



Document Title

SINGLE ASSESSMENT GUIDELINES, Single Assessment Process (SAP)

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1. Introduction and Background

As many colleagues will be aware, the Single Assessment process was prescribed by the National Service Framework for Older People (HSC 2001/007 & LAC (2001) 12 and is to be fully implemented by April 2004. It applies equally to Health and Social Services.

The expectation is that agencies will work in partnership to produce co-ordinated, person-centred and effective care planning, bringing about convergence of the current multiplicity of assessment methods.

Implementation of the single assessment process will mean re-iterating and in some contexts, implementing a procedural framework to ensure clear assessment practice and to expedite data sharing between professional staff.

The key ethos is that older people give the information once and that it is shared across professional and agency boundaries.

This document has been drafted in response to a need to re-issue agreed guidance notes about its meaning in practice, which documents to use and how information flows. The aim being to describe reality, not aspirations, for example, information flows currently include telephone contacts, conversations and paper information flows.

IT

Although at the time of writing, (December 2003) there are plans for electronic exchanges of information; Cumbria CC is working with Morecambe Bay PCT and the Strategic Health Authority towards a single set of assessment tools and electronic solution, technical capability has yet to be put in place and protocols agreed. Single assessment capability will undoubtedly be powerfully enhanced when IT solutions are implemented, but the clarification of existing procedures is not to be delayed pending IT developments.

Dissemination

This guide is to be accompanied by briefings for all Health and Social Services staff. Many of whom it is acknowledged, will have already been working together as aligned teams for some time. Health and Social Services staff will deliver the briefings jointly.

This guide will be reviewed and updated as necessary as care communities evolve, to ensure that no care groups are excluded and that it complies with future guidance.

This guide and programme of training will be available on the Cumbria County Council website and Morecambe Bay PCT website or with a link from the MBPCT website to the Cumbria County Council website.

2. Scope of Guidelines

Single Assessment is the process under which agencies will work in partnership to produce co-ordinated, person-centred and effective care planning.

The care delivered under Single Assessment will be no different to the present care offered to service users and patients and this care may be provided by NHS and/or Local Authority Social Services in a variety of settings, including a person's own home.

This document refers to what the process means in practice; individual partner agencies will have in place more prescriptive guidance as to their own tools and protocols. (Such as the detailed Cumbria Social Services Single Assessment Guide) It is not the intention of this document to re-write individual agency's own practice guidance. Its scope will be the how and when of information exchange, at the interfaces between agencies and promotion of a framework to facilitate convergence of assessment methods.

Newly inducted staff should refer to the practice guides and protocols of their respective agency.

The scope of these guidelines refers to the single assessment process and the implementation of the procedural framework, which ensures non-duplicated assessment practice and aims to ensure efficient data sharing across professional boundaries.

The overarching concern of the Single Assessment process relates to Older People and is prescribed by the National Service Framework for Older People (HSC 2001/007 & LAC (2001) 12, this is the main focus of this document. It is envisaged that the care of adults (over eighteen) with physical disabilities and those with chronic Health and Care needs will be managed similarly. Staff managing the needs of Adults with Learning Disabilities will have a separate protocol; staff working with people in contact with specialist mental health services will refer to the Care Coordination (CPA/Care Management) and Single Assessment Process (SAP) Protocol.

3. Relevant Legislation and National Policy Guidance

KEY IMPLICATIONS FOR OLDER PEOPLE

The single assessment process was outlined in the National Service Framework for Older People (Department of Health, 2001), and details for local implementation are given in further guidance (Department of Health, 2002). The single assessment process applies to health and social services, having been implemented from June 2002. It recognises that many older people have health and social care needs, and that agencies need to work together so that assessment and care planning are person-centred, effective and co-ordinated. Implementation will ensure that:

- the scale and depth of assessment is in proportion to older people's needs,
- agencies avoid duplication of assessments, and
- professionals contribute to assessments in the most effective way.

Older people are the most important participants in single assessment, for two reasons. First, the assessment is about them. Second, the greatest experts on their situation are usually the older people. They will know when they are having difficulties; their nature and what might be done to resolve them.

To enable them to contribute fully in the single assessment process and make informed choices, older people should be given information about access, assessment, services, charges, and complaints procedures - in accessible formats. Much of this information should be provided in local "Better care, higher standards" charters, which apply to local health, social services and housing services, from whom copies can be obtained.

Older people should expect respect and courtesy from health and social care professionals who are helping them. They should expect assessments of their needs to begin with their perspective and for their views to be kept to the fore throughout the assessment, care planning and service delivery. They should expect assessment to focus on their needs and on the strengths and abilities they can bring to bear in addressing these needs the assessment should help them achieve maximum possible independence. Assessment should take account of support older people receive from family members, relatives, friends and neighbours, and the needs of these carers.

Older people should feel confident in taking the lead in their own assessment, and help to complete some of the official assessment forms if they choose. To help them do this, where possible, agencies should prepare individuals for the assessment, letting them know what issues are to be covered and in what way. Older people should feel confident in requesting and being offered translation, interpretation and advocacy services, or specific communication equipment, to help with their assessment. Health and social care services should ensure that translators and interpreters are accredited, and that advocates are both competent and independent of statutory services.

Older people should be able to provide information about their needs and circumstances privately and confidentially. They should be aware that information about them may be shared with other professionals and agencies, and their consent to this sharing should normally be obtained.

Older people should expect to be involved in all decisions about their needs and subsequent care, and to be notified of key decisions in writing or other suitable formats. All older people who subsequently receive services should have a care plan. Where needs are low and a single service is provided, the care plan will amount to a simple statement of services. Where needs are more complex, the care plan will be fuller. All care plans should include the reasons for providing help, the objectives, and a review date.

Older people should expect their needs and services to be reviewed at regular intervals. As a minimum, first reviews should be carried out within three months of services starting; further reviews should be carried out annually. Older people should play a full and active part in such reviews, and may request reviews in advance of a scheduled review, should the need arise.

Older people should know who to contact and what to do if they feel they have been unfairly treated, or when they wish to challenge decisions, or if things go wrong or crises develop. Information on these matters should be included in local "Better care, higher standards" charters, and in individual's care plans. No older person should feel reluctant to complain for fear of reprisals by professionals or withdrawal of services by agencies. No older person should be unfairly discriminated against on account of their age, sex, race, lifestyle or other factors.

4. Shared Values and Principles

Introduction

Standard Two of the NSF for Older People (Person Centred Care) aims:

“To ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and Social Service boundaries”.

(National Service Framework for Older People – Executive Summary page 8)

Health and social services organizations are being asked to develop a Single Assessment Process (SAP) for the integrated provision of services for older people in their localities.

The purpose of Shared Values and Principles

This document sets out a number of shared values and principles across agencies, seeking to provide a foundation to understanding of the Single Assessment Process in South Cumbria.

The importance of Shared Values

The SAP Guidance for local implementation states *“Single Assessment Process will promote better care services and better outcomes for older people, and more effective use of professional resources,”*

SAP aims to ensure that different agencies and professionals will work in a more co-ordinated manner to the benefit of older people. It is therefore important for all agencies contributing to the SAP to understand the contribution each respective profession makes, to the assessment and service delivery process, including the contribution of users and carers.

Values are important, because they are foundational to respective practice and how it is performed on a daily basis.

The Guidance highlights a *‘person centred approach’* as a critical attribute of SAP. To enable agencies and professionals to develop a single assessment process, which aspires to improve outcomes for older people; a mutual understanding of values and desired outcomes through respective contributions is essential.

SINGLE ASSESSMENT PROCESS SHARED VALUES

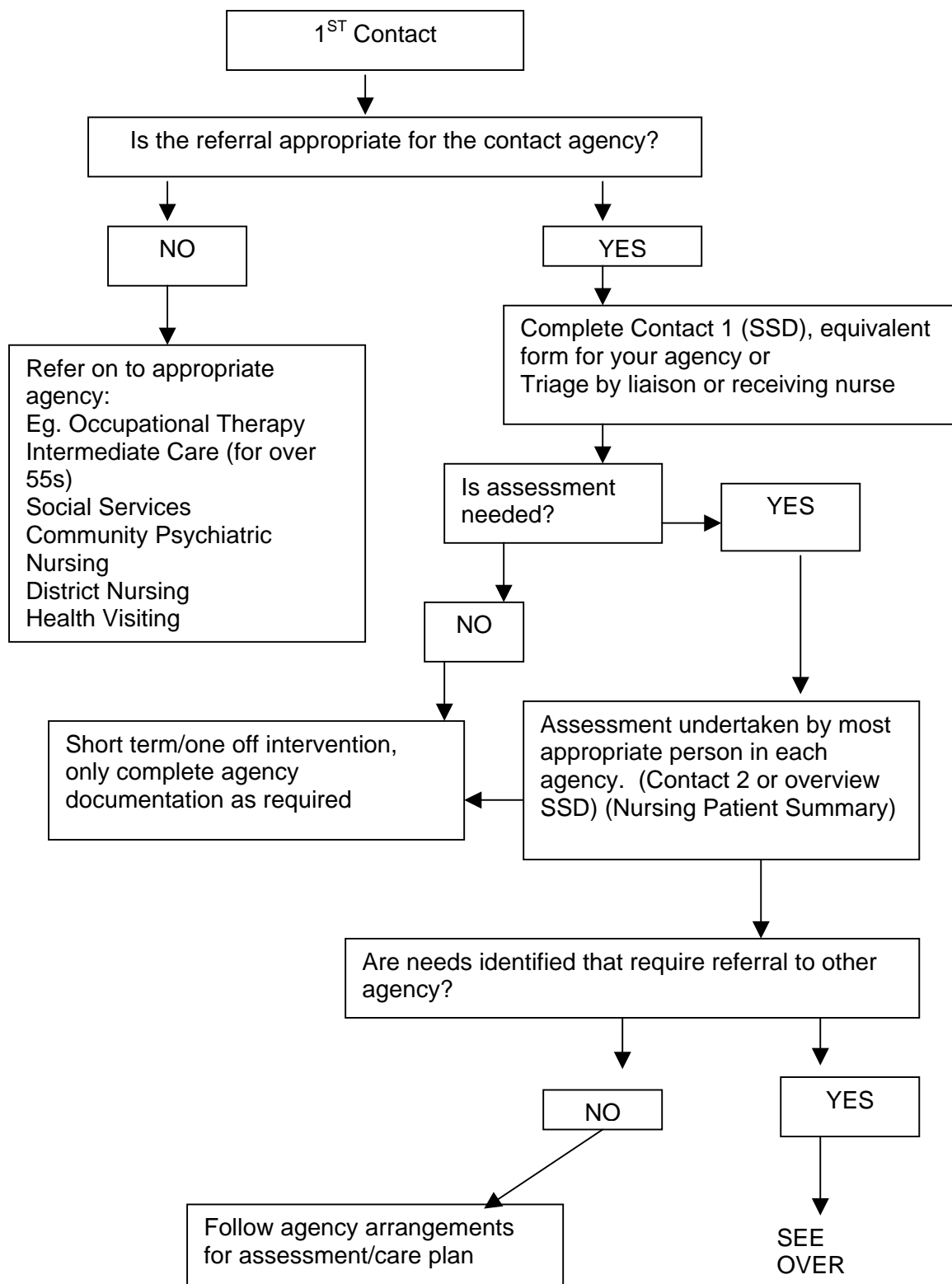
Core Values

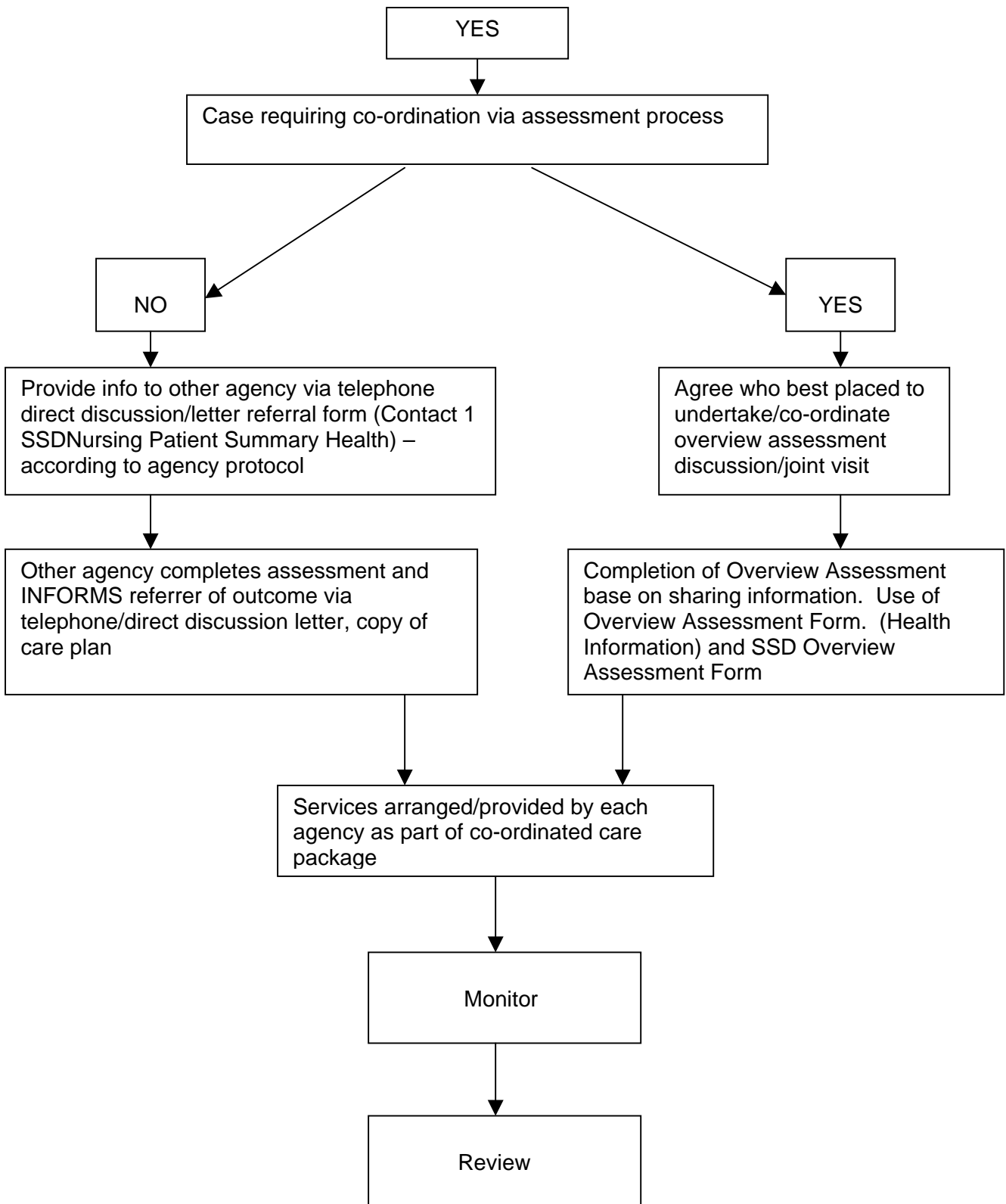
- Respect self-determination of the individual.
- To ensure that all service provision is perceived by the user to be one package of care, under SAP.
- Informed consent being an essential pre-requisite to each component of the care package.
- Age alone, should not determine service eligibility or access.
- Where an individual older person lacks capacity to give their agreement, agencies should have procedures in place to enable the maximum level of participation and safeguard the older person's interest.
- The single assessment should promote individual health and well-being and optimise independence.
- Service information should be understandable and accessible.
- Professionals should be competent to work with older people and should be active in Continuing Professional Development.
- All staff will promote good practice and adhere to legal requirements, standards of practice and confidentiality.
- Communication will be honest, open and comprehensible.
- SAP will seek recognise the whole picture of individual needs.

5. FLOWCHARTS AND DESCRIPTION OF SINGLE ASSESSMENT PROCESS

CO-ORDINATION OF ASSESSMENTS (CONTACT AND OVERVIEW)

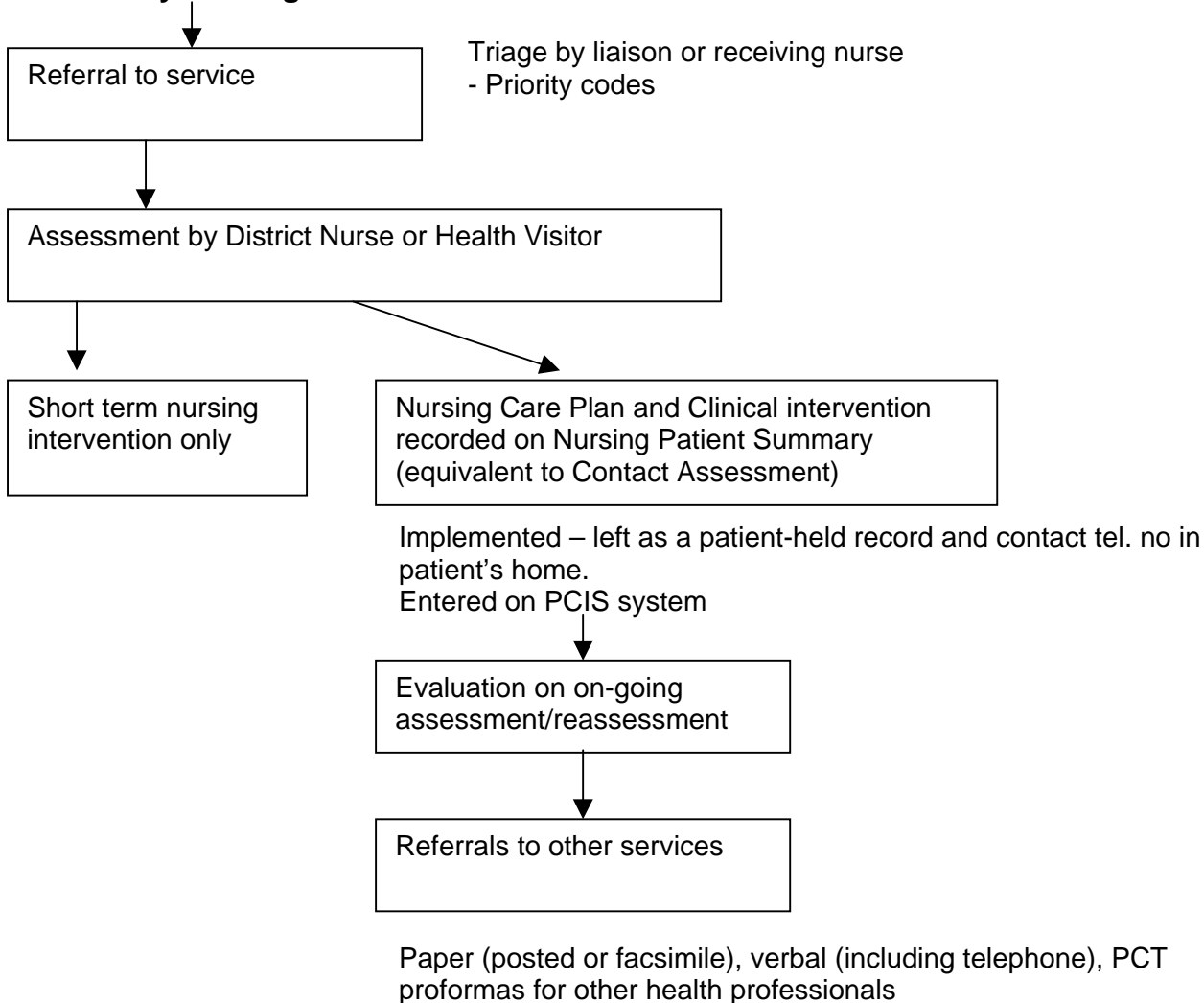
Good practice dictates that the Contact 2 and Overview Assessment remains with the service user, in the shared folder, for ease of access between all agencies to avoid duplication, subject to service user consent.





**CO-ORDINATION OF ASSESSMENTS IN MENTAL HEALTH
(CONTACT/OVERVIEW/COMPREHENSIVE/SPECIALIST) – as described in CPA/SAP Protocol**

Community Nursing



Referrals are made at end of the visit list

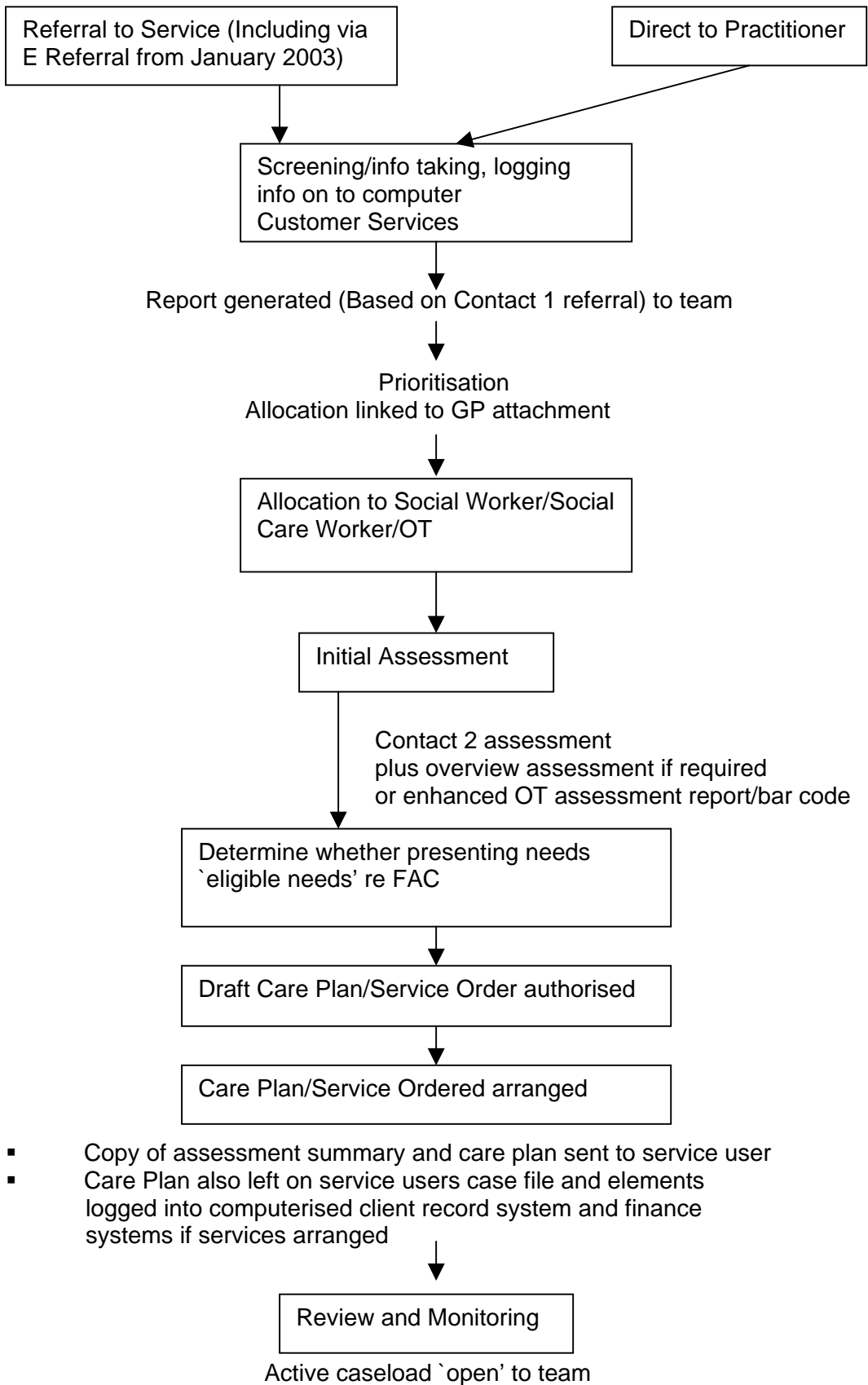
Summary

Paper assessment – Nursing Patient Summary

Paper Care Plan

Computer – PCIS – record referrals, risk assessments

SOCIAL SERVICES



For examples of how different agencies link to the process see Appendix 1

6. Information exchange (prior to an IT solution)

At the time of writing, (December 2003) there are plans for electronic exchanges of information; Cumbria CC is working closely with Morecambe Bay PCT and the Strategic Health Authority towards a single set of assessment tools and an electronic solution. Technical capability has yet to be put in place and protocols agreed. Single assessment capability will undoubtedly be powerfully enhanced when IT solutions are implemented, but the clarification of existing procedures is not to be delayed pending IT developments.

The intention, reflected by most current practice, is that respecting confidentiality conventions, information will flow between agencies, carers and service users, on a 'need to know' basis.

Current arrangements

Community Nursing need only

Managed by Community Nursing

Social Care Needs only

Managed by Social Services

No routine info exchange – no need

At contact

- If Social Services (Customer Services) receives contact and identifies person has health need only – patient/carers is advised to contact GP direct.
- If Community Nursing/GP receptionist etc receive request for advice/info about a social care service then patient advised to contact SSD direct
- Where patient/service user is being seen by a Social Worker/Community Nurse/OT etc

Either on first visit or after a number of visits, professional identifies potential need for referral to other agency.

Information is shared between professionals via:

telephone

letter

facsimile

face to face discussion

transfer of agency `contact/patient summary form

E Referral (from January 2003)

use of formal referral forms (PCT) by Community Nurses to other health professionals (e.g. Physio)

- For ongoing cases involving both health and social services

Information routinely exchanged via:

Telephone
Letter
Facsimile
Face to face discussion

The intention is that practitioners have sight of a copy of the nursing assessment/care plan, social services assessment/care plan, usually left in the patient's home. This practice is not yet universal. Care plans and the assessment if requested, are to be left in the Health and Social Services shared file.

Where Social Services is undertaking an overview assessment, requiring information about an individual's health care needs, the Social Worker will complete the relevant section of SSD form, based on information obtained from the service user, family, and community nurse (by face to face discussion/telephone). Alternatively Social Worker can ask for and receive copy of nurse's overview assessment form.

For assessments regarding nursing home care. Information sharing will be via use of Social Services Contact 1 and 2 plus MBPCT Nursing determination form. Together, both constitute an overview assessment.

Pending introduction of computerised systems to exchange info under Single Assessment, the arrangements outlined above remain essentially the same. Info is still communicated via telephone, face-to-face contact and discussion, letters and use of each agencies own referral/Contact 1 forms (which are becoming Single Assessment compliant re. info recorded).

Specialist mental health services.

Information exchange is as described in the Care Co-ordination (CPA/Care Management) and Single Assessment (SAP) Protocol.

7. Links with Care Programme Approach

When older people are referred for assessment of their mental health needs to specialist mental health services, it is vital that continuity of care and support lies at the heart of both the referral process, and of any subsequent care and treatment provision that is agreed as appropriate.

Single Assessment, as a process of assessing, planning and reviewing, needs to be aligned with the mental health Care Programme Approach processes of assessment, care planning and review, as prescribed by the NSF related guidance 'Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach'. 1999. As well as sharing similar process elements, SAP and CPA share as well the core values of a person centred approach to the delivery of interventions and services in a needs led way.

Specialist mental health services will provide the equivalent of 'comprehensive' and 'specialist' level SAP assessments, as described in the national SAP guidance, delivering the accompanying care and treatment at the levels of either Standard or Enhanced CPA, as described in the national CPA guidance.

More detailed guidance on the pathway between SAP and CPA is described in the separate 'Care Co-ordination (CPA/Care Management) and Single Assessment Process (SAP) Protocol'.

8. Glossary of Terms

Definition of Terms for use in the Single Assessment Process by Health and Social Care Providers

Accessibility	A measure of ease/difficulty with which patients/clients are able to obtain a service
Advocacy	The expression of a client's wishes and concerns by a third party
Agree	When service user and professional mutually accept to proceed on a particular course of action, whilst acknowledging any differences in opinion
Assessment	A way of determining levels of need
CSSD	Cumbria Social Services Department
Care	Provision of Service/s for those unable to provide for themselves
Care Co-ordination	Is when one person (e.g. a Nurse or Social Worker) has overall responsibility for ensuring that the actions agreed in the Care Plan are delivered in an effective and efficient manner
Care Co-ordination (mental health)	System for the delivery of care and treatment in specialist mental health services (Care Programme Approach and Care Management).
Care Pathway	The route taken by a service user through the care process from point of referral to completion of care
Care Co-ordination Pathway (MH)	Route taken by the service user and carer through the care and treatment processes in specialist mental health services from point of referral to completion of care.

Care Plan	Is a set of actions and tasks which need to be carried out to address the needs identified in the assessment
Care Worker	A person who cares for the wellbeing of a person unable to function alone and receives payment for doing so
Carer	An unpaid person who cares for the wellbeing of another person unable to function alone
Client	A person in receipt of any health or social care service/s i.e. a patient or service user of those providing the service/s.
Common	Something normal, occurring often
Complex Needs	A term used by professionals to describe someone who requires the support of a number of professionals/individuals to meet the needs identified in the Care Plan
Confidentiality	The handling of clinical or social information in which a patient may be identified. Where only relevant and necessary parts of that information are shared between providers of care and the permission of the client/patient is obtained in advance
Contact One	The Initial form on which assessments are recorded and referrals made.
Contact Two	The level of assessment documentation above Contact One
Criteria	A set of rules/regulations, which determines whether or not a person has access to a service.
Effectiveness	A measure of the relative success or otherwise of a package of care or treatment regime to meet a client's needs
Eligibility	The satisfaction of the criteria governing the receipt of a service or services

Empowered	When patients/clients feel that they have control over their lives
Enabling	Helping to achieve and opening up possibilities
Ethos	The cultural environment which influences how services are provided
Goal Setting	Agreeing a set of targets to achieve desired outcomes
Level of Assessment	The depth and range of relevant information, which is required to be gathered in each case. This would determine whether assessment is simple, short term or more complicated
Measures	Steps that someone takes to achieve a particular outcome
Needs	The physical, social, psychological, spiritual and emotional requirements of a patient/client which a care package should be designed to address
Needs Led	Where the delivery of services to individuals are based on the agreed needs of the patient/client
Open Access	Where there are no limitations to the route in the service
Outcome	The result of a course of action in health/and or social care in respect of an aspect of a service user's or carer's life e.g. morbidity, quality of life of a patient/client
Palliative Care	Services that are provided to enhance the quality of life of people with chronic and terminal conditions

Person Centred Care	Care which is sensitive to the wishes and perceived needs of the client
Quality	Is the perception of how good (or bad) a service in relation to a set of standards
Rehabilitation	The return to optimum health and independence in the community or elsewhere
Risk	Potentially harmful factors which must be weighed against benefits when choosing a course of action
SSD	Social Services Department
Service User	A person who is in receipt of any health or social care service/s i.e. a patient or client of those providing the service/s
Value	How much worth you attribute to something

Key

Terms as agreed at MB LIT Implementing Single Assessment Task Group 14th August 2003 and subsequently augmented by task group and inter-agency consultation.

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Appendix 1

Examples of engagement with the Single Assessment Process from different agencies

A non-exhaustive list of examples of how allied health professions engage via the Single Assessment Process follows below, not in order of priority:

Allied Health Professions

Application of The Single Assessment process, to patients over 18 years of age is currently limited to the referral having been made to physiotherapy on the Contact One form.

Community Psychiatric Nursing:

Have received documentation and considered feasible to utilise in practice. Nurse Consultant looking at developing training sessions for staff prior to roll out.

District Nursing and Health Visiting:

Contact One form, or SAP compliant equivalent (Patient Summary), being used as a referral to other agencies with exception of Hospice at Home/PCANN/ Marie Curie services, as specific information pertinent to these services is required on referrals.

Contact Two and Overview assessment are used alongside Roper and Tierney's Activities of Daily Living Assessment Tool and individualised assessment tools, according to patient need.

Intermediate Care (South Cumbria) Service

Intermediate Care Service, at present offers a service to all residents of South Cumbria aged 55 years & over.

The South Cumbria Intermediate Care Service uses the single assessment process for all work in & through the service. Referrals to the service use the contact 1 referral documentation, together with contact 2 initial assessment, if the referring agency has completed an assessment prior to referral to Intermediate Care.

At the end of the Intermediate Care episode, the single assessment process is used to transfer the current information to a follow-up agency, transferring the single assessment documentation (overview or contact 2), together with discharge information to the relevant agencies.

Service Users have documentation within their own home with assessment, care & treatment plans & diary recordings. These records are shared with other services as the service user directs.

Contact One and Contact Two information is left in patients home in a folder.

Occupational Therapy

The Single Assessment process applies to adults eighteen to death. The Contact One form being used as a referral to other agencies. The Contact Two is completed on assessment of client/patient alongside current Occupational Therapy specific assessment documentation.

Social Services:

Contact One is completed at time of referral to Social Services by admin support. A computer printout is then forwarded to the Care Manager taking the allocation. This can be circulated to other professionals contacting SS to establish if 'case open' or making a referral.

Referral pathway for Social Services has been put together for other professionals to clarify terminology and process used. Contact Two and Overview are completed on assessment of needs. They are not routinely left in service users homes due to bureaucratic sensitivity of information.

Information on contact 2 form (ethnic origin) is a mandatory requirement for Social Services that is required for data returns. This must be completed by the assessing individual therefore it is on contact 2 not contact 1 forms.

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