

Examples of assessment tools that can provide a framework for comprehensive assessment are given on [www.doh.gov.uk/scg/sap](http://www.doh.gov.uk/scg/sap); click on **SAP – Tools and Scales**.

## **Other Guidance**

### **Comprehensive assessment for frail older people:** (Source: British Geriatric Society).

The British Geriatric Society recognises this as a multi-disciplinary diagnostic process focussed on determining a frail older person's medical, psychological and functional capability in order to develop a co-ordinated and integrated plan for treatment and long term follow-up.

### **Fair Access to Care Services (FACS)**

Please see below for DH information about FACS.

Guidance providing councils with a framework for setting their eligibility criteria for adult social care.

The framework is based on individuals' needs and associated risks to independence, and includes four eligibility bands - **critical, substantial, moderate and low**. When placing individuals in these bands, the guidance stresses that councils should not only identify immediate needs but also needs that would worsen for the lack of timely help.

At the heart of the guidance is the principle that councils should operate just one eligibility decision for all adults seeking social care support; that is, should people be helped or not? Councils should not operate eligibility criteria for the type and depth of assessments that they carry out; likewise, they should not operate eligibility criteria for specific services. The guidance explains how assessments and subsequent care planning should be carried out, in proportion to needs and in good time.

The guidance emphasises that reviews of individual service users' circumstances should be carried out by appropriate council professionals on a regular and routine basis. These reviews should incorporate re-assessments of individuals' need, and will help councils to reach decisions on continuing eligibility. Councils are advised of the action they should take when significantly reducing and withdrawing services following a review, and of the particular sensitivity they should exercise in situations where reviews have not been carried out for some time prior to the implementation of the guidance.

The guidance confirms that when setting their eligibility criteria, councils should take account of the resources locally allocated to adult social care. Because of the different resource positions of councils, the guidance does not require councils to reach similar decisions on eligibility, or to provide similar services, to people in similar needs.

**See also Centre for Policy on Ageing website for additional material**

## Annex 5.4

### **SAP and Complex Assessments - Sub-group 4 Feedback and questions/issues from Triggering into Comprehensive Assessments Workshop - break out session.**

- A. TOPICS SUGGESTED FOR COVERAGE.**
- B. KEY THEMES EMERGING.**
- C. BREAK-OUT SESSION ATTENDEES.**

#### **A TOPICS SUGGESTED FOR COVERAGE**

- 1. Response to the presentation**
- 2. Specific responses to the topic of ‘triggers’ – and particularly**
  - a. how that might strengthen the links between health and social care**
  - b. if different SAP models might imply different approaches to ‘triggers’**
- 3. Views on unresolved issues**
- 4. Suggested next steps.**

#### **B KEY THEMES EMERGING**

##### **1. Response to the presentation**

General discussion including:

- How does continuing care fit into SAP?
- Observations of need for eligibility trail given ombudsman interest.
- Potential for confusion between the process of assessment, tools to collect material and the outcome
- Recognition that current situation often gives rise to duplication of information collection.
- SAP is seen as the sum of assessments built up over time.
- Case example given (Castlefields PCT) where joint assessments had been gradually introduced with health and social services working together initially and then gradually moving to provide assessments which both used (took about a year).
- Suggestion that there is no common understanding of ‘comprehensive assessment’ or agreement of what ‘triggers’ are in place or need to be in place – it is essential to have common definitions to enable team working.

##### **2. Specific responses to the topic of ‘triggers’ – and particularly**

- a. how that might strengthen the links between health and social care**
- b. if different SAP models might imply different approaches to ‘triggers’.**

General discussion on ‘triggers’ including:

- The process for SAP/Joint assessments and triggers needs to be sufficiently robust to enable colleagues familiar with the system and those meeting it for the first time to easily gain access and use the material.
- Recognition of need for ‘link’ person/key worker.
- Term ‘triggers’ could imply either anticipatory or reactive response – and associated ‘cultural’ shift. It could also be either ‘positive’ or negative’.

a How that might strengthen the links between health and social care?

- Castlefields PCT case example provided by David Lyon – gave example of approach and indication of timescale. (See above).
- Views expressed about need for tailored training

b if different SAP models might imply different approaches to ‘triggers’.

- Example of Evercare tool given – giving rise to observation of positive and negative triggers.
- Potential for both standard and client specific triggers.
- Difference between signposts and triggers drawn out.
- Alerts (for multi-use) also be implied – as was need for practitioner engagement to define these.

**3. Views on unresolved issues**

Summarised as need for:

- Need for clarification if triggering into complex or comprehensive assessments.
- Clarification of how continuing care fits into SAP.
- Further work on alerts/signposts/triggers – for current SAP and future e-SAP/move to common assessment.
- Education/training – to reflect the cultural shifts that may be required.
- Sharing of good practice examples more widely so others can adopt/tailor to specific local circumstances.
- User access to both information and resources may be problematic eg downloading resources from CPA site for individual older people/carers/relatives needing service information and how can this be enabled.

**4. Suggested next steps.**

- Feedback to plenary session – and include reference within project report.

**C BREAK-OUT SESSION ATTENDEES**

There were 18 attendees.

**Sub-group 4 – Bev Castleton, Richard Carthew, Jenny Stephany  
Delegates joining session:**

Mary Maconachy	Best Practice Process Design lead
Shirley Hay	Development Manager NSF older people
Steve Griffiths	Service Manager
Sheila Hillhouse	Deputy Director of Nursing
Nan Newberry	Acting Programme Manager - Cancer
David Lyon	Clinical Lead DOaS – complex conditions
Maggie Rastall	NSF Older People Manager
Michael Pountney	Learning and development lead - SAP
Penny Hill	Member of CRDB/Information Strategy Manager Warwickshire
Oliver King	OPAG

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Peter Jones	Clinical Specialist NCRS Project/Informatics
Wendy Emerson	Information and Performance Manager – Older People Modernisation team - Leeds
Ann Caperwell	Consultant Physician/Clinical Director Care of the Elderly
Pauline Hobson	SAP Business Change lead
Philippa Garner	Falls co-ordinator
Elissa Renouf	Senior consultant – Central Consultancy and Training
Judith Whittam	Health and Social Care Change Agent DH
Glenys Jones	Director of Social Services

Appendix 5 SAP Sub Group 4

Respondent	Rob Tomlinson	Jane Taubman	Maggie Rastall	Howard Smith	Jane Bearman	Charlie Clerk	Nicky Binder	Jane Tilston
Location	Barking & Dagenham	Camden	Greenwich	Islington	Kingston	Enfield	Richmond	Newham
Popn size	23,000	100,000	-	-	151,815	-	-	240,000
Interviewer	-	-	-	-	-	-	-	-
Date	-	-	60113	60119	60117	-	-	-
1. SAP used	Y	Y	Y	-	Y	Y	Y	Y
2. For what								
Case finding		Y	Y	Y	N	Y	Y	
Referral	Y	Y	Y	Y	Y	Y	Y	
Contact	Y	Y	Y	Y	Y	Y	Y	
Overview	Y	Y	Y	Y	Y	Y	Y	
Spec assess	Y		N	N	Y	N	Y	
Comprehensive	Y		N		Y	Y – but no clear definition	Y	
Care planning	Y	Y	Y		No, but being developed	N	Y	Y
3. Client groups								
65+	Y	Y	Y	Y	Y	Y		Y
younger dis		Y, over 18	Y	Y	Y	N		
LD		Y, over 18	N	N	Y/Phase 2	N		
All adults		Y	N	Y	Y/Phase 2	N	Y (except for CPA)	

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Respondent	Clive Bowman	Cathy Gillard	Shirley Hay	Aileen Fraser	Glenys Jones	Ruth Pyner	Beverley Waddell	Ian Donald
Location	BUPA	Hackney	Redbridge	Bristol North PCT	Sunderland	Hounslow	East Lancashire	Gloucestershire
Popn size	21,000 beds	-	263,000	150,000	-	-	68,632	500,000
Interviewer	JS	-	-	-	-	-	-	-
Date	60113	-	60118	60117	60116	60118	60124	60120
1. SAP used	Y - MDS	Y	Y	Y	Y	Y	Y	Y
2. For what								
Case finding	Y – hearing/sight	N	Y	N	N	Y	Y	N
Referral	d/k	Y	Y	Not yet	Y	Y	Y	Y
Contact	Admissions assessment	Y	Y	Y	Y	Y	Y	Sort of - referral
Overview		Y	Y, by C	Y	Y	Y	Y	Y
Spec assess	Y – use of AP	Y	N	Y	Y	Y	Y	Y
Comprehensive	Y	Y	N	Y	Y	Y		N
Care planning	Y	N	N		Y	Y	Y	N
3. Client groups								
65+	Y – main	Y	Y - contact	Y	Y	Y	Y	Y
younger dis		N	Y – contact		Y	Y		
LD		N	Y – contact		N	Y		
All adults	Y	N	Y – contact		N	Y		



Appendix 5 SAP Sub Group 4

Respondent	Rob Tomlinson	Jane Taubman	Maggie Rastall	Howard Smith	Jane Bearman	Charlie Clerk	Nicky Binder	Jane Tilston
Location	Barking & Dagenham	Camden	Greenwich	Islington	Kingston	Enfield	Richmond	Newham
4. LTC link	<p>Three Community Matrons have just been appointed. The new CMs will take a lead role in relation to LTC and are keen to engage with the SAP process. District nurses have also been engaged in revising the overview to meet LTC / case management needs.</p>	<p>Now looking at 'processes' of communication for multi-professional working, rather than fixing on SAP specific documentation. Beginning joint meetings across shared services, and teams working with same type clients – seminar on Monday 16<sup>th</sup> - 'Let's Talk' with Community Care teams, DN's, intermediate Care (REACH), physical disabilities, mental health, IT SS, IT PCT, SS Ots</p>	<p>All these teams are using sap as the basis of their assessment and referral process</p>	<p>LTC strategy looks to using SAP model and system for managing care –co-ordination. We are moving details of all high level patients/users on to the SAP Protocol web system and using case finding and care co-ordination model to manage intervention and info sharing via Community Matrons and LTC team. Contact me about this or Mary Price LTC Lead - mary.price@islingtonpct.nhs.uk</p>	<p>Community matrons will use "Protocol SAP" system to record casework. Specialist assessments have been linked to this. We have identified high risk LTC cases and linked their SWIFT and Protocol records A&amp;E and key acute sector staff will then be able to access this info shortly through Protocol. We are undertaking a review of case management competencies within community and primary care teams against LTC guidance on case management. Developing tool particularly around self management competencies. This work will lead to personal development plans.</p>	<p>Community matrons using contact and overview assessment [ ] as basis for assessment and care provision</p>	<p>The PCT has an LTC lead -&gt; Steering Group. The SSD has an LTC lead too! (part of the Steering Group). No community matrons yet appointed. I have stressed the importance of me being more involved with the LTC discussions ... and I'm still banging on the door. -&gt; still in planning stages</p>	<p>There is a LTC project to develop case management within context of Community Matrons programme, linking with this to address SAP approaches to assessment and care planning</p>

Appendix 5 SAP Sub Group 4

Respondent	Clive Bowman	Cathy Gillard	Shirley Hay	Aileen Fraser	Glenys Jones	Ruth Pyner	Beverley Waddell	Ian Donald
Location	BUPA	Hackney	Redbridge	Bristol North PCT	Sunderland	Hounslow	East Lancashire	Gloucestershire
4. LTC link	Some use of MDS (RAI) but SAP information does not flow into care home with patient/client.	The advanced primary care practitioners (community matrons) are using the SAP overview assessments as their referrals to social services; they are checking whether there is an existing involvement from Social Services, if so they are getting a copy of the latest assessment of care. Please Contact Bakison at Bakison.Kansinde@chpc.t.nhs.uk.	Long Term Conditions are using SAP Contact and Overview as their initial assessment case Software is currently being developed for the Long Term Conditions Team so that the tool can be used electronically. The team have completed many assessments and have used the documentation to work closely with Intermediate Care and the Integrated Falls Services, The Borough and the Voluntary Sector. Discussions are currently taking place with the team and the Borough to develop a pilot which enables the Long Term Conditions Team to directly commission small packages of care which will enable them to support people at home and prevent unnecessary hospital admission.	We are linking on the use of patient held documentations. The assessment documentation for patients requiring case management is now shared across disciplines to reduce the duplication of assessment.	There are two social services Long Term Conditions teams in Sunderland. These teams use the Easy care contact and overview assessments. They already have close working relationships with specialist nurses working with people with LTC's. They anticipate that they will have very close working relationships with the recently appointed Modern Matrons (12) for LTC in the City. The SSD teams are working with the SAP development officer and Sheffield University to devise a more appropriate easy care overview for younger people	It is planned that LTC Case Managers / Community Matrons when they start will work within the SAP framework and will use SAP documentation to form the generic assessment stage of their work. They will also use the Shared Care Plan, which is in use in Hounslow.	It has been identified through an A&E project carried out by Bev Waddell Nurse Consultant for Older People that SAP is essential in A&E to prevent unnecessary hospital admission of older people with long-term conditions and falls. Funding has been obtained by the East Lancs SAP subgroup to link A&E, Community matrons, the older people's nursing team, intermediate care teams, community hospital to social services (ISSIS) Integrated Social Services Information System, which is now fully SAP compliant. There are several integration projects underway including long-term conditions, primary care and unscheduled / intermediate care, with high level Chief Executive sign up . A shared access to care pilot has commenced. This is a team of health and social care staff who have been trained to be able to access low	District Nurses and Community matrons are using the overview as their standard assessment tool when undertaking case management. This is proving a good way of getting them to sue the tool more routinely and to understand the importance of comprehensive geriatric assessment in their work.

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Respondent	Rob Tomlinson	Jane Taubman	Maggie Rastall	Howard Smith	Jane Bearman	Charlie Clerk	Nicky Binder	Jane Tilston
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5. Cont care link	We are currently working on the use of overview, both in terms of practice (how can we really use this in a person centred way) and how it links most effectively to specialist assessment and decision making / resource allocation processes.	As above (4) – also developing Rapid Response in Intermediate Care with Community Matron (physio/OT as well as nurse) working with the REACH team, to catch people in crisis, but who do not necessarily need medical attention	They are not at the moment – SE Sector had developed its own form. Obviously overview feeds into it but not used in the way it was suggested in SAP guidance	Will link with above model – currently developing this.	Nursing Needs assessments on SAP but not specialist CC assessment. Need to consider further developments in this area.	Reviewing data requirements at present and exploring join up with contact/overview assessment documents	Continuing Care Panels require specialist As and Overview to support application (I think). Our Review Dxt [?] flags cont care as a review outcome	SAP tools used as part of documentation feeding into CCare decisions. Workshop on older people's CC updating process on CC.

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5. Cont care link	Looking to develop more 'managed care' – with case managers (probably nurses) and limiting use of GP – likely to trail with chronic conditions and then long term care. Sees development of dementia care as 'biggest issue' – currently looking at extending input beyond care homes to more comprehensive 'programme basis' – ie beyond walls of care home.	Not really happening/	Continuing Care developments are linked to SAP via the Contact Assessment as present. This will generate a Social Care Assessment which in turn will produce a statement of need which is part of the paperwork sent to the continuing care panel. Eventually when the electronic roll out of SAP takes place the Single Assessment Tool will be used as the assessment and this will be down loaded into the Social Care Record System.	Not at the moment	SSD staff complete overview assessments in all cases where CHC is indicated and they work with nursing staff to complete the CHC matrix.	This workstream is just about to commence and will look at incorporating CC within the SAP framework.	Continuing care developments have not been linked at this moment. When all district nurses are utilising the SAP IT system the information required for a continuing care assessment will be contained in a specialist document. The information collected in the contact, overview and specialist assessments will not be duplicated. Information will be added to meet the requirements for a continuing care assessment	We have an integrated specialist assessment form (we call it specialist, but you could call it comprehensive) for complex care and long term care, which includes assessment for CHC, and for the banding assessment by RNCC – all the information is collected/collated on this one form. It helps bring this together, and make the links between CHC and RNCC clearer. The idea that CHC and RNCC assessments are completely different is, in our opinion, stupid.

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6. Other generics	Nursing assessment, CPA and housing welfare. We are engaging partners in tool and process redesign to improve ownership of SAP across agencies	As 4, we are looking at where people are duplicating the SAP Overview with clients. Communication between teams remains an issue, as does knowing who else is already involved in the client's life prior to a first visit.	CPA –currently looking at this	CPA still used in MH – Overview/contact has replaced SW Community Care Assessment and Nursing core doc – but still Nursing Clinical docs.Working to joint care planning – Already have joint comprehensive risk assessment	A range of specialist assessments will be recorded on the SAP system as clinicians want to be able to place all their assessments in the same system and they provide a complete and in depth view of the person's /carers needs. Current assessments on system include pressure sores, wound care, leg ulcers and catheterisation check. Others, including continence and nutrition, will be added.	Overview is core to DN and SW assessments; CPA n use separately (unresolved issues of priority)	What does this question ask exactly. As a generic assessment, an Overview assessment is a pretty good example	Nursing, CPA – linking elements of SAP with these
7. Personalised CP	Y	Yes – but this varies between professions	Y	Y	Not at present but we intend to develop the relevant module of the Protocol SAP system to do this.	Y	Y, in part. Specialist Care Plans exist and form part of an 'overall service plan' on the User Held Record	Shared care plan being finalised

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6. Other generics	Driven by risk management considerations focus is on RAPs- resident assessment protocols eg falls and behavioural assessments (eg BASOLL) – score and risk level for challenging behaviour.	Nursing assessments are used but the front 2 pages form the initial contact of the SAP which is used as a referral and to share info with other services- we call the nursing assessment a specialist rather than a generic.	As we have had considerable problems with the development of the IT infrastructure which will support SAP The contact assessment is the only form that is being used as a referral by all services and is 'joined up' at present. Until we are in a position to resolve the IT issues, we are currently looking at one service user held record that is shared by all services involved in the service user's care. This folder will contain basic personal information, Statement of need and care plan together with individual sections for each service. There will also be a list of services engaged in providing care and a closing summary will be completed when a service is not longer required	All agencies are now using the domains of SAP for generic assessments	The following scales and tools have been agreed for use by all staff in Sunderland and are written into our local SAP guidance: Braden; Bartel; Falls Assessment Tool; Mini Mental Test; Geriatric Depression Test; Nutritional Scale. The results of these tests are passed between professionals as required with an explanation of the results and what this is likely to mean to the person being assessed. Where professionals have access to E – Sap we are working on attaching these documents to the persons Liquid logic record.	CPA is still being used at present, more work is needed to ensure that the SAP framework dovetails with this in a usable format. District Nurses and Care Managers all use SAP as their generic assessment.	In the areas not linked with the initial IT developments nursing paper documentation is currently being used in addition to the contact assessment. In the IT pilot sites nursing tools and scales not covered by the overview assessment are being used. CPA is still a problem and duplicated.	Social services routinely use Overview for all referrals accepted after contact assessment, which is done by their helpdesk. CPA is still used, unchanged by SAP. Nursing assessments are various across the county, but we are making slow steady progress in adopting Overview in place of nursing general assessments.
7. Personalised CP	Y. CB notes the requirements on independent providers to undertake assessments – but that the minimum expectations of an assessment are not explicit – hampering a tool being developed.)	Y	Y	Y	Y	Y	Y	Y

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8. Comp defined	Yes (should be clearer after a key meeting of adult and older people services on 30/1)	Yes, but as Overview Assessments	N	Y	Y	N	Y	Y
9. Comp definition	Same as in glossary.	-	-	Overview Plus specialist assessments = comprehensive Will incorporate specialist summary E Form document in Phase 2	We do not have a separate form and do not see the need for a hard and fast definition of a "comprehensive assessment". In line with para 2 of the glossary, we regard a comprehensive assessment as a combination of a contact and overview assessment together with a number of specialist assessments. Where circumstances indicate that the specialist assessments should be made first, we would still expect an overview to be completed in due course to pick up any areas not already covered. The Protocol system shows a full listing of assessments made, together with date, assessor etc. so that the range of assessments made and in hand can be seen at a glance.	No approved definition; some local practices agreements/arrangements	As per SAP definition of Comprehensive Ax – is there a definition other than a "collection of specialist Axs"?	Those done by MDT leading to CC, long term care placements Holistic approach of Integrated Stroke Team

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8. Comp defined	N	Sort of !	N	Y	Y	N	Y	N
9. Comp definition	No standardisation – so wide range of tools are in use. BUPA is looking to consolidate this internally. (BUPA also happy to share activity with DH with a view to agreeing standardised expectations).	An Initial Contact Assessment plus a specialist	-	We are defining complex needs as the involvement of two or more services.	Where two or more professionals are involved and where the person presents complex needs.	-	A comprehensive assessment is where the person has a number of medical, social and psychological needs and a case manager or care co-ordinator is required to work closely with the patient, carer and family to devise an agreed care plan to prevent unnecessary hospital admissions. Also to respond in a timely manner to deteriorations in the persons health or circumstances.	(Left to specialist departments to undertake their own CGA)



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10. Trigger	N. We are in the midst of defining triggers at present. We shall have this work completed by early Feb. As the overview will be the core element of a comprehensive assessment we will not "leapfrog" the overview, but will have a parallel / fast track process.	N	N	N	Difficult to answer this question in view of information in preceding section. Specialist assessments can be made as a result of indications within the overview assessment or may be made independently at any time.	N. Local arrangements in teams and between SW and DN	N. I think the trigger stems from the outcome of the Contact Ax; if multiple agency Axs are required, management will decide pathway based on urgency of service need	N. There are triggers in the overview which direct people to the next relevant stage
11. FACS	Social care use of contact and overview or specialist.	Yes, the new version 5 FACE has FA CS rating included and this is being used by Social Services Adult community care teams. The overview is then accepted by panel as the only assessment needed which reduces duplication	Overview assessment informs eligibility and care plan identifies FACS banding with each item of need identified	Islington Needs and Care Plan electronic tool establishes eligibility need by need	Health and Social Care needs section near the end of the FACE Overview assessment records overall FACS banding. This is informed by the responses earlier in that assessment and knowledge of other assessments recorded in Protocol and SWIFT.	Contact/Overview documents have FACS eligibility grid attached to inform bandings recommended to social care commissioning	Contact, Overview, SW Specialist and Sensory Services Axs: all are integrated with local SAP tools	The SW 'specialist' FACS tool mirrors the SAP overview + FACS grid

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10. Trigger	CB notes that most beds are for long term cases – giving rise to ‘comprehensive assessment’. Short term care eg respite might give rise to overview assessment – but in turn this is unlikely to ‘trigger’ more comprehensive assessment as limited stay likely.	N. There isn’t a mechanism, staff will look at each case and decide if it’s more appropriate to do a specialist assessment	N	N	Y The introduction of the above trigger has not been necessary, as professional staff in Sunderland Health and Social care community have always completed comprehensive assessments of needs, where required. The introduction of this way of working within SAP has only underlined this good practise. However, it has been difficult to introduce the term Comprehensive assessment to their practise!	N	N	N. Triggers from Overview to other assessments and referrals eg falls clinic, mental health services, but not to comprehensive assessments. The specialist assessment is used without the overview in hospital settings.
11. FACS	n/a as BUPA is provider (rather than ‘gatekeeper’)	-	FACS is included in the SAP assessment	Social services assessment but they are not yet integrated	Social services staff use the Easy care contact and overview assessments to inform FACS. Needs bands are recorded in the summary of these assessments and then also recorded in SWIFT to inform future trends.	FACs determination is primarily completed following an Overview Assessment currently. However plans are in place to introduce FAC’s determination following Contact Assessment where possible. Self-referral will also be introduced this year from which a FACs determination may be made.	The assessments required for FACS are fully integrated into the contact, overview and specialist social work assessment	The info gathered by Overview does determine FACS rating.

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12. Tool	Y	Y	Y	Y	Y	Y	Y	-
13. SAP tools								
EasyCare								
FACE		B	B	E	E	P	B	
CAT	E							
MDS RAI								
STEP								
NOAT								
Local								Y
Combination								

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12. Tool	Aware that SAP is in use in localities where BUPA has Care Homes. BUPA have been using MDS from 2005 – in c300 beds (UK license) – ie use on admission to care homes.	Y	Y, with LTC Team	Y	Y	Y		
13. SAP tools								
EasyCare					B	N		
FACE						B		
CAT		B – modified	P			N		
MDS RAI	P					N		
STEP						N		
NOAT						N		
Local				B		Yes (Contact, Shared Care Plan); B	B	
Combination		B				B		

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14. Info flow	We use an electronic notebook for assessments, but do not yet have a clear way forward on electronic transfer. Assessment and care plan information is usually exchanged by phone and fax	FACE Background and Contact ; Overview; some reports (eg OT, physio), some GP letters, sometimes client medical notes	Contact assessments/referrals using contact assessment and overview assessments	Online Web based SAP assessment E-forms plus attached word or PDF specialist, care plans etc. Also information between TCC and Swift databases incorporated into SAP record using interface programmes.	Contact assessment will flow very shortly between PCT, SSD, Housing Floating Support and Age Concern. Overview ditto above. Acute will have read only access We hope to "sell" the system to primary care teams once the community matrons have cases that are live which can be demonstrated to GP's in terms of the usefulness of info flow on their patient list.	Contact/Overview Developing use of Word template on Tablet PCs	Contact Ax, Care plans, Spec Ax. The user held record is a 'shared tool'.	Contact, referrals, overview – in part

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14. Info flow	Info may flow within statutory organisations but observes that it does not flow from them to the independent sector. Notes that discharge summary typically goes to last registered GP not to Care Home (some consultants may copy on individual basis)	CAs, referrals and overviews are exchanged around the community	Contact by all services. Plus Overview Assessment where appropriate by Long Term Conditions Team.	This is not yet in place but we would plan to share contact and summary assessments with overview available on request.	The local agreement is that all referrals are made and shared between agencies, eg. GPs, Community Nursing, Housing, on a Contact assessment. This can be a paper based form or an electronic referral through Liquid logic. Electronic referrals are routinely made, through Liquid Logic between staff on the Care of the Elderly wards at the local acute hospital and SSD, and in and between social services teams. There are plans for Community nurses to introduce this system in the near future. Care Plans are not routinely shared but plans are in place to commence using this functionality in Liquid Logic this year so that those professionals using E- Sap will have access to this information too.	Contact Assessments, referrals are shared as standard and Overviews more infrequently. Care plans will be shared between the care team members this year.	A paper contact assessment is being used across all PCT staff, housing staff and social services. This is then inputted onto the social services ISSIS system. In the IT pilots electronic contact, overview and care plans are being used. Specialist assessments are paper documents	Overview and specialist assessments – currently in paper form, but IT version of Overview starting very soon.

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15. Info flow mechs	As above.	Phone, fax, post, email (between social services teams),	Fax, post, from April will have Personal held Records	SAP Protocol system. Social Services shared filing repository (word docs) across x 3 localities. Email - only secure network or password protected, Fax (some), Post. Referrals and workflow is also handled by SAP protocol, system.	Liquid Logic Protocol system which interfaces with SWIFT. Acute access through NHS net. Paper alternatives are generated for staff/organisations not linked electronically or those not yet trained on the electronic processes	FAX, post; some use of NHSmail	FAX only !! and post as required – these solutions are not good enough	SAP secure email pilot being developed
16. CSR use	N	No, but using summary record for REACH which also acts as a discharge letter to GPs and other services , as well as client	N	N	Protocol SAP can automatically generate a current summary record based on service user demographics and their latest contact and overview assessments. The summary record can be modified to reflect recent information. Stored electronically and may also be printed out. So facility exists, but the usefulness of the summary record in practice is not yet clear	N	N. We use the User Held Record which is fairly close to the CSR Domains	N

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15. Info flow mechs	Mechanisms are inconsistent and may not be timely. Information flow is not guaranteed. Pre-admissions forms are usually done by BUPA/Care Home to capture information. (ie initiated by BUPA, not using information already collected).	Fax, phone and e-mail	Fax mostly.	Fax and paper forms	Post; Fax; paper based forms and E – Sap.	Fax primarily between organisations where secure email is not available. Email between services within an organisation where secure email is available.	Fax for paper contact assessments and the electronic system where teams are linked	Fax and post at present; IT version on web-enabled system, but on a system hosted by Social Services.
16. CSR use	N. BUPA don't receive information consistently – collects it within pre-admission forms	N	Yes The SAP Tool covers all the domains in the Current Summary Record.	Y	Yes. Available to all staff using E – Sap.	N	N	N



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17. Training for CA	None recently as we have focused on revising the tool and developing the process, a process which we will have concluded in February. We have identified a need for training that ensures that assessment is proportionate and reflects discussion and agreement on the areas to be covered between assessor and client (taking into account views of carer / third parties).	See 4	Series of whole day SAP training on principals , tools etcFrom march/April will be training on personal held record	None	Staff in integrated health/social care locality teams have common training on SAP principles and the electronic applications. Appropriate training will be provided to other teams (e.g. in acute) to enable them to link into the overall processes including access to the electronic applications.	No focus on comprehensive assessment yet – training to be planned	Nothing specific – SAP training discussed definitions of Ax types only. The comprehensive Ax concept is still a nebulous one.	Initial workshops, all multi-disciplinary. Ongoing SAP training programme. Modular eSAP training programme being developed.

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17. Training for CA	n/a – suggest ask PCT/LA field contacts.	-	N	Initially 1.5 days multi agency and professional training. Recently 2 hour training for all team leaders – trainers from health and social services. The project lead is developing a CD for use within teams.	Some working together because of the size of the implementation it has been necessary for each organisation to be responsible for its own training	All SAP training is jointly trained in Hounslow. To date this has focused on the background and the use of the Contact and Overview assessments. Practitioners are made aware of the Comprehensive assessment. They understand that the Comprehensive assessment is the sum of the other parts. Care Co-ordination has not yet been implemented.	All staff have undergone awareness and hearts and minds SAP training. A comprehensive training strategy has been developed to support integration and the SAP IT links. The shared access to care pilot staff are under going this comprehensive training currently	Lots of sessions, each person will only have attended once. Done generally in localities.

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18. Success criteria	Clear and consistent process. Good working relationships.	Development of a SAP steering group – involvement of senior management from LA and PCT and Mental Health etc	Not being an early implementer –so not making costly mistakesA good steering group where excellent relationships were made across all agenciesChoosing FACE - been well accepted by staffHave not tried to engage GP's until things better understood. I think this was a good decision given that still unclear particularly now in terms of RIO etc	One PCT/Social services -co-located – Early establishment of FACE across SW and Nursing in Word format – interim data and E-file management systems. IT Facing workforce. Commitment from Senior PCT and S/Services managers. Needs of LTC to use SAP model has driven PCT interest	Working in an environment where there have been considerable advances in integrated models of care such as the joint older peoples locality teams. Operational staff are keen for SAP to be developed to support their integrated practice which they wish to develop further, where workers are working to competencies rather than their professional boundaries ie CPN's and D/N undertaking case management and commissioning functions also social workers undertaking previously seen as health roles smoking cessation and fitness for health programmes.Dedicated posts to take SAP forwardEngagement at an early stage of housing and Age Concern so that the process evolves with a cross section of organisation needs met rather than just SSD and PCT.	Practitioner and front line manager commitment. Multi-disciplinary training. Link to national agenda.	SAP is only partially working, to be honest. One year on much has been achieved, but good business processes are integral to good SAP implementation	Funding for project work, Head of Assessment and Care Mgt undertaking research study, LDP commitment, commitment from Older People's Partnership, staff commitment

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18. Success criteria	CB considers assessment and associated information flow is NOT working. Acknowledges that there may have been progress in community assessments but this is not flowing through to Care Homes. Considers that future developments in regulation may assist further improvements	-	-	The will to work together from all agencies and the realisation of the problems caused to older people by the problems in communication and duplication.	Joint working from an early stage. - 2001 Agreement on the 12 steps of implementation leading to a Locally agreed joint policy and procedure for SAP. A jointly agreed Confidentiality Policy. Clear business change processes. Senior Officer 'buy in' has been the most crucial element. The appointment in SSD of SAP Development/ Training officer in SSD	Joint training and high-level sign up have really helped. A broad staff group having an understanding of the principles and aims of SAP is invaluable. A dedicated Project Management post is also essential to implementation across health and social care.	Critical to the success has been the integration projects which have shown that integration can not work without SAP. Also the hard work which has gone into paper pilots and the training programme. Social services developing their already excellent IT systems to be SAP compliant. The support of SHA funding for the integration an long-term conditions projects, including A&E	Overall, not that much change to the way things work due to SAP. Social services insisting on changing to overview has helped them, and is probably stimulating their broader thinking. Hard to evaluate the impact of this. It has been a nuisance/obstacle within Intermediate Care where there really is not time for comprehensive assessments, yet social services are insisting on it. Case management is most important area where we are pushing now.

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19. Barriers	IT and electronic transferNew structures, new staff, new responsibilities, new initiatives - different priorities	See 4	Sharing the information –this has still not been fully overcome as passing on of SAP documents is still not part of practice in District nursing etc. Hoping that personal held records in the home will help this	Info sharing potential is huge – only realistic way to progress E - SAP is to enable practitioners access to one definitive web based record one assessment. Workflow and buisness processes more efficient – has already had significant positive impact on OT performance and waiting listsDis-benefits Financial limitations – ie getting PCT to pay for enough licenses a headache. Out put for service users not a good as Word based docs all in HTML so generate big printouts.	Difficulty in engaging senior officers across organisations to champion SAP when there are unclear messages regarding the priority for implementation.In our area there is now a chronic lack of funding available and capacity within the PCT to support any developments within SAPBuilding robust and reliable interfaces between with Anite as a player.	Communication and cultural issues [still need] addressing, still priorities in some areas	Continue to be overcome. IT sharing capabilities; GP involvement; management (first line) sign-up is integral	Lack of IT solutions nationally to support ease of using SAP, competing agendas for staff groups

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Respondent	Clive Bowman	Cathy Gillard	Shirley Hay	Aileen Fraser	Glenys Jones	Ruth Pyner	Beverley Waddell	Ian Donald
Location	BUPA	Hackney	Redbridge	Bristol North PCT	Sunderland	Hounslow	East Lancashire	Gloucestershire
19. Barriers	<p>The requirements on independent providers to undertake assessments – but that the minimum expectations of an assessment are not explicit – hampering a tool being developed.). (ie difficulty in agreeing a single tool and process for re-assessments). Notes that US, Canada, Japan and Australia use MDS for initial and review assessments – both on paper and electronically. The main focus of SAP is on assessments in the community rather than covering all care settings <b>Key barrier is lack of political commitment to progressing assessment – across all settings</b></p>	-	<p>Practitioners are signed up to the Single Assessment Process and are working a more co-ordinated way. Barriers that still exist: Resolving the issues around the IT infrastructure.</p>	<p>Progress has been slow. Robust IT systems will be essential to improve the communication across services as this still remains our major challenge to overcome. However there is still work that can be done ie improving discharge summaries to GPs and training staff in using IT which will be effective.</p>	<p>Differing Health and Social Care agendas. No integration with existing IT systems. Budget Not all agencies using E – SAP. Paper systems are too cumbersome and make sharing of information time consuming for staff.</p>	<p>The engagement and involvement of GP's is ongoing. Work has begun in the local acute Trust to implement SAP but this will be a long-term project. Full engagement with mental health is still to be achieved.</p>	<p>Senior management buy in has been the main barrier. This has been overcome by the high level sign in to integration. Most staff have now realised the benefits of SAP however some are still not convinced and are protecting their own professional roles.</p>	<p>The IT one; things change too fast during acute illnesses, and so the system has much less to offer in that setting, we have found – but IT access to find out about previous assessments could be great. Time constraints on nursing in hospital and community make implementation difficult.</p>

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Respondent	Rob Tomlinson	Jane Taubman	Maggie Rastall	Howard Smith	Jane Bearman	Charlie Clerk	Nicky Binder	Jane Tilston
Location	Barking & Dagenham	Camden	Greenwich	Islington	Kingston	Enfield	Richmond	Newham
20. AoB	-	-	SAP has been a real challenge –although much good has come from it in terms of interagency working etc – many hours have been wasted and still this is going on around the IT implementation. Policy needed to have been piloted and a standard tool given to be used across England. I hope with IT implementation they will select a standard assessment tool.	Why have I had two different forms about DOAS to fill in !?	-	Promotion of thinking in pathways rather than teams in implementation of SAP	Effectiveness of SAP is dependent on both SSDs and PCTs wanting to seek improvements for their community. Locally the PCT has been a bit of a 'sleeping organisation' and not well structured. SAP has as a consequence experienced mixed results.	-

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Respondent	Clive Bowman	Cathy Gillard	Shirley Hay	Aileen Fraser	Glenys Jones	Ruth Pyner	Beverley Waddell	Ian Donald
Location	BUPA	Hackney	Redbridge	Bristol North PCT	Sunderland	Hounslow	East Lancashire	Gloucestershire
20. AoB	<p>BUPA interview covers care homes only. Appears that DH assessment focus is those in community and assessment – ie not those in independent sector Care Homes. Concerned about the <b>risk to NHS system currently due to the lack of organisation of care – potential for ‘log jam’</b> Notes that 2 reports are due early in 2006 – Rowntree and Wanless/Kings Fund which are likely to give similar messages. CB’s <b>aim</b> is to get corporate standard (assessment tool) across Care Homes – needs steer on whether DH may offer this standardised tool or whether to proceed with BUPA’s current pilot (s) – due across 2 care homes. CB happy to participate in further work in this area.</p>	-	-	-	<p>Locally developed training on E- SAP has been a crucial element in our success so far. The centrally devised training did not meet our needs and this has now been recognised. There is much more consultation between the LSP and local agencies now. ‘Floor walking’ following training at the point of implementation has been crucial in SSD. Other agencies are now realising that they should have done this. Access to a live practise site before implementation allowed those training to accurately see how the system would work after delivery. In practise this was very different to what the developers expected.</p>	-	<p>IT links are key to the success of SAP and the delay in Connecting for Health developments has created difficulties.</p>	



## Annex 5.6

DOaS – SAP. Working paper - Scan of fieldwork (2) Nurse Consultant material returned by 10<sup>th</sup> February 2006.

	Respondent	Baker	Clegg	Homer	Mousley/ Uliasz
	Location	East Yorks PCT	Leeds	Lambeth	East Surrey
	Mode/Date of submission				
<b>1</b>	<b>Use of SAP in locality</b>	Yes (elec planned from 30/1/06)	Yes	Yes	Yes
<b>2</b>	<b>Used for what</b>				
	Case finding	Y	Y	Pilot	?
	Referral	Y	Y	Y	?
	Contact	Y	Y	Y	Y
	Overview	Y	Y	Y	Y
	Specialist (in-depth)	N	N	Y	?
	Comp Assess	N	Y	Y	?
	Care Planning	N	Y	Y	?
<b>3</b>	<b>Client gps</b>				
	Elderly – over 65	Y		Y	Y
	Younger disabled	18+		N	Y
	Those with Learning disabilities	Y		Y	N
	All adults	Y		Y	?
<b>4</b>	<b>LTC link</b>	<p>LTC are linked into our SAP solution. LTC was piloted and incorporated in the locality piloting SAP. One of the keys to success was SAP and sharing of information.</p> <p>Too early to highlight areas of good practice as we are just recruiting our community matrons and our electronic SAP solution goes live on the 30<sup>th</sup> January 2006</p>	<p>Community matrons in NW Leeds – a well established model, are using the EasyCare contact and overview assessment for each referral into the service. They currently have 200 registered patients found using PARR tool and local intelligence.</p> <p>Contact: angie.clegg@leedsth.nhs.uk.</p> <p>Leeds Rapid Response / Intermediate Care Services</p>	<p>Through information sharing and integrated working between primary, community and social care. Using joint discussion forums and PARR tool. This is a pilot at the moment and will be better assessed later.</p>	<p>We are starting to link the care co-ordination role with management of long term conditions. ESPCT is licensed to use Face 5 and will be licensed for the RAT and second line assessment tools which will primarily be used by the community matrons. We are also implementing the current summary record.</p>

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			also use the contact assessment for all patients and the overview for people with complex needs.  Leeds Social Services Use both Contact and Overview.		
5.	<b>Continuing care link</b>	Currently not included, they will be in our second phase of implementation in April 2006.	A contact and overview are completed prior to nursing determination.	Nothing formally agreed currently.	This is a work in progress, the notes are SAP compliant.
6	<b>Use of other generic assessments</b>	We are using contact & overview EasyCare assessments in an electronic format in one locality as from 30 <sup>th</sup> January 2006.  Plus review of assessment documentation to reduce duplication	Mental health services still use the CPA.  Otherwise SAP has replaced most if not all other generic assessments	CPA needs to be joined up.	The DN service is to start using Face from 01/02/06, they also use the BPI, Waterlow Pressure Ulcer Prediction tool, leg ulcer assessment, wound assessment, risk assessment and a pain assessment form. Social care staff still complete section 47 assessments under the NHS & Community Care Act.
7	<b>Assessments contribution to personalised care plan?</b>	Yes – in longer term	Yes	Yes	Yes
8	<b>Definition of comprehensive/complex assessment available?</b>	Yes	Yes	Yes	?
9	<b>Outline of definition</b>	In summary a comprehensive assessment is completed within a multi-agency/disciplinary arena where an individuals care is complicated requiring a join coordinated approach that places the individual's needs at the centre.	A comprehensive assessment is multidisciplinary and includes the completion of contact, overview and a two or more specialist assessments	Undertaken for a person likely to require intensive or prolonged support and treatment, (e.g. permanent move to a care home, intermediate care services, or substantial packages of care at home). Under the single assessment process, a comprehensive	?

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				assessment is where more that one specialist assessment has been completed together with a fully completed contact assessment and overview assessment.	
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		<b>Baker</b>	<b>Clegg</b>	<b>Homer</b>	<b>Mousley/ Uliasz</b>
<b>10</b>	<b>Mechanisms to trigger? Y/N</b>	Y Issues or risks highlighted in the assessment will trigger further assessment.	Overview forms part of the comprehensive assessment	Y At contact	Work in progress.
<b>11</b>	<b>Assessments linked to FACS and link with SAP</b>				
<b>12</b>	<b>Use of SAP</b>	Yes	Yes	Yes	Yes
<b>13</b>	<b>Which tools and if electronic/paper</b>				
	<b>Easycare</b>	E – and paper in training	P		
	<b>FACE</b>			Both	Paper
	<b>CAT</b>				
	<b>MDS/RAI</b>				
	<b>STEP</b>				
	<b>NOAT</b>				
	<b>Locally developed tool</b>				
	<b>Combination tool</b>				
<b>14</b>	<b>Info flow – between organisations</b>	Any information that with consent supports the individual care needs of the patient/service-user	Faxed Contact and Specialist assessments flow between organisations. Paper overview is patient held	This hasn't worked on paper – we're about to start the process with IT and then all information would flow over.	
<b>15</b>	<b>Mechanisms to enable info flow</b>	Information will be shared through a secure email system. Other avenues will be accessed if necessary.	Mainly fax	Phone, fax, e-mail, post, paper based forms and very soon joint PCT/DSS database.	

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<b>16</b>	<b>Use of current summary record</b>	Will do so when 'go live'.	No	No	Yes as from 1/2/06
<b>17</b>	<b>Joint training</b>	SAP awareness training has occurred. Discussions have started about the next stage, but no formal training  Paper version is used in preparation and training, allowing staff groups to move away from traditional assessment documentation.	Extensive 3 tier training in 2003/4 across health and social services	Focused/tailored training sessions in Nov'04 and large scale multidisciplinary/agency training in Feb & March '05. Renewal/induction training for new staff in Feb'06 and on-going.	All staff must attend the SAP awareness and SAP training.
<b>18</b>	<b>Critical success factors</b>				
<b>19</b>	<b>Misc other factors</b>		NB old version of template used.		

	<b>Respondent</b>	<b>Wadell (repeated)</b>	<b>Whitcher/Honeyman</b>	<b>Joss</b>	
	Location	Ribble	Crawley PCT/SCS	New Forest PCT/ETVS PCT	
	Mode/Date of submission				
<b>1</b>	<b>Use of SAP in locality</b>	?Y!	Y	Yes	
<b>2</b>	<b>Used for what</b>				
	Case finding	Y	N	N	
	Referral	Y	Y	Y	
	Contact	Y	Y	Y	
	Overview	Y	Y	Y	
	Specialist (in-depth)	Y	N	N	
	Comp Assess	N	N	Y	
	Care Planning	Y	Y		
<b>3</b>	<b>Client gps</b>				
	Elderly – over 65	Y	Y	Y	
	Younger disabled	?	Y		
	Those with Learning disabilities	?	?		
	All adults	?	Y		
<b>4</b>	<b>LTC link</b>	It has been identified through an A&E project	Our Community Matrons all use SAP paperwork for all	SAP project manager in place since 2002.	

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		<p>carried out by Bev Waddell Nurse Consultant for Older People that SAP is essential in A&amp;E to prevent unnecessary hospital admission of older people with long-term conditions and falls. Funding has been obtained by the East Lancs SAP subgroup to link A&amp;E, Community matrons, the older people's nursing team, intermediate care teams, community hospital to social services (ISSIS) Integrated Social Services Information System, which is now fully SAP compliant. There are several integration projects underway including long-term conditions, primary care and unscheduled / intermediate care, with high level Chief Executive sign up. A shared access to care pilot has commenced. This is a team of health and social care staff who have been trained to be able to access low level services utilising the single assessment to prevent hospital admission.</p>	<p>their cases. They refer patients to Social and Caring Services and other health care professionals. Tel: 01293 572168. Awaiting further discussion in SCS</p>	<p>NB Alliance initiative Hampshire/IOW web based SAP collection system in place – accessible to social services, GPs and all health organisations in patch.</p>	
5.	<b>Continuing care link</b>	<p>Continuing care developments have not been linked at this moment. When all district nurses are utilising the SAP IT system the information required for a continuing care assessment will be</p>	<p>Not known</p>	<p>Rehab teams using similar documentation</p>	

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		contained in a specialist document.			
6	<b>Use of other generic assessments</b>	In the areas not linked with the initial IT developments nursing paper documentation is currently being used in addition to the contact assessment. In the IT pilot sites nursing tools and scales not covered by the overview assessment are being used.  CPA is still a problem and duplicated.	Nursing, therapy, Community Care, CPA	Rehab teams using similar documentation  Plans underway to re-structure community services.	
7	<b>Assessments contribution to personalised care plan?</b>	Yes	Yes	Yes	
8	<b>Definition of comprehensive/complex assessment available?</b>	Yes	Yes	Yes	
9	<b>Outline of definition</b>	A comprehensive assessment is where the person has a number of medical, social and psychological needs and a case manager or care co-ordinator is required to work closely with the patient, carer and family to devise an agreed care plan to prevent unnecessary hospital admissions. Also to respond in a timely manner to deteriorations in the persons health or circumstances.	Case management by Community Matrons. Where there are multi social & health needs as per FACS, where there are carer needs, where there are more than two services required.	A complex assessment is defined as one that needs input from one or more specialist clinicians/practitioners	

	<b>Respondent.</b>	<b>Wadell (repeated)</b>	<b>Whitcher/Honeyman</b>	<b>Joss</b>	
10	<b>Mechanisms to trigger? Y/N</b>	No	Yes Overview assessments are	Yes	

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			carried out on all patients with complex needs in health to identify what services may be necessary. This is not the case for SCS	Clinical judgement supported by Maff paperwork.	
11	<b>Assessments linked to FACS and link with SAP</b>				
12	<b>Use of SAP</b>	Yes	Yes	Yes	
13	<b>Which tools and if electronic/paper</b>				
	<b>Easycare</b>				
	<b>FACE</b>		both		
	<b>CAT</b>				
	<b>MDS/RAI</b>				
	<b>STEP</b>				
	<b>NOAT</b>				
	<b>Locally developed tool</b>	both		both	
	<b>Combination tool</b>		both		
14	<b>Info flow – between organisations</b>	A paper contact assessment is being used across all PCT staff, housing staff and social services. This is then inputted onto the social services ISSIS system. In the IT pilots electronic contact, overview and care plans are being used. Specialist assessments are paper documents	Contact assessment, overview assessment, referrals, care plans, action plans where decided is appropriate	contact assessments, referrals, overview assessments (whole or in part), care plans, list of the care team involved,	
15	<b>Mechanisms to enable info flow</b>	Fax for paper contact assessments and the electronic system where teams are linked	Phone, fax, e-mail (not patient details), post, paper-based forms in patient held records, Face-to-face.	Phone, fax, paper based forms, will use electronic version when able (see comments)  Across Hampshire and the Isle of Wight, the SHA has made available a secure web based SAP data collection system at no	

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				<p>cost to the organisations.</p> <p>This is based on a secure server at the SHA and is one of the front ends to the SHA wide Clinical Data Repository.</p> <p>This has the advantage of being accessible to Social Services Departments via a shared secure link and being able to feed into and access clinical data from GP surgeries and All Health organisations across Hampshire and the Isle of Wight and contains a current summary record</p>	
16	<b>Use of current summary record</b>	No	No	No – but local CSR in place for web based initiative	
17	<b>Joint training</b>	All staff have undergone awareness and hearts and minds SAP training. A comprehensive training strategy has been developed to support integration and the SAP IT links. The shared access to care pilot staff are under going this comprehensive training currently	Comprehensive assessment has not been fully developed but practitioners have had the opportunity to discuss how it will be used in practice. Paperwork has been developed but there are a number of issues to resolve before it can be properly implemented.	<p>Not explicitly covered but reference to</p> <p>Work sharing and networking through the Hampshire and Isle of Wight SAP steering Group</p>	
18	<b>Critical success factors</b>				
19	<b>Misc other factors</b>			Hampshire/IOW initiative.	

Annex 5.7



## Appendix 5 SAP Sub Group 4

List of additional material collected but not presented in this analysis.

- Q1 - Use of SAP in locality
- Q2 - Use of SAP in locality
- Q3 – Client groups covered
- Q6 – Other generic assessments still being used
- Q11 – Assessments which inform eligibility under Fair Access to Care Services (FACS) – and if integrated.
- Q18 – What has made things work in the locality?
- Q19 – What have been the main barriers overcome?
- Q20 – additional comments.

### Annex 5.8

Additional contacts.

<b>Contact</b>	<b>Reason</b>	<b>Comments</b>
John Gladman	British Geriatrics Society	For info
Ian Donald	British Geriatrics Society	Fieldwork participant – on basis of experience in the locality - BGS Forum link to other geriatricians
Chris Dunstan	SHAW PCT/FAME	FAME sites Woking and Wirral – evaluation Newcastle Univ.
Iain Carpenter	Research and standards lead RCP	

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Dagmar Long	Fieldwork	Comprehensive Assessments, Leeds
Matthew Fagg	DH	Link to the White Paper and proposed Common Assessment Framework
Clare Whittington	DH	Long Term Care Lead
Mary Simpson	DH Information Dept	Links to White Paper
Sue Roberts	Long Term conditions, diabetes	Future ways in which the SAP and Diabetes DOAS projects could work together were explored
Sally Bassett	DH/Community Matrons lead	Link to the White Paper and proposed Common Assessment Framework
Colin Gordan	DOaS Heart Failure plus Royal Brompton	SAP/Complex conditions Joined conference
Teresa Moss	Cancer Assessment Process	Advice on how to use SAP as basis for Cancer Assessment Tool Development
David Lyon	DOaS complex conditions	Joined conference and breakout session
Julia Ross, Alison Smith, Charis Isted	Transforming Chronic Care Programme	SAP linked to risk assessments/developments

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Eleanor Bell

Information Centre

Involved in original dataset  
work

Links made with DOaS groups during the course of this project as a whole included Falls, Complex Conditions, Cancer, Children's Mental Health, Heart Failure, Learning Disabilities and Diabetes.