APPENDIX 1

FINAL DRAFT APRIL 2005

SINGLE ASSESSMENT PROCESS

LOCAL PARTNERSHIP

POLICY DOCUMENT

2005

Darlington Borough Council

Darlington Primary Care Trust

County Durham & Darlington Priority Services Trust

County Durham & Darlington NHS Acute Trust

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Darlington Borough Council and Darlington Primary Care Trust
Policy for Single Assessment Process

1. Introduction

The Single Assessment Process (SAP) was outlined in Standard 2 of the National Services Framework (NSF) for Older People (Department of Health DoH 2001). Guidance on implementation was provided within the Health Service Circular HSC 2002/001 and Local Authority Circular LAC (2002) 1 and applies to both health and social services. SAP recognizes that many people have health and social care needs and that agencies need to work together so that the assessment and care planning are person centred, effective and coordinated. Locally the Community Strategy (Darlington Partnership 2003/2004) outlines the vision for building a better future for Darlington through a partnership with local people and organizations. A major themed goal within the Community Strategy is ‘A place for living safely and well’, which will be achieved through partnership working with core agencies to improve the public health and well-being. This policy underpins both national and local goals and objectives.

This policy has been reviewed in accordance with the Human Rights Act 1998 and requirements of the Race Relations Act 2000 and Darlington PCT & Darlington Borough Councils Equality Impact Assessment Protocol. The policy is unlikely to breach human rights and the potential for discrimination is very low or non-existent.

2. Policy Statement

Darlington Borough Council and Darlington Primary Care Trust are committed to and support the joint implementation, delivery, monitoring and review of the Single Assessment Process as defined by the DoH Single Assessment Guidance LAC (2002) 1, HSC 2002/001.

3. Scope

This policy is intended for use by all health and social care staff, employed by Darlington PCT & Darlington Borough Council, including Primary Health Care Teams, Social Services Community Assessment Teams, the Discharge Management Team based in Darlington Memorial Hospital (DMH), and acute trust staff, engaged in the assessment, care planning, delivery, monitoring and reviewing of services. See Appendix 1 – Key Implications, for details of professional roles and responsibilities.

SAP will apply to people who:

- live in the Borough of Darlington and
- are registered with a Darlington PCT GP practice and
- are aged 18 plus with a Physical or Sensory Impairment and
- Older People, including those with a mental health need aged 65 plus.

3.1 People living outside the Borough of Darlington.

For those people who are registered with a Darlington PCT GP Practice and live outside the Borough of Darlington the single assessment process will be completed in relation to Community Nursing. If social service support is required the information will be forwarded to the appropriate Local Authority who will follow their locally agreed SAP.

3.2 People with Adult Mental Health and Learning Disability

For Adult Mental Health the Care Programme Approach will continue to apply and Care Coordination for Learning Disability. However for Community Health Services information will be shared between these services, supported by the SAP Information Sharing Protocol and Adult Mental Health and Learning Disability Information Sharing Data Flow Agreements.

4. Aims

Local implementation of SAP by health and social care systems will promote better care services and better outcomes for Older People, and more effective use of professional resources (LAC (2002) 1, HSC 2002/001). In order to achieve this SAP should ensure that:

- The scale and depth of assessment is kept in proportion to peoples needs
- Agencies and professionals do not duplicate each others assessments
- Professionals contribute to assessments in the most effective way
- It provides information to support the determination of the Registered Nursing Care Contribution for people who have nursing needs
- It provides information to assist in the decision making process for Continuing Health Care
- Supports the principle of informed consent with regard to information on a person's needs and circumstances that may be collected and shared.

These aims are underpinned by Annex A 'Key Attributes' defined in HSC 2002/001 and LAC (2002)1, please refer to Appendix 2.

5. Values

The Shared Values defined within Annex D of HSC 2002/001 and LAC (2002)1 have been adopted by Darlington Borough Council and Darlington PCT and underpin the principles of the SAP in Darlington, please refer to Appendix 3.

6. Definitions

- **Policy** – is a statement representing a principle or course of action adopted by Darlington Borough Council and Darlington NHS PCT. It enables management and staff to make decisions and take action consistently and effectively, in line with relevant legislation, guidance, national service frameworks, organizational rules and good working practices. *Compliance with relevant Policies is required from all permanent and temporary employees, contractors and sub-contractors.*

- **Protocols, Procedures, Guidelines, Work Instructions** – are agreed ways of working based on expert opinion, past practice, research and experience. They provide explicit step-by-step instructions to standardize systems, and describe how various procedures will normally be carried out. They may stand alone, or be attached as appendices to Policies, detailing how a specific policy will be implemented. *Compliance is required from all permanent and temporary employees, contractors and sub-contactors.*

- **Single Assessment Process (SAP)** – Is a framework that will ensure good person centred assessment practice by the professionals involved and will assist in the sharing of information between professions. It requires professionals to work to agreed principles, around best practice on assessment and care management. This process relates to first point of

contact, assessment, care planning, care provision, monitoring, review and closure.

Please refer to the SAP Glossary of Terms for further definitions see Appendix 4

7. Responsibilities

Darlington PCT Trust Board and Darlington Borough Councils Members/Scrutiny processes, are responsible for setting the strategic context and for the formal review and endorsement of this policy. These bodies are responsible for receiving, directly or through the appropriate committees/cabinets, periodic reports describing the implementation, risk and governance arrangements associated with particular policies.

The Director of SSD and The Chief Executive of PCT have overall responsibility and accountability for the Corporate Governance of their organizations. The Director of Primary Care PCT and the Assistant Director of Social Services, Adult Services, are the Executive Directors designated as the, accountable responsible officer for implementing the Single Assessment Process.

The Multi Agency SAP Steering Group is responsible for ensuring local implementation, monitoring and review of SAP.

All staff within Darlington Borough Council, including Discharge Management Team based in DMH, Darlington PCT, plus, temporary, agency, subcontractors and voluntary organization, with responsibility for implementing SAP are responsible for following this policy as part of their contractual duties and responsibilities.

8. Implementation Process

Please refer to separate SAP Contact and Overview guidance and Appendix 5a for SAP Learning and Development Framework and 5b for Implementation Schedule.

8.1 Information Sharing

Darlington SSD, PCT, County Durham and Darlington NHS Acute Trust and County Durham and Darlington Priority Services NHS Trust have all signed up to the County Durham & Tees Valley & North Yorkshire - Overarching Information Sharing Protocol Document No. DTY IST (December 2003). This is underpinned by the Local SAP Information Sharing Protocol and Data Flow Agreement, which complies with information governance requirements and will be adopted by all stakeholders covered by this policy, as a key requirement for SAP implementation. In addition Community Health Services information will be shared between Adult Mental Health and Learning Disabilities Integrated Services, supported by the SAP Information Sharing Protocol and Adult Mental Health and Learning Disability Information Sharing Data Flow Agreements.

8.2 IT & SAP

IT connectivity has been achieved locally through PCT Community Health utilizing the SSD Carefirst Database to store and retrieve information in support of the SAP. For further guidance relating to information governance and sharing information please refer to the Local SAP Information Sharing Protocol and Data Flow Agreement. Work is on going to achieve the following:

- Regional IT connectivity – in accordance with LPfIT
- National IT connectivity – in accordance with NPfIT

8.3 Integrated Multi Disciplinary Teams
Local stakeholders support the development and implementation of integrated working practices between health and social care through the development of revised roles and responsibilities and team definitions, resulting in integrated multi disciplinary teams.

8.4 Single Point of Access
Local stakeholders have agreed access points to SAP as follows:

- SSD – Central House
- PCT – Dr Piper House
- DMH – Discharge Management Team
- Intermediate Care Services – Hundens Rehab Unit re Health and
- Intermediate Care Residential Services – Independent Sector Providers
- Hospice and Macmillan Care – St Teresa's

As IT systems improve work will continue to achieve a single point of access across health and social care.

8.5 Integrated Commissioning
Local stakeholders support the principle of integrated services and continue to work towards achieving integrated commissioning to support person centred care.

9. Support, Monitoring and Review
The effective implementation of this Policy will ensure that the SAP as defined in DoH guidance is adopted as core practice across health and social care in Darlington. To support this Darlington Borough Council and Darlington PCT will:

- Ensure that all staff and stakeholders have access to a copy of this document.
- Make available the appropriate resources to implement this Policy.
- Ensure that staff, have the knowledge, skills, support and access to expert advice necessary to implement this policy and associated procedures.
- Monitor and review the implementation of this Policy through the SAP Steering Group initially and then responsibility will transfer to mainstream core services.
- Ensure that the policy is reviewed annually and if necessary make revisions in the light of legislative, guidance or organizational change.

10. Referenced Documents/Websites

DoH 2001 National Service Framework for Older People (NSF)
DoH 2002/001 Health Service Circular
DoH (2002) 1 Local Authority Circular LAC
DoH 1990 National Health Service and Community Care Act
HMSO 1998 Data Protection Act
HMSO 2000 Human Rights Act
HMSO 2000 Race Relations Act
DoH 2001 Fair Access to Care Services - Policy Guidance
Information on Referrals, Assessment and Packages of Care (RAP) in Adult Social Services - Data Collection
DoH Performance Assessment Framework (PAF)
DoH 2000 Carers and Disabled Children's Act
DoH 2001 A Practitioners Guide to Carers Assessment
Darlington Partnership 2003/04 Community Strategy
Darlington PCT 2004 IM&T Strategy
Darlington PCT 2004 IM&T Security Policy
Darlington PCT 2004 Consent Policy
County Durham & Tees Valley & North Yorkshire Overarching Information Sharing Protocol Document No. DTY ISP December 2003
Single Assessment Process – Darlington Locality Specific Protocol and Data Flow Agreement Governing the Exchange of Information between Health and Social Care Organizations – Draft April 2005
Darlington Borough Council and Darlington Primary Care Trust Single Assessment Process Contact Assessment Guidance April 2005
Darlington Borough Council and Darlington Primary Care Trust Single Assessment Process Overview Assessment Guidance April 2005

Appendix 1 – 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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- **the scale and depth of assessment is kept in proportion to older people's needs,**
- **agencies do not duplicate each other's assessments, and**
- **professionals contribute to assessments in the most effective way.**

Older people are the most important participants in the single assessment process. There are two reasons for this. First, the assessment is about and for them. Second, of all the experts in the care of older people, the greatest experts are older people themselves. They will know when they are having difficulties, the nature of those difficulties, and what might be done to resolve them. In the past, assessments may have been done to, not with, older people; and services planned without considering their views and wishes.

So that they can play a full part in the single assessment process and make informed choices, older people should expect to receive, and be given, information about access, assessment, services, charges, and complaints procedures in appropriate and accessible formats. Much of this information should be provided in local "Better care, higher standards" charters which applies to local health, social services and housing services, from whom copies can be obtained.

At all times, 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 and subsequent stages of care planning and service delivery. They should expect assessment to focus not only on their needs, but also on the strengths and abilities they can bring to bear in addressing these needs, and for assessment to help them achieve maximum possible independence. Assessment should take account of support older people receive from family members, relatives, friends and neighbours, and whether these carers have needs in their own right.

Older people should feel confident in taking the lead in their own assessment, even helping to filling out some of the official assessment forms if that is appropriate and what they want. 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 share information about their needs and circumstances in private and in confidence. 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 and a range of services is provided, 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 the services they receive, to be reviewed at regular intervals. As a minimum, first reviews should be carried out within three months of services starting, and further reviews should be carried out annually. As with assessment, older people should play a full and active part in such reviews, and indeed may request reviews in advance of a scheduled review, if the need arises.

Older people should know who to turn to, or 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 equivalent factors.

Appendix 1 – Key implications for social workers

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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- the scale and depth of assessment is kept in proportion to older people's needs,
- agencies do not duplicate each other's assessments, and
- professionals contribute to assessments in the most effective way.

Social workers have expertise and experience in working with older people who are experiencing health and social care difficulties. They often have to understand these difficulties in the wider context of the older person's family, social, financial, housing and other circumstances. Social workers also play an important role in contributing to, or co-ordinating, assessment and care planning where a number of agencies are involved.

The single assessment process guidance builds on these strengths. Social workers will, therefore, contribute to all four types of assessment set out in the detailed guidance; undertake many overview assessments; and play an important role in co-ordinating assessments and care planning.

Social workers should be prepared to update their skills and knowledge so that they are able to work effectively with older people, other disciplines and the assessment procedures. In particular, when carrying out overview assessments, they will need to accurately identify those colleagues best placed to carry out in-depth assessments. On occasion it will be social workers themselves, particularly those with specialist roles or working in specialist teams, who will be required to undertake in-depth assessments.

Many older people will need long-term support from social services, and social workers and their managers should consider how best to manage social workers' input so that their time and expertise is most effectively used. In doing so, they should take account of the Fair Access to Care Services guidance (Department of Health, 2002), and the role they should play in reviews.

It is likely that social workers will need to take account of all aspects of the single assessment process guidance. An overview of the single assessment process is given in the main guidance, and social workers are recommended to begin their reading here. Elements of the more detailed material that will be of particular interest to social workers are the stages of assessment (including the four types of assessment) and care management in Annex E, and joint working in Annex G.

Appendix 1 – Key implications for nurses

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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that:

- the scale and depth of assessment is kept in proportion to older people's needs,
- agencies do not duplicate each other's assessments, and
- professionals contribute to assessments in the most effective way.

Nurses in practice, community, hospital and other settings, and health visitors, have expertise and experience in working with older people who are experiencing health and social care difficulties. They often have to understand these difficulties in the wider context of the older person's family, social, financial, housing and other circumstances. Nurses can also play an important role in contributing to, or co-ordinating, assessment and care planning where a number of agencies are involved.

The single assessment process guidance builds on these strengths. Nurses in all settings, like social workers, will contribute to all the four types of assessment, undertake many overview assessments, and play a key part in care co-ordination. For many older people, their contact with practice and community nurses will be long-term and important to them.

Nurses in all settings, for their part, will need to ensure that their skills and knowledge are up-to-date, and they will need to accurately identify those colleagues best placed to carry out specialist assessments. Nurse, themselves, will undertake many specialist assessments as appropriate.

Registered nurses will have the additional responsibility of using information from comprehensive assessments to determine the Registered Nursing Care Contribution for older people who are admitted to care homes which provide nursing care.

It is likely that nurses will need to take account of all aspects of this guidance. An overview of the single assessment process is given in the main guidance, and nurses are recommended to begin their reading here. Of the more detailed material that will be of particular interest to nurses are the stages of assessment (including the four types of assessment) and care management in Annex E, joint working in Annex G, and the link between single assessment and the Registered Nursing Care Contribution for older people admitted to care homes which provide nursing care in Annex H.

Appendix 1 – Key implications for therapists

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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- the scale and depth of assessment is kept in proportion to older people's needs,
- agencies do not duplicate each other's assessments, and
- professionals contribute to assessments in the most effective way.

Physiotherapists, occupational therapists, speech and language therapists and other therapists, as part of allied health professionals, play a critical role in assessing the needs of older people, and all have expertise and experience in working with older people who are experiencing health and social care difficulties. Too often this contribution is under-recognised. However, like social workers and nurses, therapists will contribute to all types of assessment described in the detailed single assessment process guidance.

While they may do their fair share of overview assessments, therapists will contribute greatly to specialist assessments and comprehensive assessments. They can offer a specialist contribution to the assessment of mobility, transfers, speech, language, eating, drinking, and functional capacity, and the impact of the home and wider environment on assessed needs. In particular therapists are skilled in the assessment of the potential for rehabilitation and independence.

They will act as care co-ordinators in some cases. They should ensure that assessment scales to identify physical and personal care problems have a prominent role in assessment procedures, but that these scales do not predominate and are used to support professional judgement.

It is likely that therapists will need to take account of all aspects of this guidance. An overview of the single assessment process is given in the main guidance, and therapists are recommended to begin their reading here. Of the more detailed material that will be of particular interest to therapists are the stages of assessment (including the four types of assessment) and care management in Annex E, and joint working in Annex G.

Appendix 1 – Key implications for General Practitioners

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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- the scale and depth of assessment is kept in proportion to older people's needs,
- agencies do not duplicate each other's assessments, and
- professionals contribute to assessments in the most effective way.

GPs and their practice teams are constantly assessing patients in order to decide on the appropriate care for them. They do this by drawing together the information currently held about them, adding new information about the current situation and then assessing all this to produce an action plan to deal with the problems.

When GPs or their practice nurses are the only professionals involved, and they are using their own GP computing system, the process can run smoothly. But when they go beyond that to out-of-hours deputising services, secondary care or social services, problems may occur with sharing of information and duplication of information gathering. The former may result in decisions being made without all the relevant information, and the latter wastes time. The different language used by each professional group further complicates matters. However, flows of information will be improved with the introduction of new quality standards and closer integration between NHS Direct and GP out-of-hours services. By 2004 NHS Direct will triage all calls to out of hours health care.

Implementation of the single assessment process is intended to address these problems, and lead to a more effective and efficient response to older people's problems.

The key implementation issues for GPs are :

- Understanding the values underpinning the NSF for Older People and the single assessment process. See Annex D. These can be summarised as person-centred care with involvement of patients and carers in decision making, and a focus on achieving agreed treatment objectives.
- Knowing about the stages of assessment as set out in Annex E. Although GPs may contribute to all types of assessment, GPs will be mostly concerned with contact assessment, Here the use of professional judgement is the only way of deciding whether an assessment should be taken further.
- Not treating all contacts with older people who come to their surgeries as occasions for contact assessment as defined in the single assessment process guidance. The full single assessment process is not intended to apply to all older people who have specific needs that can be readily addressed with no wider repercussions. (Annex E provides more details.)
- Understanding the uses of tools and scales. In case finding and other proactive health screening purposes, assessment tools and scales are useful in identifying those with a particular problem. In other stages of

assessment, they can support professional judgement and can also help ensure that no areas of assessment, needing to be covered, are missed.

- Structuring the information on GP medical systems so that it is easy to share with other care professionals when necessary and appropriate. GPs are in an excellent position to contribute valuable information to the assessment process. Basic personal information can be collected at the time of registration and then shared in an agreed format. Medical information about key diagnoses and medication, summarised in an agreed way, is also of great help to other decision makers. See Annex I for details on the single assessment summary.

In addition, GPs can use good computer system products such as PRODIGY and PROFESS to help them in their daily practice, including assessment and diagnosis.

- PRODIGY is a computerised decision and learning support tool for GPs offering a series of recommendations for the treatment of diagnosed conditions in terms of therapy options, non-specific drug advice or referral on. PRODIGY is a core requirement of RFA99, and as systems are upgraded to the latest specification, access to PRODIGY will increase. Further information on PRODIGY can be found on:

prodigy (external link)

- PROFESS is a tool for providing comparison data for reflective learning in general practice. Using PROFESS, a GP would, for example, be able to compare data pertaining to their own patients in specific disease groups such as coronary heart disease or diabetes with aggregate anonymised and secure data from other participating practices. Further information on PROFESS can be found on:

schin (external link)

Appendix 1 – Key implications for geriatricians and old age psychiatrists

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, and should be 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 subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- **the scale and depth of assessment is kept in proportion to older people's needs,**
- **agencies do not duplicate each other's assessments, and**
- **professionals contribute to assessments in the most effective way.**

Many specialist assessments and most, if not all, comprehensive assessments (sometimes known as comprehensive old age or comprehensive geriatric assessments) should involve geriatricians or old age psychiatrists and their teams on behalf of, or working with, primary care and social services. A key role of these teams will be to ensure treatable and reversible conditions are not overlooked, and that assessments are timely, appropriate and in proportion to individuals' needs. Many geriatricians and old age psychiatrists will often have much understanding of the best use of assessment tools in specialist or comprehensive assessments. They will be central in providing the medical assessment, diagnosis and subsequent prognosis for future action.

Bearing this in mind, geriatricians and old age psychiatrists can play a critical role in the local implementation of the single assessment process by :

- Assisting in the selection of assessment tools.
- Identifying one of their number to take a special interest in the assessment process and to act as a focal point for medical involvement in implementation.
- Working with other managers to help ensure that secondary health services are able to support implementation.
- Ensuring that assessments undertaken by other secondary health departments, not primarily associated with care of older people, are aligned to the single assessment process, and there is consistency of assessment across the hospital.
- Ensuring training about assessment procedures is available for hospital doctors, especially specialist registrars, senior house officers and those on vocational training schemes, and making related links with primary care teams.
- Stimulating and undertaking research into assessment procedures.
- Linking assessment procedures to clinical governance for geriatricians and old age psychiatrists, their departments and their clinical service networks.

Appendix 2: Annex A – Key Attributes of the Single Assessment Process

Agreed local approaches to the single assessment process should establish the following purpose and outcomes:

A person-centred approach whereby:

a) The person seeking help from health and social care services experiences a single assessment process where:
   - Information about needs is given once, no matter that the assessment and subsequent care planning and service delivery involves a number of professionals and agencies.
   - Professionals work together in the best interests of the person.

a) The person's views and wishes are central to the assessment process and, where appropriate and possible, assessment commences with a biography in the person's own words;

b) Assessment builds a rounded picture of their needs and circumstances;

c) The depth and detail of the assessment is proportionate to their needs.

d) Consideration of carers' needs is an integral part of the process.

A standardised approach that:

a) Is supported by an agreed evidence based assessment tool;

b) Builds on, and supports, existing good practice and identifies poor practice;

c) Is useful to those practitioners responsible for its day-to-day operation;

d) Enables professionals to see each others' contributions to assessment, which are subsequently trusted and accepted;

e) Produces sets of Standardised Assessment Information, and a single summary record, on individual cases;

f) Facilitates the sharing of this case information between professionals; and

g) Generates information for strategic planning and performance monitoring.

An outcome-centred approach that:

a) evaluates assessment information and translates it into appropriate and effective care plans and services; and

b) promotes the health, independence and quality of life of adults/carers seeking help, and helps them to fulfil their potential for rehabilitation.

Appendix 3: Annex D – Shared Values of the SAP Process

All health and social care systems must work to the following common set of shared values, drawn from the NHS Plan and the NSF for Older People, if adults are to receive appropriate and effective services. Similar values already underpin the work of many individual agencies. Localities should confirm their commitment to the values and agree other values that are important to them.

VALUING PERSON-CENTRED CARE AND INDEPENDENCE

- People should be informed of services and how to access them, and their comments on services should be actively sought.
- Their views and wishes should be kept to the fore throughout assessment, care planning and service delivery.
- Assessment should help people to maximise their potential for independence.
- People should be involved in decisions about their care, and empowered to determine the level of risk they are prepared to take.
- People should have advice and information about options for how their needs may be met.
- People should consent to information that is collected on them and shared.
- Where individual people lack capacity to make decisions or give their agreement, agencies should have procedures in place to secure the maximum possible participation and safeguard the person's interests.
- Professionals should be aware of the impact of age, gender, race, living arrangement, personal relationships, lifestyle choices and disability on people and their needs, and be prepared to respond appropriately.

VALUING CARERS AND FAMILY MEMBERS

- The contribution that carers and family members make to the well-being of those they are caring for should be acknowledged by all agencies and professionals.
- In addition, carers should always be informed of their rights to an assessment and their needs considered when decisions are being made about the provision of services to those they are caring for.

VALUING INTEGRATED AND RESPONSIVE SERVICES

- Age, of itself, should not determine how services are accessed or provided.
- Access to services, particularly where an integrated response is required, should be straightforward, and duplication of assessment kept to a minimum.
- Effective information sharing between professionals, where confidentiality is respected, can be crucial for effective person-centred care.
- Where an adult needs the help of more than one agency, agencies should co-ordinate service delivery in the best interests of the person in need.
- Promoting health and well-being is as important as helping when needs arise. The potential for rehabilitation should be explored at assessment and subsequently kept under review.

VALUING STAFF

- Professionals who work with adults need to be properly trained and have the appropriate level of skills.
- Font-line professionals should be supported to take responsibility for planning the care of individual adults via supervision and appraisal.
- Professionals should value and trust other care professionals involved in anyone Single Assessment Process.

APPENDIX 4 – SAP GLOSSARY OF TERMS DARLINGTON 2005

SAP SPECIFIC TERMINOLOGY		
Single Assessment Process	-	Is a framework that will ensure good person centred assessment practice by the professionals involved and will assist in the sharing of information between professions'. It requires professionals to work to agreed principles, around best practice on assessment and care management. This process relates to first point of contact, assessment, care planning, care provision, monitoring, review and closure.
Contact Assessment	-	Is the first point of contact between an individual and health/social services where needs are first described or suspected. Basic personal information is collected and the nature of the presenting problem is established and the potential presence of wider health and social care needs is explored. This information is screened and may result in the need for an overview assessment.
Overview Assessment	-	Is a more in-depth assessment of an individuals needs. The assessment process is made up of domains and sub-domains, accredited tools and scales that enables the individual and the assessor to explore areas of identified need and agree a course of action.
Specialist Assessment	-	Is a request to a specialist professional for a detailed assessment of an individual's needs. It enables the specialist to determine if their services are required and to provide advice, information and support to the Care Coordinator/Assessor, who is responsible for the co-ordination of all assessments, care planning and case management.
Overview Assessment	-	Is not a separate document but results from a combination of overview and specialist assessments.
Domains & Sub Domains	-	Domains' refers to the key components of the assessment and sub domains breaks the component down in to related sections.
Assessment Tools	-	Is a collection of scales, questions and checklists that have bee brought together for specific assessment purposes to aid the decision making process. They do not replace, but are used in conjunction with professional judgment.
Summary of Need	-	Is an outline of a person's needs identified during the assessment process. Identified social care needs have to be mapped against the Local Authorities Fair Access to Care Eligibility Criteria to determine if the person is eligible for services provided by social services.
Care Planning	-	Care planning is a process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved. The assessment and needs of a carer can also be identified in this process.
Care Plan Monitoring	-	Is an outcome of an assessment, it is a description of what a service users needs are and a plan of how these will be met. To observe the delivery of the Care Plan and make minor adjustments if required.
Review	-	To review the Care Package to determine if it still meets the identified needs of the individual and to adjust the care plan if appropriate or refer for reassessment. It can be planned or requested.

Care Co-ordinator **This could be:** **Care Manager** **District Nurse** **Occupational Therapist** **Physiotherapist** **Intermediate Care Assessor**	**-**	A practitioner who ensures that the care plan is effectively delivered through: ➢ taking lead responsibility for ensuring effective communication between the various practitioners / agencies involved with users and carers ➢ prompting further assessment, care plan and service adjustments ➢ and ensuring monitoring and review activity takes place
Open Case	**-**	A case which requires ongoing input from either a health or social care worker to ensure effective and timely delivery of the services to meet assessed needs for a service user on an ongoing basis.

		SAP ASSOCIATE TERMINOLOGY
Advocacy	-	When a person or group speak up for themselves and / or others. To support and sometimes represent people's needs and opinions. They are independent of service provision to avoid conflict of interest.
Age discrimination	-	Action, which adversely affects the older person because of their chronological age alone. Discrimination can also mean positive discrimination, that is action taken to promote the best interests of the older person. But the term age discrimination is generally used in the negative sense in this National Service Framework.
Allied Health Professionals	-	Grouping of clinical professionals who are registered by the Council for Professions Supplementary to Medicine (soon to be the Health Professions Council), for example physiotherapists, occupational therapists, speech and language therapists, dieticians and psychologists.
Appointeeship	-	An appointee is someone authorised by the Benefits Agency to receive and administer benefits on behalf of someone else, with that person's consent.
Appropriate Adult	-	The Police and Criminal Evidence Act 1984 envisages special protection for a person who is mentally disordered of learning disabled when they are in a police station as suspects, witnesses or otherwise by ensuring that they have a responsible person with them when important actions or decisions take place. This would include informing of rights, police interviewing, identification procedures or charging. An appropriate adult can be a relative or guardian or someone with experience of dealing with offenders with the above needs. It cannot be a solicitor.
Approved Social Worker (ASW)	-	A specialist social worker trained and approved to carry out functions under the Mental Health Act 1983.
Assessment	-	A person centred process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated. Assessment should focus positively on what an individual can do and could be expected to achieve. The process should take account of the individual's personal and social relationships, including the wishes of the person/carer and of the carer's ability to continue to provide care.
Assessing Officer	-	Person identified by the authority for undertaking assessments of need.
Assistive equipment technology	**-**	Equipment that enables children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible.

Avoidable admission	-	Admission to an acute hospital or residential care, which would be unnecessary if alternatives, e.g. rapid response / or supported accommodation services were available.
Care Co-ordinator eg Care Manager District Nurse Occupational Therapist Physiotherapist Intermediate Care Assessor	-	A practitioner who ensures that the care plan is effectively delivered through: ➢ taking lead responsibility for ensuring effective communication between the various practitioners / agencies involved with users and carers ➢ prompting further assessment, care plan and service adjustments ➢ and ensuring monitoring and review activity takes place
Care management	-	A process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, and needs are monitored, re-assessed and reviewed.
Care manager	-	A practitioner (a health or social services employee) who, as part of their role, undertakes care management.
Care package	-	A service or combination of services designated to meet a person's assessed needs.
Care pathway	-	An agreed and explicit route an individual takes through health and social care services. Agreements between the various professionals involved will typically cover the type of care and treatment which professional will be involved and their levels of skills and where treatment or care will take place.
Care planning	-	Care planning is a process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved. The assessment and needs of a carer can also be identified in this process.
Care Programme Approach (CPA)	-	The formal process (integrated with Care Management) of assessing needs for services for people with severe mental health problems prior to and after discharge from hospital.
Carer	-	Carers are friends, family or relatives who are looking after someone who needs support as a result of age, frailty, physical impairment, learning difficulty, or mental ill health. A carer can be of any age and could include someone under 18 (young carer) or someone who is the parent of a disabled child. They may provide physical, practical, social and emotional support.
Carer's Assessment	-	A document to look at carer's own needs. To form part of a holistic assessment of service user and carer's needs. It may result in support/services provided to the service user and/or carer.
Challenging behaviour	-	Relates to behaviours, which are considered dangerous, socially inappropriate or disruptive and make special demand on service provision. This type of behaviour may pose risks to the individual, the family or other person's/agencies involved in their care.
Chronic illness	-	A long term or permanently established illness
Clinicians	-	Qualified healthcare professionals, including doctors, nurses and the allied health professions, e.g. dieticians, podiatrists (chiropodists), occupational therapists, physiotherapists and speech and language therapists.
Cognition	-	The higher mental processes of the brain and the mind, including memory, thinking, judgement, calculation, visual spatial skills and so on.

Cognitive impairment	-	Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dementia.
Commissioning	-	Accessing appropriate services identified within the assessment process.
Community Care	-	The assessment of an individual's needs and the provision and management of a package of personal care and support to assist the person and his/her carer(s) to achieve, maintain or restore an acceptable level of social independence or quality of life. This is primarily the responsibility of the local authority but working in partnership with other agencies.
Community equipment services	-	Community equipment services provide the equipment, including assistive technologies that play a vital role in enabling people of all ages to maintain their health and independence.
Community health services	-	Health services provided to someone in their own home or in the local community.
Community Psychiatric Nurse (CPN)	-	A registered mental health nurse working within the community.
Co-morbidity	-	Other co-existing illness in addition to the particular illness, which is currently most significant.
Complex needs	-	People who have multiple needs that requires a co-ordinated approach to service delivery, which enables them to remain as independent as possible.
Confidentiality	-	Patient information is generally held under legal and ethical obligations of confidentiality. Information provided in confidence should not be used or disclosed in a form that might identify a patient without his or her consent. (DoH 2003 Confidentiality NHS Code of Practice).
Consent	-	**Is a persons agreement for a professional to assess needs, share information, plan care and provide services to meet their needs.** **The person may indicate consent non-verbally, orally, or in writing.** **For the consent to be valid, the patient must:** • **be competent to take the particular decision;** • **have received sufficient information to take it; and** • **not be acting under duress.**
Continuing Care	-	Continuing care falls into three broad categories: **Continuing NHS Health Care** is a package of care arranged and fully funded by the NHS and is free of charge. **Continuing Health and Social Care** is a joint package of care that involves services from both the NHS and social services, where the main need is for accommodation and personal care rather than for nursing of NHS care. **Continuing Social Care** is long-term care where the individual is entitled to receive community and personal care services provided by social services.

Councils	-	Councils are directly elected local bodies, which have a duty to promote the economic, social and environmental wellbeing of their areas. They do this individually and in partnership with other agencies, by commissioning and providing a wide range of local services.
Court of Protection	-	Office of the Supreme Court. It exists to protect the property and affairs of persons, who through mental health needs are incapable of managing and administering their own financial affairs. The Court's powers are wide ranging, but limited to financial and legal affairs of the person concerned.
Data Protection Act 1998	-	The main act that governs all personal data. The Act regulates the collection, storage, and use of personal data . It replaces the earlier 1984 Act, which only applied to personal data held on computerised systems. The most important new feature of the 1998 Act is that the regulations now also apply to organized manual systems of data.
Direct payments	-	Cash payments from social services in lieu of community care services, to provide them with the means to purchase their own services to meet assessed need in the most appropriate way.
Disability	-	Darlington Borough Council and Darlington PCT have adopted the social model of disability which is defined as: 'The disadvantage or restriction of activity caused by the way society is structured and organized. As a result, people are excluded and prevented from participation on equal terms from mainstream society'.
Domiciliary care	-	Care provided in an individual's own home.
Dual diagnosis	-	More than one primary diagnosis, e.g. learning disability and mental illness; stroke and diabetes.
Elderly Mentally Infirm (EMI)	-	Individuals over 65 with organic disorders.
Environmental visit	-	A check made by, for example, an occupational therapist to ensure that an individual is safe and can manage in their own home.
Free Nursing Care		Is responsibility of Health (from 31-03-2003) for funding the registered nursing care element, of the care, of all care home nursing residents.
Guardianship	-	A guardianship order is for a person over 16 years, who has difficulty looking after themselves. The guardian can be the local social services or someone appointed by them. They have the power to decide where a person can live, require a person to attend somewhere for medical treatment (although the person can refuse when they get there) and ensure a doctor or social worker, or anyone else named by the guardian, has right of access to the person.
Health Act Flexibilities	-	Powers in the 1999 Health Act that allow the NHS and local councils to form operational partnerships and enable pooled budgets, lead commissioning and integrated provision of services.
Health and social care	-	Local health authority, local council, NHS Trusts, primary care trusts and independent/voluntary sector providers of residential, nursing, home care or day services.
Independence	-	Having control over ones own life.
Independent sector	-	Includes both private and voluntary organizations providing services in residential/nursing, domiciliary and day care.
Informed consent	-	People need sufficient information before they can decide whether to give their consent. If the person is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

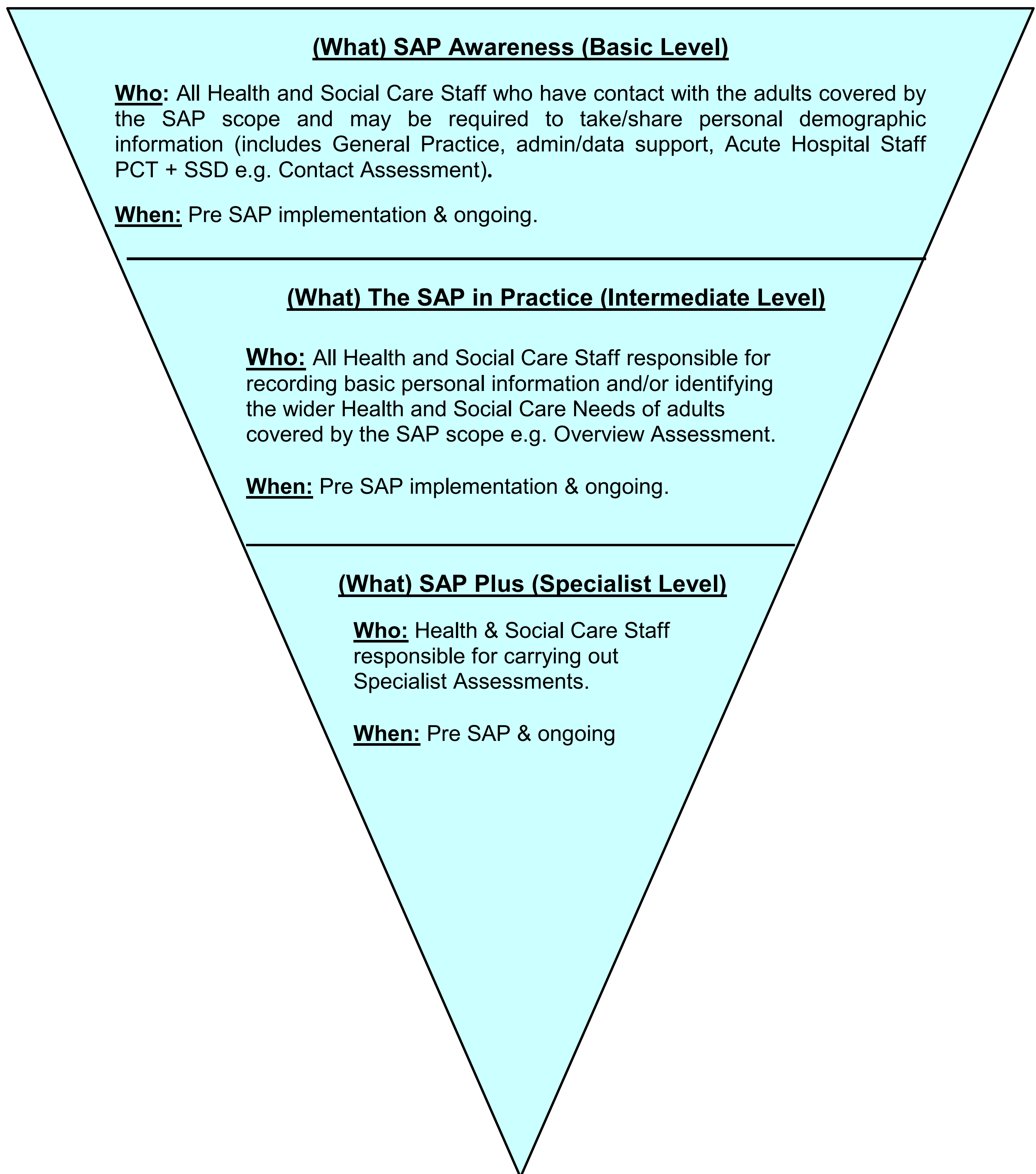
Impairment	-	Refers to that part of the body that is impaired in some way and is limited in its functioning.
Integrated continence services	-	Includes identification, assessment and care of people with incontinence, including help to maintain continence. Services are organized across primary care and specialist services.
Intermediate care	-	A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.
Local Implementation Team (LIT)	-	Group that is responsible for the development and delivery of a strategic service plan to enable the local implementation of National Service Frameworks. The group includes representatives from all relevant stakeholders.
Long term care	-	Refers to support services provided over a prolonged period of time or on a permanent basis, to adults who have difficulties associated with old age, long term illness or disability. Care may be provided in residential settings such as nursing homes or in people's own homes.
Medical Diagnosis	-	Identification of a disease from its symptoms following investigations.
Medically Fit for transfer/discharge **Decision to Discharge**	- -	Whereby a patient is no longer requiring acute intensive medical intervention and therefore ready to be transferred or discharged to an alternative setting. This decision can only be taken when: 1. clinical decision has been made that the person is fit for transfer. 2. multi-disciplinary team decision has been made that person is ready for transfer. 3. Multi-disciplinary team decision has been made that person is safe for transfer.
Medical Prognosis	-	The forecast of the course, duration and outcome of a specific health condition.
Multidisciplinary	-	Multidisciplinary refers to when professionals from different disciplines – such as social work, nursing, occupational therapy, work together.
Multidisciplinary assessment	-	Multidisciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.
Multi-sectoral	-	Multi-sectoral refers to different sectors, such as statutory agencies, voluntary organisations, private or for-profit businesses, planning or working together.
National Service Framework (NSF)	-	Evidence based national service framework setting out standards to be expected from organisations involved with older people. Major areas of need identified to be explored.
Old age medicine	-	The medical speciality that is concerned with the diagnosis, treatment and care of older people.
Person centred planning	-	A person centred approach to planning means that planning should start with the individual (not with the services) and take account of their wishes and aspirations.

Personal Data	-	Personal data is any information about an individual who is **alive** and **identifiable**. Identification need not be direct. If the data in question can be combined with other data to allow identification of living individuals, then the data is personal data. For example, data that has been anonymised is still personal data if it is possible to access a separately held list that allows the anonymous data to be assigned to living individuals.
Personal Social Services (PSS)	-	Personal care services for vulnerable people.
Primary care	-	Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, together with district nurses and health visitors, with administrative support. Primary care teams are now grouped within Primary Care Trusts (PCT) that have responsibility for commissioning specialist services as well as for providing primary care, working closely with Social Services.
Primary prevention	-	The prevention of the development of a condition, e.g. stroke, by avoidance of the lifestyle factors known to contribute to its development, e.g. smoking.
Professional	-	A person who has completed a specific qualification and is employed to carry out the relevant professional role.
Providers	-	Organisations, or designated parts of organisations, that provide health or social care services.
Rehabilitation	-	Rehabilitation is a process that enables people to regain partial or full independence after illness or injury, giving them back as much control as possible over their lives. It is about restoring the person's physical and mental capabilities involving a wide range of activities. It is an active process of building up a person's capacity to live independently.
Residential Assessment/Rehab Units	-	Short say (usually no longer than 6 weeks) to enable intensive rehab – see Intermediate Care.
Residential care	-	Residential care refers to nursing and residential care homes that provide 24 hours care for vulnerable adults who can no longer be supported in their own homes. Homes may be run by local councils or independent organisations. Admissions to residential care can be made on a temporary or permanent basis. If assistance with funding is required an assessment by Social Services has to be completed, prior to admission, and funding for placement agreed. If the person is self-funding they do not have to be assessed by social services but can request an assessment.
Seamless service	-	Describes a philosophy of care to ensure that a person's health and social care needs are provided in a co-ordinated way.
Secondary care	-	Care traditionally provided from a hospital setting in support of the primary care team, e.g. surgery, specialist medical services, including old age medicine and mental health services.
Secondary prevention	-	The prevention of the deterioration of an existing ill health condition e.g. stroke, by avoidance of the lifestyle factors known to contribute to its further deterioration, e.g. smoking and provide maintenance treatments to control the condition.
Service user	-	A person who is receiving health and/or social care services.
Social care	-	Social care is provided by statutory and independent organisations and describes a wide spectrum of activities that support and help people live their daily lives.

Social services	-	Social services are provided by local authorities in England. They provide advice, assessment, support and services to individuals, in partnership with key stakeholders.
Social Worker	-	A qualified worker within local authority or voluntary organisation.
Specialist assessment	-	An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, e.g. stroke, cardiac care, bereavement counselling.
Specialist services	-	A service which specialises in the care of particular groups of people, for example those with mental health problems.
Stakeholder	-	All those involved in the development and delivery of services.
Step-down unit	-	A unit, which provides residential rehabilitation from hospital.
Step-up unit	-	A unit, which provides residential rehabilitation from community.
Supported accommodation	-	Accommodation in which a warden has responsibility to act as a friendly neighbour and alert emergency services/next of kin. Usually linked to pendant alarm / intercom system.

Appendix 5a

THE SAP LEARNING AND DEVELOPMENT FRAMEWORK



Appendix 5b – Implementation Schedule

2001: Countywide SAP Implementation Group established
Outcome: Resulted in development of Darlington Locality SAP Group 2001

2002 – 03: Pilot of the SAP Process covering one GP Practice and involving an Integrated Health & Social Care Team
Outcome: Evaluation of the pilot lead to a report outlining the actions required for SAP implementation across Darlington locality

2003 – 04: SAP Task Groups developed – Access Points, Multi Agency Working Policy & Procedures, Access to Information and Training & Development
Outcome: Lack of strategic and operational commitment resulting in limited progress towards SAP implementation. Recognised need for identified SAP Leads from PCT & SSD

2004: Membership of Steering Group revised along with identified strategic support from PCT & SSD. Identified SAP Leads chair Steering Group and act as Project Leads
Outcome: Improved multi-agency commitment and recognition of importance to achieve implementation by April 2005

2004 – 05: Further development of SAP documentation for adoption across all health and social care community services and Acute Trust via development of Countywide Steering Group
Outcome: Countywide agreement to use of Contact Assessment across Co. Durham & Darlington Acute NHS Trust, Darlington PCT/SSD.

2004 – 05: Development of – Documentation, Process, Policy, Guidance, Information Sharing Protocol & Data Flow Agreement – to draft 1 stage, Training & Development Programme, Development & implementation of GP SAP Referral Process via fax, IT connectivity across PCT/SSD via Carefirst, Links to NPfIT.

Jan 2005 – March 2005: In-depth Training in preparation for SAP Launch

11 April 2005: SAP Launch across Acute and Community Health & Social Care Services

Post April 2005:

- On going monitoring and review via SAP Leads and Steering Group
- Future development of IT systems to support SAP and link to National Spine via NPfIT
- Pilot use of mobile technology to support SAP community staff
- Development of IT system to facilitate the electronic SAP referral by GP Practices
- Widening scope of SAP to included Independent Sector and Housing Wardens
- Information Sharing Protocol & Data Flow Agreement to be completed by SSD/PCT Information Governance Leads.