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

This report was compiled in line with the DOAS Programme Requirements.

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

A. Introduction to the work

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

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

B. Summary of previous work in the field

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

- Started in February 2004. It included the mapping of the high level health and social care process steps that are involved in SAP (not only for older people).
- In total, there were 24 Single Assessment Process workshops (8 Joint with Southern Cluster). The workshops involved 70 staff from health and social care agencies across London and the South and an older person from Tower Hamlets.
- A series of 12 field visits were also undertaken – to social services, GP surgeries, clinics and the acute sector - another 20-30 staff consulted.
- Social Services were heavily involved in this work alongside health colleagues.
- The Review process produced a total of 777 comments/questions from professionals, many of which were addressed.
- The major product of the work was the SAP Best Practice diagrams with supporting documentation that was produced in March 2005 to drive the development of the Care Records Service IT so that it meets the requirements of the system users.

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

C. Methodology

- The SAP DOAS project followed up on the London and Southern Best Practice Process Design material, using it as a basis for its work. It was distributed widely through the clusters.
- Comments were received in advance of and during a care pathway workshop. This workshop tested the Care Pathway with real cases, but in parts rather than as a whole (ignoring Information Governance issues, since these are constraints to be added by individuals themselves).
- 70 people at the Care Pathway workshop on the 13.12.05 (including core process group and helpers), raised 337 issues (although a few were duplicates).
- A core process group from clusters and centre (but primarily cluster people) was established to make decisions and revise diagrams.
- Core process group brought out the major issues, and wrote concept papers – for approval first in the core process group, and then in the main group.
- The final material will be put on the Centre for Policy on Ageing website for further consultation.

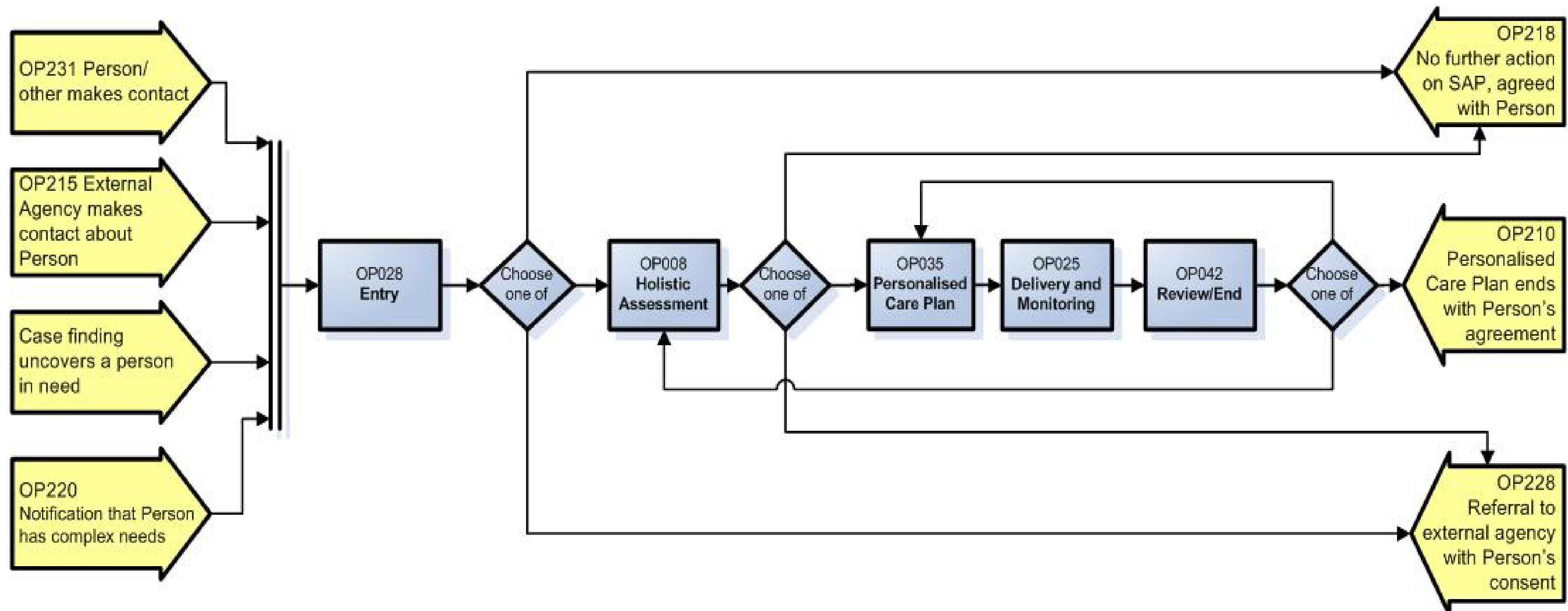
D. SAP High Level Diagram

SAP Best Practice Process Design Diagram – High Level

Throughout this process, the emphasis is on supporting the person; encouraging their participation, control and self support/care/management. Accessible information should be available for the person throughout the process; not least at the beginning.

The person's ongoing engagement in assessment (including self assessment), planning, delivery, monitoring and then reviewing their own support/ care is seen as critical. Urgent care can be accessed at any time.

The carer is not shown on these documents to avoid multiple lines. Again, their role is critical, and their needs should be addressed in the same way as the person's (and separately, if they so desire).



E. Findings/Table of results

Deliverables	Summary of Key Findings
Deliverable 1 Restate the vision for SAP which will continue to evolve (Also covered by Sub–Group 4)	The Single Assessment Process (SAP) was first mentioned in Standard 2: **Person Centred Care** in the NSF for Older People. Then came the SAP guidelines in January 2002, **“The DH stages of the single assessment process are:** • Publishing information about services • Case finding (optional) • Completing assessment – the four types • Evaluating assessment information • Deciding what help should be offered, including eligibility decisions • Care planning (leading to service delivery) • Monitoring and review” There have been times over the past 4 years when SAP has been viewed incorrectly as only an assessment tool, or 4 types of assessment, or an electronic system**.** However, as we have seen from the original guidance, the Single Assessment Process always was supposed to be a person centred, health and social care framework – entry into service, holistic assessment, personalised care plan, care delivery and review/ending (as outlined by the London/South Best Practice work and confirmed by the SAP DOAS work). Please see **D SAP High Level Diagram.** SAP was timetabled to be fully implemented by March 2004…Although progress was made this did not happen, impetus started to fade in many areas. SAP has tended to be a ‘bottom up’ approach, with the commitment of staff within health and social care (in the widest sense) in localities the greatest positive driving the integrated working agenda. SAP is already being used for other adult groups as well as older people in many localities. It links, complements and is enhanced by other key areas of policy. For example, Long term Conditions, with its emphasis on supported self care / self management, personalised care plans and using case management to provide care for individuals with complex needs. (please see **Deliverable 6**)
Deliverable 4 Describe a high level care pathway for SAP that can be agreed as a national standard with localisation areas identified (Also covered by Sub–Group 4)	Please see **B. Summary of previous work in the field** ▪ Discovered just assessment is not enough – have to deal with the complete care process for individuals. ▪ Highlighted 5 main areas: entry, holistic assessment, personalised care plan, delivery and monitoring and review (also ending). Please see **D. SAP High Level Diagram.** ▪ Person centred, based on holistic assessment and the individual’s integrated personalised care plan (emphasised in the latest White Paper). ▪ There is widespread agreement to a high level process, although documenting the process seems insufficiently person-centred. Please see revised **Care Pathway Diagrams** in Visio software (but without textual material) and also the accompanying **Spreadsheet** with material and answers and questions to the 337 issues http://www.cpa.org.uk/sap Also see DOAS SAP papers: **Beginnings and Endings**, **Coordination**
Deliverable 5 Identify current information flows	Informal feedback from health and social care staff is that many areas are still held back by using paper systems. Where there are no computer systems, sharing can be very limited. The fact that many interim electronic solutions are still not fully

between organisations Also covered by Sub–Group 2 and 4)	integrated is also a problem. Contributing factors include the lack of clarity about timescales, social care interfaces, support for assessment tools and migration plans with LSP strategic solutions.
Deliverable 6 Describe a vision for SAP (Also covered by Sub–Group 4)	From the, *White Paper, Our health, our care, our say: a new direction for community services, Chapter 5, - Support for people with longer-term needs*, January 2006, "We have already developed a Single Assessment Process for older people's services. Work is underway to **build on this to develop a Common Assessment Framework for Adults** to ensure less duplication across different agencies and allow people to self assess where possible." "An integrated health and social care information system for shared care is planned as part of the NHS Connecting for Health strategy. It is an essential requirement for effective care co-ordination." "An integrated health and social care information system will enable a shared health and social care plan to follow a person as they move through the care system" **(Note:** this should show the underlying commitment to engaging individuals and their carers in their own support/care and the choices around it). "We will ensure that, ultimately, everyone who requires and wants one has a **personal health and social care plan** as part of an integrated health and social care record. Initially we will focus on offering integrated care plans to those individuals who have complex health and social care needs." "By **2008** we would expect everyone with both long-term health and social care needs to have an integrated care plan if they want one. By **2010** we would expect everyone with a long-term condition to be offered a care plan. We will issue good practice guidance early in **2007.**" It is worth noting the influence that Long Term Conditions and Case Management (with its emphasis on self care/self management) has had in health and, in social care, it is likely that the ethos of self directed support and the growth of resource allocation to people through individual budgets will have great significance over the next few years (from 'care' to 'support'?). Please see **D. SAP High Level Diagram** and DOAS SAP papers: **Beginnings and Endings, Coordination, Medicine and Care, Specialist Assessments, SAP and Two People with Needs, Current Summary Record.**
Deliverable 7 Identify likely information flows between organisations and identify gaps in the current OBS(covered also by Sub–Group 2)	Please see DOAS SAP Paper **Beginnings and Endings** An individual may receive health care throughout their life, and the information from this may build up into periods of more complex support/care, not least if an individual has one or more Long Term Conditions. Social Services involvement is usually only required for set periods or episodes of time – and people do not receive this social services input during these episodes unless they meet eligibility criteria (a legal requirement). Information technology can support the build up of information during an individual's life, but the transition to more complex multi-professional or multi-agency support/care may need to be clearly defined - in order to identify who we communicate with and who is supporting the individual and coordinating the delivery of this complex support/care The proposed Common Assessment Framework (CAF) for Adults building on the Single Assessment Process (SAP) may encompass all levels of need. However, the triggers for identifying the transfer from simpler to more complex support/care, often through a GP (when there is substantial impact on the individual's functional

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<tr><td></td><td>abilities affecting an activity of daily living) are important, not least to ensure greater co-ordination between services.

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

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

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

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

It seems likely an assessment in line with the proposed Common Assessment Framework for Adults will also cover a number of pre-defined domains in order to take a holistic view of an individual's circumstances.

Since the care delivery following a holistic assessment could cover a number of health care services and all of social care, it is unlikely that agreement can be reached on all the data items between the different constituent players.

Sharing may best be handled on the documents that naturally form part of the process: the contact assessment, the overview (or comprehensive) assessment (or its summary of risks and needs), any specialist assessment, the care plan, the review document, also any referrals. Alongside this there needs to be mutual updates of changes to demographics or allocated workers.

See also DOAS SAP Papers **Coordination, Medicine and Care, Specialist Assessments, SAP and Two People with Needs, Current Summary Record.**</td></tr>
<tr><td>**Deliverable 8**
Review current use of datasets for SAP, such as the Current Summary Record and consider its usefulness in field (Also covered by Sub–Group 2 and 4)</td><td>The Current Summary Record appears to have limited usefulness, and there are some theoretical problems with datasets in elements of SAP.

Please see concept paper, Annex 6: **Current Summary Record** for details.</td></tr>
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Deliverable 10 Identification of training needs - building on the competencies framework (Covered by all sub-Groups)	Who undertakes coordination can be examined in light of the recent Joint White Paper's recommendation that, "by 2008 it is expected that all PCT's and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs." Attention should be drawn to Competencies Frameworks being developed for Health and Social Care - Skills for Health and Skills for Care and in, particular, the Community Matron and Long Term Conditions Case Managers Competence Framework which is currently (from March 23rd 2006) being evaluated http://www.skillsforhealth.org.uk/viewnews.php?id=43 Please see also DOAS SAP Papers **Beginnings and Endings** and **Coordination**
Deliverable 11 Consider areas currently out of scope for further work streams	As a shared process, with joint work, there must be joint electronic methods of sharing information through linking systems effectively.

F. Analysis

- Concept/Exploratory papers – list and conclusions where not documented below

G. Interdependencies with other groups/professionals

- Regular contact with other SAP DOAS sub-groups. Particularly with Jan Hoogerwerf and another part of the project – learning from existing e-SAP implementations.
- Visits to other DOAS projects workshops including Keith Strahan attending 'Complex Conditions in Later Life', 'Care Pathway' 'Learning Disabilities' and Mary Riches attending 'Falls'.
- It was noted that at the SAP DOAS Care Pathway conference that the existing London/Southern care pathways maps were fine examples of a care pathway.
- Keith Strahan has since communicated with DOAS projects leads Dee Harrington (Care Pathway) and Dr David Lyon ('Complex Conditions in Later Life'). There are clear links with 'Complex Conditions in Later Life' DOAS project. There is a willingness to work together in future.
- Richard Allen communicating with Learning Disabilities Lead Jacqui Howard.
- Keith Strahan attended 'In-Control' Individualised Budgets conference on the 9.3.06.
- Long Term Conditions – Keith Strahan met with LTC national leads at Richmond House on the 22.12.05.
- Keith Strahan attended DH White Paper meeting on the 3.12.05.
- Ian Swanson communicated with colleagues in ADSS.
- All linked to work led by Seamus Bream, Sara Bird and Matthew Fagg.
- Each of the cluster representatives had contact back with cluster groups on SAP.
- Because SAP is a generic process, all areas of complex multi-professional and multi-agency care in the community should potentially use the same process.

H. Conclusions and Recommendations

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

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

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

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

Deliverable 8 Review current use of datasets for SAP, such as the Current Summary Record	• There is limited use of a common data set: some locally defined common data sets were found. The Current Summary Record - SAP (CSR) is not frequently used unless it is available in electronic form. • There are doubts about the coding of the support/care elements of the current dataset for information sharing purposes • A link between the SAP dataset and other datasets was not explicit. • We need to move from sharing something created artificially, the Current Summary Record, with no clear timing to share (and therefore potentially lacking currency) to sharing items naturally created as they happen, and especially the items (like the personalised care plan) which are shared with the individual (and might typically be found in their person-held record). • These items typically made up the Current Summary Record, but were reduced in it to limited codes in the NHSIA dataset. • Within these items, there is the need for a medical summary highlighting current conditions and their treatment, and any major matters of history.	• Move from the concept of a current summary record to the sharing of the following items between systems, as they happen or as they are compiled, and define the content (which may be free text in some circumstances): ❖ **Medical summary** ❖ **Basic Personal information** ❖ **Event details of all assessments and their conclusions (and potentially access to them)** ❖ **Allocated professional/care team details** ❖ **Integrated Care Plan** ❖ **Referrals** ❖ **Consent:** above to be shared with individual's informed consent.
Deliverable 10 Identification of training needs	• There are still differences across health and social care, especially in terms of vocabularies, joint working attitudes and cultures. • The question as to who can undertake coordination should be examined in light of the recent White Paper's recommendation that, "by 2008 it is expected that all PCTs and local authorities will have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs."	• There is a necessity for clarification about Care Management/Case Management roles in light of the White Paper. **Link to proposed Common Assessment Framework developments.** • There should be a combined Competency Framework (with the acknowledgement of each disciplines specialist area). Attention should be drawn to Competencies Frameworks being developed for Health and Social Care - Skills for Health and Skills for Care and in, particular, the Community Matron and Long Term Conditions Case Managers Competence Framework which is currently (from March 23rd 2006) being evaluated http://www.skillsforhealth.org.uk/viewnews.php?id=43 **Link with Skills for Health and Skills for Care.** • Continue to address cultural change towards greater joint working. There must be a properly resourced joint training plan in each 'locality'. **See Above.** • The requirement for a responsible professional /

		named contact (not necessarily a qualified worker) to support individuals with their lower level needs will also need definition. **Link to proposed Common Assessment Framework developments.** • A shift to 'signposting on' in health and social care rather than 'screening out' is essential, not least when eligibility decisions are made. **Link to proposed Common Assessment Framework developments.** • Examine how IT enables an individual take control of their own life; including coordinating and managing their own health and social care support. **This has implications for HealthSpace.** • What access will individuals have to their electronic 'case' file in the future– not least their integrated care plan? **Part of next phase of DOAS project.**
Deliverable 11 Consider areas currently out of scope	As a shared process, with joint work, there must be joint electronic methods of sharing information through linking systems effectively.	

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

Sub-Group Membership

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