

LEICESTER, LEICESTERSHIRE AND
RUTLAND

THE
SINGLE ASSESSMENT
MODULAR WORKSHOP
TRAINING PACKAGE

Developed By
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Acknowledgements: Sheffield - First for Health SAP Training Package
Avon, Gloucestershire and Wiltshire – SAP Training Resource

Elements of the above have been adapted for local use.

This Modular Workshop Training Package has been provided to assist you with implementing the Single Assessment Process (SAP). There are a variety of different ways that staff can learn about it:

1. They can visit the Department of Health Website, read about it, and download information that will never be read.
2. They can hide away from it and pretend that it isn't happening, and then panic when they realise that they have to deal with it.

OR

They can attend interactive workshops, where they can discuss the realities of implementing SAP, meet and talk to professionals from different backgrounds and agencies who are also involved in implementing SAP, and practically work through a series of modules aimed to help them understand the principles and benefits of SAP.

It is intended that this package is run over 2 ½ - 3 days using the Modular approach. For some staff it will be necessary to complete ALL modules if they have had no exposure or information in relation to Single Assessment; whereas for others, it may only be necessary to complete modules 2 –3.

It is also envisaged that the groups will be of mixed professions and agencies, in order that the full effect of some of the exercises can be achieved.

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Single Assessment Training Package

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Introduction and Supporting policies and guidance for the implementation of the Single Assessment Process

There is no doubt that access to comprehensive, multi-disciplinary assessment has been quoted as the single most important determinant of effective service provision and quality care for vulnerable people. This was reflected recently by Professor Ian Philp, in his keynote addresses to the regional SAP roadshows held during February and March 2004. He underlined the importance of single assessment as ‘ a practical lever in achieving genuinely person-centred and integrated services, envisaged in the National Service Framework for Older People’.

The following supporting **policy** documents and frameworks refer to the need, not only for effective partnership arrangements and joint working at all levels but also to ensure that the assessment process is owned and delivered collectively.

[The NHS Plan \(DOH, 1999\)](#) refers to the need for a single assessment process for health and social care, that includes a proactive process for identifying and inviting vulnerable people to take part the assessment process by April 2002 (later guidance moved the target date to April 2004).

[The National Service Framework \(NSF\) for Older People \(DOH, 2001\)](#) Standard 2 (Person Centred Care) covers the detailed requirements and steps for working towards responsiveness to individual needs, and person-centred assessment and care. This includes the introduction of a Single Assessment Process. In addition to the eight core standards and evidence based service models, it addresses the interfaces between health and social care; both generally and more explicitly between primary and community based services and secondary, specialist services.

The White Paper, [Valuing People: A New Strategy for Learning Disabilities for the 21st Century](#) (DOH, March 2001) sets out proposals for improving the lives of all children, young people, adults and older people with learning disabilities and their families. It is based on the key principles of legal and civil rights, independence , choice and inclusion. This represents an agenda of significant developments outlining objectives for service and partnership developments over the next 5 years.

“ Valuing People” makes it clear that Person Centred Planning and person centred approaches to service planning and care management are key to improving the lives of people who are, at present, amongst the most vulnerable and socially excluded today.

[Fair Access to Care](#) guidance (DOH 2001) is intended to tackle differences in access to social services funded or purchased care around the country. Through the use of a standard framework to determine eligibility, it is envisaged that local implementation should lead to a more consistent approach to eligibility and fairer access to care services across the country. It outlines the four bands for determining local authority eligibility criteria for social care services: critical; substantial; moderate; low. It also sets out central government's expectation that all recipients of social care services will have their care needs reviewed between April 2002 and March 2003; that there should be an initial review within 3 months of services first being provided; and that reviews should be scheduled at least annually. The model of assessment, eligibility criteria and care management described in the guidance is therefore not 'service led'. Rather, it starts with the service users' perspective, taking a holistic view of their needs.

[Shifting the Balance of Power within the NHS](#) (DOH, 2001): It is about putting patients and staff at the heart of the NHS. It outlines the organisational and cultural changes required to deliver the NHS Plan, setting out an ambitious programme of reform that is both structural and attitudinal across all health care organisations.

[Caring About Carers](#) – The national strategy for carers – (DOH, 1999) focuses on the needs of informal carers, many of them family caregivers who may be frail or ill themselves. In particular it introduces the requirements for ensuring all carers receive an assessment of their needs, separate from any assessment regarding the cared for person.

[National Service Framework for Long Term Health Conditions](#) is expected to be published in early 2004 with an implementation date for 2005 and focuses on the quality and effectiveness of assessment and care delivery mechanisms for people with neurological disabilities and brain or spinal injury, and will also consider some of the generic issues of relevance to a wide range of people with long term conditions and disabilities.

[The Single Assessment Process](#): separate guidance on developing and implementing a single assessment process was issued for consultation in August 2001, with the intention that the requirements of Standard 2 of the NSF were delivered with effect from April 2002. Guidance issued in January 2002 outlined the key steps to be taken between 2002 and April 2004.

MODULE 1

What is the Single Assessment Process?

WHY DO WE NEED SAP?

An exercise on establishing participants perceptions

TRUE OR FALSE?

1. The single assessment process only applies in this geographical area.
True / False
2. The single assessment process forms part of the government's agenda for modernising health and social care.
True / False
3. It's up to local areas to decide whether to implement the process, or wait and see how other areas are doing it.
True / False
4. The single assessment process will be applicable to all people who need some sort of care
True / False
5. One of the reasons the single assessment process has been introduced has been to try and avoid duplication of assessments
True / False
6. The single assessment process will only be carried out by particular disciplines
True / False
7. The single assessment process introduces new levels of assessment
True / False
8. The single assessment process means more paperwork
True / False
9. The way information is shared between agencies will be subject to the person's written consent
True / False
10. Person centred care is at the heart of this process
True / False

True or False? **Answers**

1. The single assessment process only applies in this geographical area.
False – its is a national initiative
2. The single assessment process forms part of the government's agenda for modernising health and social care
True – its part of Standard 2 National Service Framework for Older People
3. It's up to local areas to decide whether to implement the process, or wait and see how other areas are doing it.
False – SAP was introduced in all areas from 01.04.04
4. The single assessment process will be applicable to all people who need some sort of care
False – it is usually only applied where people have health and social care needs
5. One of the reasons the single assessment process has been introduced has been to try and avoid duplication of assessments
True – yes this was the experience of many people
6. The single assessment process will only be carried out by particular disciplines.
False – SAP should be part of good multi-disciplinary working
7. The single assessment process introduces new levels of assessment
True – there are 4 levels of assessment
8. The single assessment process means more paperwork
Depends on how it is being implemented!
9. The way information is shared between agencies will be subject to the person's written consent
True – it builds on best practice with written consent usually being required
10. Person centred care is at the heart of this process
True – this is one of the main aims of the process.

WHAT IS THE SINGLE ASSESSMENT PROCESS (SAP)



'The Right Care, in the Right Place, at the Right Time'

It is aimed to promote a consistent and co-ordinated approach to assessment by enabling all agencies and professionals to work together.

Three key attributes were identified in the Guidance for Local Implementation of SAP (DOH, 2002). These are:

- A person-centred approach
- A standardised approach
- An outcome-centred approach

Activity

With the above approaches in mind, consider at least 5 ways in which you feel that SAP might improve the working practices to work in your area.

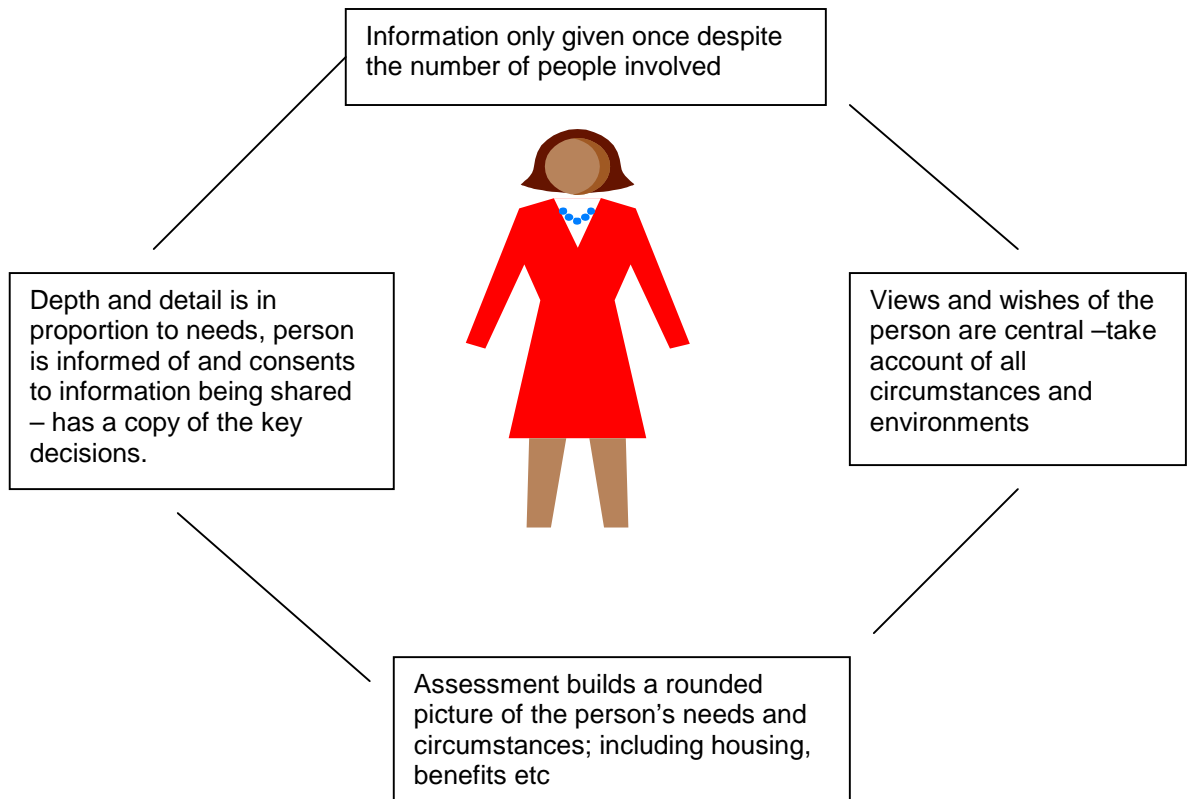


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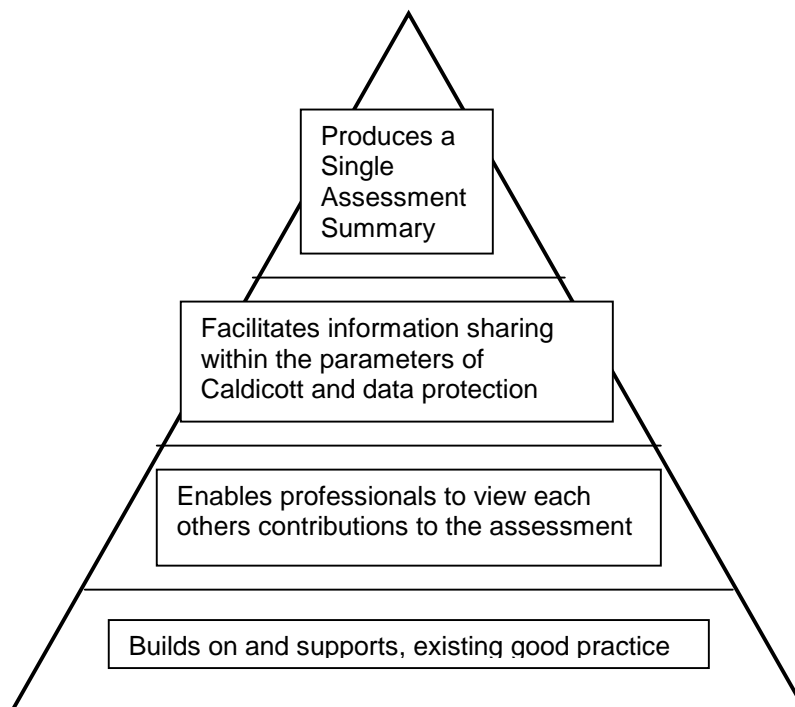
Use this area for any issues or thoughts that the approaches raise for you.

What do the Approaches mean?

PERSON CENTRED



STANDARDISED



OUTCOME-CENTRED

Translates all assessment information into appropriate and effective care plans and services



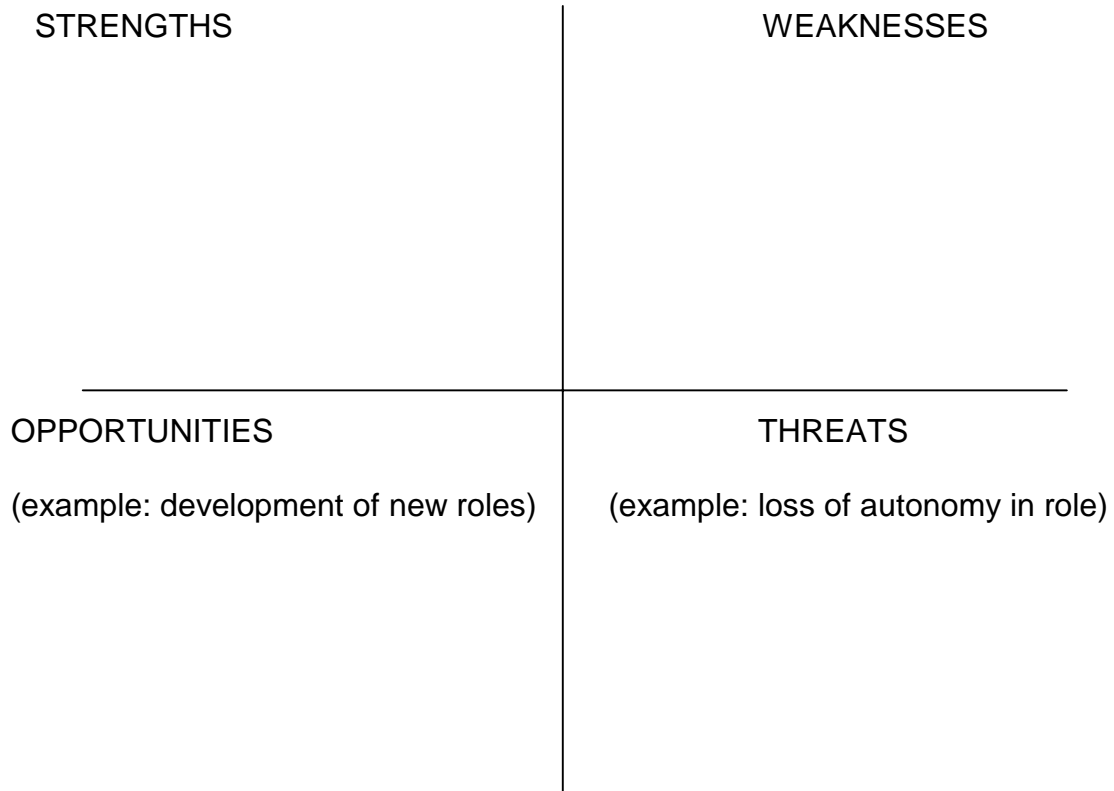
Promotes health, independence and quality of life by helping them to fulfil their potential for rehabilitation

Activity

What could stop the Single Assessment Process from being developed and implemented and what could help its successful implementation.



Write down at least 3 key words relating to the implementation of SAP within each of the SWOT analysis boxes.





Effective people are not problem-minded; they're opportunity minded.
They feed opportunities and starve problems.
(Steven Covey)

Consider the Weaknesses and Threats that have been identified and convert these into Strengths and Opportunities.

This is an important step, as SAP has to work in order to benefit patients/ clients.

Activity



Try to convert the Weaknesses and Threats that have been identified

STRENGTHS

OPPORTUNITIES

Identify the work that needs to be done in order to ensure that the above can be achieved.

HOW WILL SAP WORK?



The Department of Health advised that the Single Assessment Process can be divided into 4 potential stages

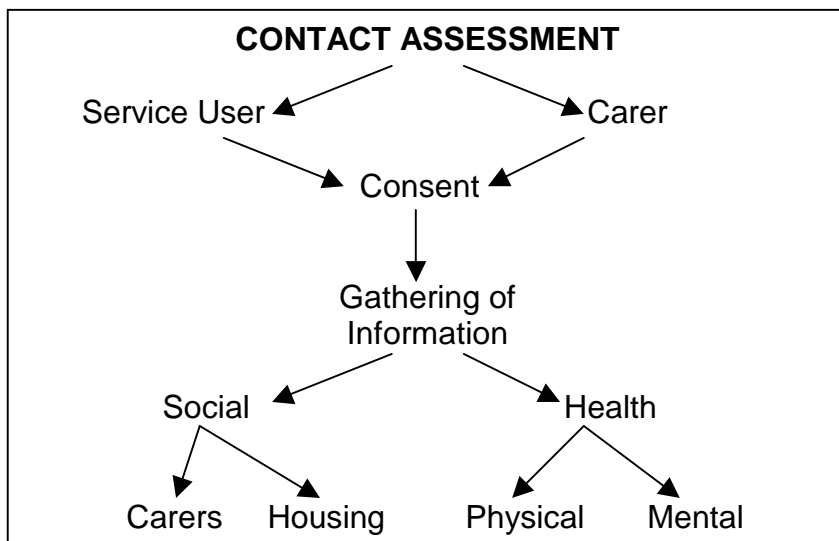
Stage 1: Contact Assessment

This refers to a contact between an older person and any professional assessing for health and social care services, where **significant needs are first described or suspected**. It has been designed by a multi-disciplinary/ multi-agency team, to serve a number of purposes:

- when referring people from one agency or service to another
- to gain consent from one person to share information or not share information with other agencies
- used to record simple assessments

The Contact Assessment also consists of service user and carer information and can prompt the need for a carers assessment where and when necessary.

Diagram of the Contact Assessment Process:



Stage 2: Overview Assessment

The Overview Assessment provides a framework of a number of specific areas, to collect more in-depth information about the service user and any indications that wider needs exist that require further investigation. The categories (domains and sub-domains) are explored depending on the response from the service user and your own professional judgement (see details of domains and sub-domains at the end of the chapter).

The need for an overview assessment may be immediately apparent, and should be commenced once the contact assessment has been completed. In some situations a

specialist assessment of a specific problem may have been carried out, with the overview assessment providing subsequent contextual information.

The Overview Assessment should be carried out in the presence of the service user, and if they are unable to indicate their views, this should be clearly documented and identification of where the information has come from made obvious.

When the Overview has been completed you will have:

- Agreed with the individual, where they are able to do so, the actions that should be taken.
- Determined the key actions
- Collected information about the individuals' assessed needs that have triggered referrals to other agencies
- Assessed the risks associated with the assessed needs

Stage 3: Specialist Assessment

This offers a way of exploring specific needs, often in detail and may be indicated by either a Contact or Overview Assessment. As a result of a Specialist Assessment, professionals should be able to confirm the presence, extent, cause and likely development of a health condition/ problem or social care need and establish links to other conditions, problems and needs.

Specialist assessments will rely on their quality on the involvement and judgement of appropriately qualified and competent professionals. They will rely on the use of assessment scales in support of their professional judgement.

Those carrying out specialist assessments may draw on information collected at either contact or overview assessment, where these have been carried out.

Stage 4: Comprehensive Assessment

This may arise in several ways, for example, from the outset it may be obvious to a doctor or other qualified professional that based on their professional judgement, the needs and circumstances of an older person are such that a Comprehensive Assessment involving Specialist Assessments of all or most of the domains of the Single Assessment Process should be commenced. In this situation, conducting an Overview Assessment would be unnecessary and may delay getting the right help for the individual.

Alternatively at initial contact there would be less certainty and an Overview Assessment may be carried out to explore areas of concern, when all the domains of an Overview have been surveyed and Specialist Assessment carried out in most of them, the result is also a Comprehensive Assessment.

In addition, Comprehensive Assessments should be completed for people where the level of support and treatment likely to be offered is intensive or prolonged, including

permanent admission to a care home, intermediate care services or substantial packages of care at home.

Most commonly it is believed that the Comprehensive Assessment is carried out where there are two or more Specialist Assessments.

Therefore the Contact and Overview Assessments are a foundation for the Specialist and Comprehensive Assessments.

Care Co-ordination

The Department of Health have indicated that the Single Assessment Process uses a co-ordinator to deal with Comprehensive Assessments. Professionals will be asked to complete their appropriate Specialist Assessments and submit the assessments or summaries to the person who has been identified as co-ordinating the Comprehensive Assessment.

The co-ordinator then evaluates and interprets the various assessments that have been carried out in order to complete a summary of identified needs and subsequent care plan.



Although the documentation is on paper at this stage, the long-term plan is to develop a system of using computers which enables each agency to transfer relevant and appropriate information and actually talk to each other. Whatever happens it is vitally important that every effort is made to ensure that the paper work gets to where it is needed.

Activity

Consider your understanding of the Contact, Overview, Specialist and Comprehensive Assessments in relation to the processes that you currently use.

1. Does this represent anything different for you?
2. Will this make sharing information more effective and timely for you?
3. Reflect on any other feelings that you have about using the Process.

Domains and Sub-domains of the Overview and Comprehensive assessment

<p style="text-align: center;">User's Perspective</p> <ul style="list-style-type: none"> • Problems and issues in the user's own words • User's expectations and motivations 	<p>Personal fulfilment Spiritual fulfilment</p>
<p style="text-align: center;">Clinical Background</p> <ul style="list-style-type: none"> • History of medical problems • History of falls • Medication use and ability to self-medicate 	
<p style="text-align: center;">Disease Prevention</p> <ul style="list-style-type: none"> • History of blood pressure monitoring • Nutrition • Vaccination history • Drinking and smoking history • Exercise pattern • History of cervical and breast screening 	
<p style="text-align: center;">Personal Care and Physical well-being</p> <ul style="list-style-type: none"> • Personal hygiene, including washing, bathing ,toileting and grooming • Dressing • Pain • Oral hygiene • Foot-care • Tissue Viability • Mobility • Continence and other aspects of elimination 	<p>Eating, drinking and swallowing Breathing difficulties</p>
<p style="text-align: center;">Senses</p> <ul style="list-style-type: none"> • Sight • Hearing • Communication 	
<p style="text-align: center;">Mental Health</p> <ul style="list-style-type: none"> • Cognition and dementia, including orientation and memory • Mental Health including depression, reactions to loss and emotional difficulties 	
<p style="text-align: center;">Relationships</p> <ul style="list-style-type: none"> • Social contact, relationships and involvement in leisure, hobbies, work and learning • Caring arrangements 	<p>Personal relationships and lifestyle choices</p>
<p style="text-align: center;">Safety</p> <ul style="list-style-type: none"> • Abuse and neglect • Other aspects of personal safety • Public safety 	
<p style="text-align: center;">Immediate Environment and resources</p> <ul style="list-style-type: none"> • Care of the home and managing daily tasks such as food preparation • Accommodation and heating • Level and management of finances • Access to local facilities and services 	

Group Exercise

Planning the Single Assessment Process

The Activity

1. Organise the participants into groups of six to eight, each with a facilitator. It is best to have the facilitator from outside the group. It is also helpful if staff from different agencies are in each group.
2. Facilitators need to lead quite structured discussions about the following topics and record the views of the group. This activity is very much about:
 - giving people the chance to air their worries and concerns
 - finding out what they feel they have understood so farTopics for discussion:
 - Key principles of the single assessment Process
 - Likes and Dislikes
 - Ideas for making it work
 - Questions
3. Ask each group to identify a key issue in each Area to share with the other groups.
4. Use the Flowchart below to assist with mapping which teams or groups will undertake which part of the assessment on a majority basis.
5. These issues can be fed back to the Locality Group and the Project Board to provide answers and note potential problems.

Aim

To bring all the issues that are brewing about the introduction and implementation of Single Assessment, out into the open. This provides an opportunity for you as a trainer to:

- Check people's understanding of the process
- Allow them to ask questions
- Feedback to trainers and managers any possible areas of difficulty that you the trainer identify.

This makes a good exercise for the end of the first session, so long as there are follow-up sessions when managers can come back with responses to questions they cannot answer the first time around!

Time

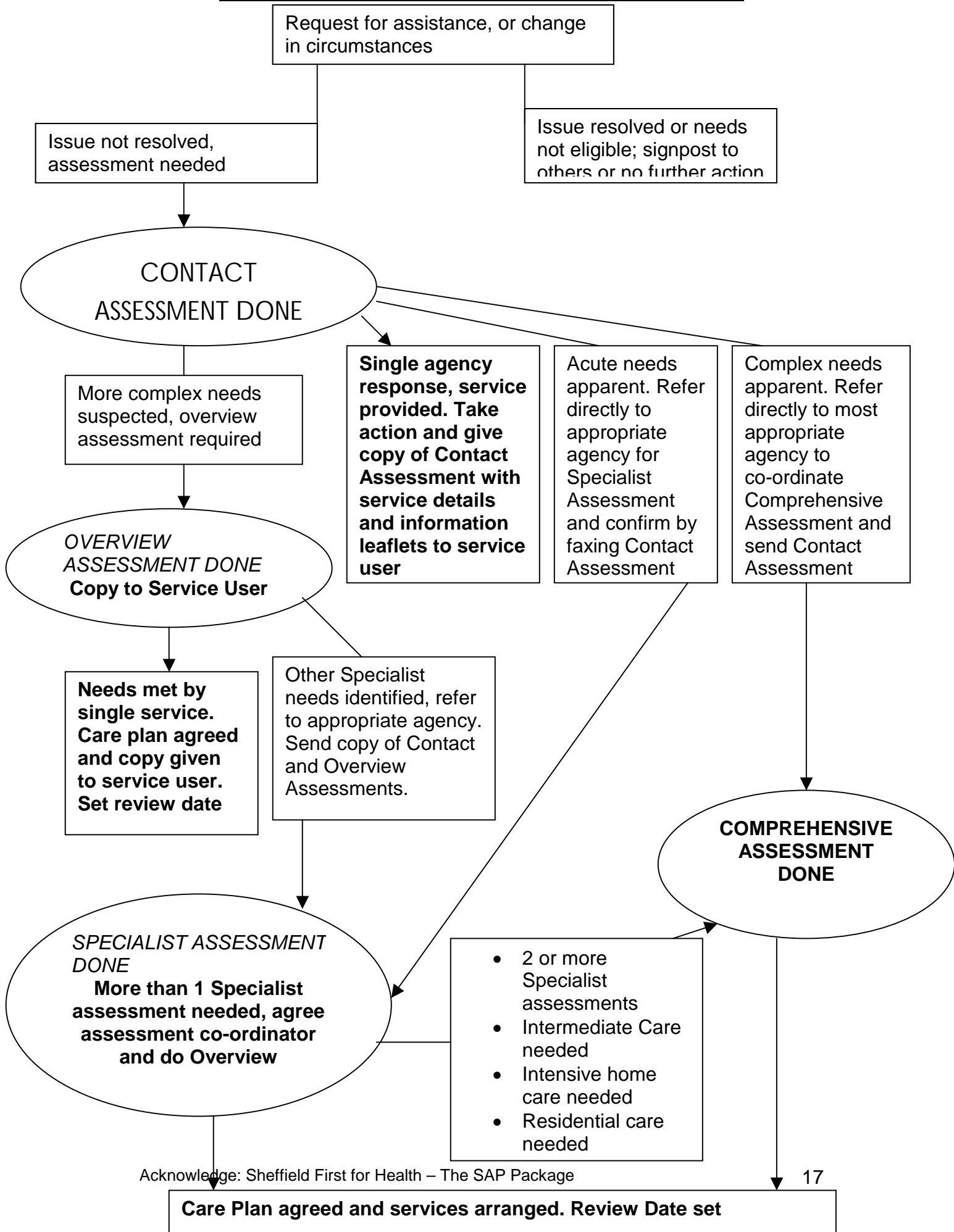
30 minutes, plus time for feedback (about 20 minutes, depending on the number of groups)

You will need

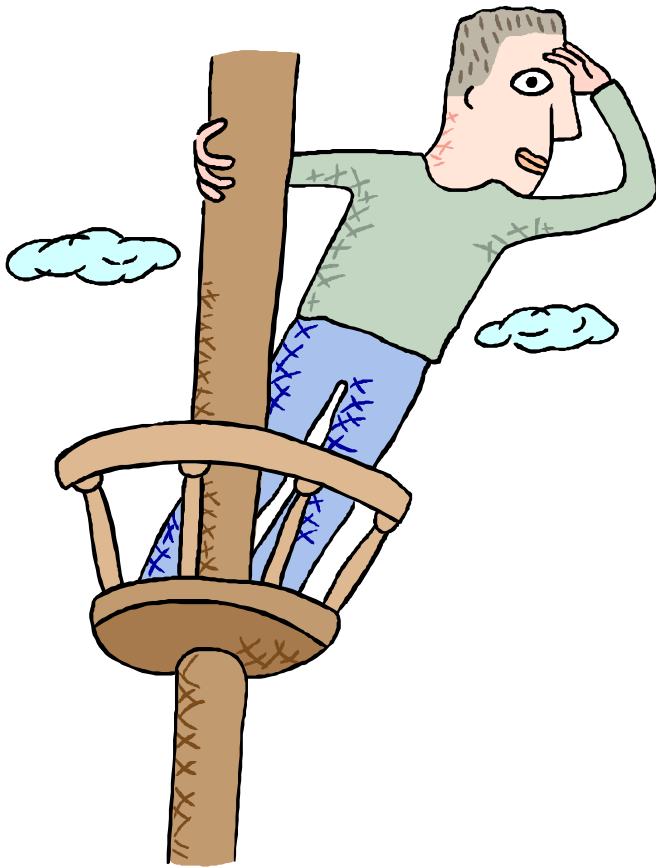
Flipchart and marker pens.

It is really important that the message goes out to staff that there is still room for improving and refining the process and therefore their ideas are important. Locality Groups need to ensure that they are able to provide the answers to their queries in a consistent way.

SINGLE ASSESSMENT PROCESS FLOWCHART



WHO, WHERE AND WHEN?



WHO SHOULD CARRY OUT SAP?

This is the easy answer – **you should**, if you meet the criteria for undertaking any part of the assessment process. It is your responsibility and ultimately all of our responsibility to ensure that SAP is carried out successfully for the benefit of service users and carers.

The person who can carry out the Contact and Overview Assessment is an experienced, suitably trained person but not necessarily a qualified practitioner.



Make a note here of all, the agencies involved in SAP.



Within each of the agencies make a note of those people/ roles, who you think will be able to do the Contact and Overview Assessments

Contact Assessment

Overview Assessment

WHERE SHOULD SAP BE CARRIED OUT?



As you can imagine, where SAP takes place is crucial. Overall it takes place wherever you are and you see that a service user has needs.

The two most obvious places are:

- In the person's home
- In a care setting



Make a note of the settings that you are most likely to be carrying out Assessments in.



Write down a list of reasons for Assessments being conducted within your own environment and consider the impact on the service user.

Use this space to write reflections on current practice and any issues this raises in relation to SAP.

WHEN SHOULD SAP BE CARRIED OUT?

Why is it important to think about when and where?



It is about being person-centred.

When you do the assessment is also important.

- First of all, you need to do an assessment if there is no evidence of SAP and the situation indicates that it needs to be instigated.
- You may also need to update your assessment if you have met the individuals' needs before and their needs have changed.
- The assessment is also necessary if you have been called in as a Specialist.

Use this space for any reflections.

Group Exercise

Getting to know you!

Aim: To improve the participants understanding of the older person's view of assessment

Time: 15 minutes

You will need; A4 paper and pens, Flipchart and marker pens.

The Activity

1. Ask participants to imagine they are an older person who has had increasing difficulty preparing meals because of arthritis in their hands. They are expecting someone to call to discuss the problems they are facing. In role as the older person they should consider the following questions (it may help to put them up on the wall):

What information do you want?

What do you expect from this assessment?

2. Ask them to take a few minutes on their own to consider questions, jotting down some ideas. Then ask them to join with the three other people to share their ideas and begin to build a composite list, recording it in a written note or on flipchart paper.
3. Address each of these two questions and begin to record the groups' responses on a flipchart. Alternatively you could ask one group to present their findings by referring to their previous notes. Other groups can add or enlarge upon the presentation.
4. The expected responses are noted below, and you should raise any of these issues which don't come up during the discussion.

Responses to 'What information do you want?'

- Who is the assessor?
- What agency do they work for?
- What do they do?
- What kind of help can they offer?
- What information do they want?
- What happens to this information?
- Is it written down, or stored on a computer?

- Who can have access to this information?
- Can I see this information?
- What is the point in answering all these questions?

Responses to ‘What do I expect from this person?’

I expect the assessor to:

- be friendly, interested and to listen to me
- take time and work at a pace to suit me
- offer me choices
- sort things out for me
- be knowledgeable
- be honest with me
- give me key decisions and issues in writing or in another appropriate format
- write down what I say at the time (I am worried they will forget otherwise).

MODULE 2

Information Sharing and the Law

ETHICAL CONSIDERATIONS



What is confidential patient information?

Patients entrust us with, or allow us to gather, sensitive information relating to their health and other matters as part of seeking treatment. They do so in confidence and they have the legitimate expectation that staff will respect their privacy and act appropriately. In some circumstances patients may lack the competence to extend this trust, or may be unconscious, but this does not diminish the duty of confidence. It is essential, if the legal requirements are to be met and the trust of service users/patients is to be retained, that as service providers we provide and are seen to provide, a confidential service.

It is extremely important that patients are made aware of information disclosures that must take place in order to provide them with high quality care. In particular, clinical governance and clinical audits, which are legitimate components of healthcare provision, might not be obvious to patients and should be drawn to their attention. Similarly, whilst patients may understand that information needs to be shared between members of care teams and between organisations involved in healthcare provision, this may not be the case and efforts should be made to inform them with respect to the breadth of the disclosure required.

Patient Consent

Patients generally have the right to object to the use and disclosure of confidential information that identifies them, and need to be made aware of this right. Sometimes, if patients choose to prohibit information being disclosed to professionals involved in providing care, it might mean that the care that can be provided is limited and, in extremely rare circumstances, that it is not possible to offer certain treatment options. Service users/ patients must be informed if their decisions about disclosure have implications for the provision of care or treatment. Clinicians cannot usually treat patients safely, nor provide continuity of care, without having the relevant information about the patient's condition and medical history.



One of the most significant changes to the assessment process for all professionals with the introduction and implementation of single assessment, is in relation to consent and information sharing on a grander scale.

Consent may already be a considerable part of the documentation that you use currently, however, in this instance consent is in relation to the service user/patient/client, giving permission for the information that you have collected to be shared with other professionals

Previously this has not been an issue, as consent to sharing information has been implied. In other words, the service user would not have provided information told if they did not want you to know. Now this has become a much more formal process where these types of assumptions cannot be made.



Key points for consent

The Department of Health issued guidelines for consent in relation to treatments and procedures. Although these were in a different context the principles remain the same because the Human Rights Act (2000) stipulates these conditions

Article 8 of the Human Rights Act (2000) reads: ' Everyone has the right to respect for his private and family life, his home and his correspondence'.

Where service users/ patients have been informed:

- (a) the use and disclosure of their information associated with their healthcare; and
- (b) the choices that they have and the implications of choosing to limit how information may be used or shared;

then explicit consent is not usually required for information disclosures needed to provide that healthcare. Even so, opportunities to check that patients understand what may happen and are content should be taken.

The key issues to consider in relation to consent are:

- Consent is a process, not an event
- Consent which is not based upon understanding is not valid
- A signature on a form is only evidence of a signature
- Consent MUST be voluntary
- Consent to share information can be withdrawn at any time.

The right to privacy can present problems when collecting information. The Human Rights Act (2000, Article 8) identifies that a person has the right to respect and privacy and family life. This means that anyone can choose not to share information either with you or anyone else. They also have the right to make decisions about what you see and hear about them. The dilemma is therefore, how this affects the assessment of the service user and what the implications are for the actions taken as a result of the assessment.

Confidentiality, Data Protection, Caldicott and Seamless Care

Government policy places a strong emphasis on agencies working together, in partnership with each other and with people in contact with our services, to provide a seamless service that is centred on the needs of the individual.

Government policy also emphasises the importance of security and confidentiality of personal information, informing individuals about the use of this information, and their rights in relation to this. Legislation and guidance has been strengthened through the Data Protection Act 1998 and Caldicott guidance.

Keeping information about service users/patients secure and confidential should not be confused with keeping information secret. The appropriate sharing of relevant information is essential for the provision of a seamless approach to care. Having all the relevant information aids the assessment process and enables informed decisions to be made in discussion with the service user/ patient about the support, care and treatment that is required.

The sharing of information is particularly important in cases of mental health and child protection. Numerous inquiries (many of which have been well publicised) have shown that it is both the inappropriate withholding of, and the failure to share information between organisations, across professional boundaries, and with carers, that has led to adverse consequences both for others and for the individuals concerned.

Common law duty of confidence

All NHS bodies, Local Authorities and those carrying out functions on behalf of the NHS and Local Authorities have a common law duty of confidence to service users/patients of our services and a duty to maintain ethical standards of confidentiality.

Everyone working for the NHS and Local Authority, or in partnership with them, who comes into contact with personal information has a personal common law duty of confidence to service users/ patients of the service and to their employer. The duty of confidence continues after the service user/ patient's death, or after the employee leaves the organisation.

In general, any personal information, given or received in confidence for a particular purpose cannot be used for a different purpose unless the individual has given consent. Confidential information can only be disclosed if the person in receipt of the information has grounds to do so. The grounds on which an obligation of confidence does not apply or can be breached are:

- Where the individual has given consent
- Where there is a legal compulsion or
- Where there is an overriding public interest

Examples of circumstances where information can be disclosed without consent include:

- Where information is required by court order
- Where information is required by statute such as the notification of births, deaths, abortions and some infectious diseases.
- Where there is a serious risk of harm to the individual
- Where a child is believed to be at risk (Children Act 1989)
- Where information is required for the prevention, detection or prosecution of a serious crime

- If the individual gives information about a serious crime that has been committed, such as murder, rape, treason or kidnapping (Police and Criminal Evidence Act 1984)



Make a list of the dilemmas that might present themselves in relation to privacy either by using the case study or recalling a service user from previous experience.

After discussion with the group or with a colleague, reflect on how important these issues are in relation to your role and then write down your decisions in relation to the following questions:

1. How much would you really need to know as opposed to what might be nice to know?
2. How much do you really need to write down of what you know?
3. How much do you need to share?
4. What are the consequences of your answers to the previous questions?

Caldicott

What is Caldicott?

- A review commissioned by the Chief Medical Officer to investigate the ways in which patient information is used in the NHS.
- The Caldicott committee made a number of recommendations aimed at improving the way that NHS handles and protects service user/ patient information.

- These are summarised as the **six Caldicott general principles** for information management

The six Caldicott general principles

1. Justify the purpose(s)

Every proposed use or transfer of personally-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuity uses regularly reviewed by an appropriate Guardian.

2. Don't use personally-identifiable information unless it is absolutely necessary

Personally-identifiable information items should not be used unless there is no alternative.

3. Use the minimum information that is required

Where use of personally-identifiable information is considered to be essential, each individual item of information should be justified with the aim of reducing identifiability.

4. Access should be strictly on a need-to-know basis

Only those individuals who need access should have access to it, and they should have access to the information items that they need to see.

5. Everyone must understand his or her responsibilities

Both practitioner and non-practitioner staff are aware of their responsibilities and obligations to respect an individual's confidentiality.

6. Understand and comply with the law

Every use of personally-identifiable information must be lawful. Someone in each organisation should be responsible for ensuring that the organisation complies with legal requirements.

Data Protection Act 1998

What is it?

- It became law in March 2000 and sets out standards which must be satisfied when obtaining, recording, holding, using or disposing of personal data.
- These standards are summarised as the **eight Data Protection Act principles**

The Eight DPA Principles

Personal data must be:

1. Processed fairly and lawfully – there should be no surprises, so... inform subjects why the data is being collected, what is being done with it and with whom it is likely to be shared.

Be open, honest and clear

2. Processed for specific purposes – only used for the purpose for which it was obtained and only share information if you are certain that it is appropriate and necessary to do so.

If in doubt, check first

3. Adequate, relevant and not excessive – only collect and keep information required; it is not acceptable to hold information unless you have a view as to how it will be used and do not collect information 'just in case'

4. Accurate and kept up to date – Ensure when inputting that it is done accurately, check existing records before adding new ones and avoid creating duplicate records

5. Not kept for longer than necessary – follow retention guidelines; check retention policy of the organisation, check disposal policy and dispose of information correctly

6. Processed in accordance with the rights of data subjects (service user) – subject access, prevention of processing, compensation, request and assessment.

7. Protected by appropriate security (this has two parts – practical and organisational)

Practical: Use of safe haven or secure faxes, **always** keep confidential papers locked away, ensure confidential conversations cannot be overheard, ensure confidential information is transported securely.

Organisational: Good information management policies, guidelines on IT security, staff training, confidentiality clauses in employment contracts, procedures for access to personal data, disposal policy and procedures for confidential information, confidentiality contracts with third parties

8. Not transferred outside the European Economic Area (EEA) without adequate protection – ensure consent is obtained and it is adequately protected, care about putting information on websites and check where information is going

Issues of Confidentiality

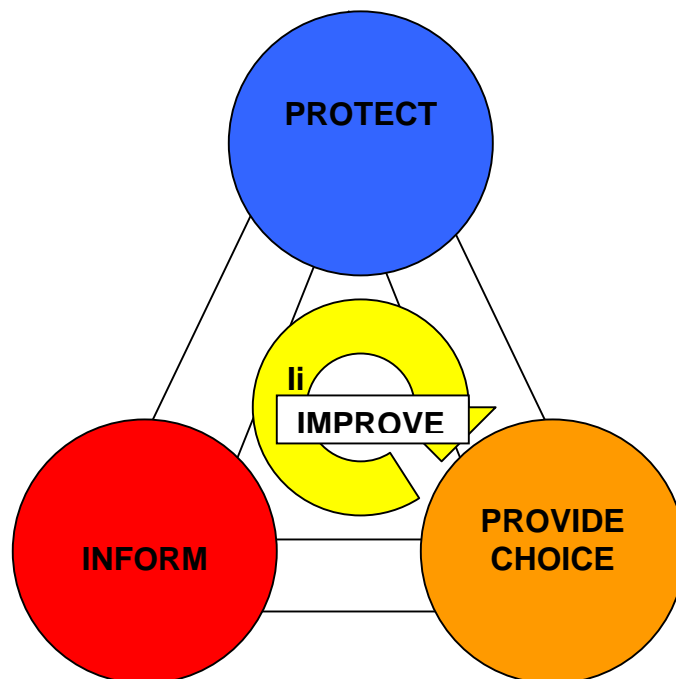
The Confidentiality Model (as outlined in Confidentiality: NHS Code of Practice, Nov.2003)

It outlines the requirements that must be met in order to provide patients with a confidential service. Record holders must inform patients of the intended use of their information, give them the choice to give or withhold consent as well as protecting their identifiable information from unwarranted disclosures. The four main requirements are:

- a. **PROTECT** –look after the patient’s information
- b. **INFORM** – ensure that patients are aware of how their information is used
- c. **PROVIDE CHOICE** – allow patients to decide whether their information can be disclosed or used in particular ways.

To support these three requirements, there is a fourth:

- d. **IMPROVE** – always look for better ways to protect, inform, and provide choice.



PROTECT

- Recognising that confidentiality is an obligation for all staff, external contractors and volunteers
 - Duty of confidence, professional obligations and staff employment contracts (including those of contractors). Breach of confidentiality, inappropriate use of health records or abuse of computer systems may lead to disciplinary measures.

- Voluntary staff and students are also under obligations of confidentiality, and must sign an agreement indicating their understanding when working within the NHS.
- Recording patient information accurately and consistently
 - Maintaining proper records is vital to patient care. Patient records should:
 - (a) be factual, consistent and accurate: written as soon after the event; written clearly and legibly; alterations or additions dated and timed, and signed; accurately dated, timed and signed; readable when photocopied; written with the involvement of the patient/ carer; be clear and unambiguous; be consecutive
 - (b) be relevant and useful: identify problems that have arisen and action to rectify them; provide evidence of care planned, decisions made, care delivered and information shared; provide evidence of actions agreed with the patient.
 - (c) And include: medical observations; relevant disclosures by the patient; facts presented to the patient and correspondence for the patient or other parties.
 - (d) Should not include: unnecessary abbreviations or jargon; meaningless phrases, irrelevant speculation or offensive subjective statements; irrelevant personal opinions regarding the patient.
- Keeping patient information private
 - This includes aspects such as not gossiping and taking care when discussing cases in public places
- Keeping patient information physically and electronically secure
 - Staff should not leave portable computers, medical notes or files unattended or in easily accessible areas.
 - All files and portable equipment should be under lock and key when not actually being used.
 - Should not normally be taken home, but where this cannot be avoided, procedures for safeguarding information effectively should be locally agreed.

INFORM PATIENTS EFFECTIVELY – NO SURPRISES

Patients must be made aware that the information they give may be recorded, shared (in order to provide them with care); and may be used to support local clinical audit.

Consider whether patients would be surprised to learn that their information was being used in any of the above ways – if so, they are not being informed correctly.

- Check patients have seen available and appropriate information leaflets.
- Make clear to patients when information is recorded or health records accessed
 - this should occur as part of the natural conversation.
- Make clear to patients when information is or may be disclosed to others
 - in respect of a referral letter: *'I am writing to the consultant to let them know about your medical history'*; or
 - with electronic records: *'The hospital specialist is able to view your health records to understand your medical history'*; or
 - in respect of other agencies: *'I will tell Social Services about your dietary needs to help them arrange Meals on Wheels'*
- The amount of disclosure should be proportionate to the actual need.
- Check that patients are aware of the choices available in respect of how much information may be used or shared.
 - patients have the right to choose whether or not to agree to information being used or shared, beyond what they understood to be the case.
- Check that patients have no concerns or queries about information is used
 - staff should be explicit about what information is being recorded, and asked if they are happy for the information to be shared.
- Answer any queries personally or direct patients to others who can answer their questions or other sources of information.
 - it is much better for patients if their concerns can be addressed immediately, but if staff cannot answer the questions, they must refer to a better source.
- Respect the right of patients to have access to their health records
 - patients have a right to see and/ or have copies under the Data Protection Act.
- Communicate effectively with patients to help them understand

PROVIDE CHOICE TO PATIENTS

Patients have different needs and values. Patients have the right to choose whether or not to accept a form of care and the information disclosure needed to provide that care, and to choose whether or not information that can identify them can be used for non-healthcare purposes.

- Ask patients before using their personal information in ways that do not directly contribute to, or support the delivery of their care
 - ensure that patient identifiable information is anonymised where possible.
 - Efforts should be made to obtain and record consent
- Respect patients' decisions to restrict the disclosure and/ or use of information
 - it may not be possible to meet some patient's requests directly and in these circumstances a compromise arrangement should be agreed.
 - It is essential that complete records are kept of all care provided and of any restrictions placed on disclosing by patients. When patients impose constraints it is important to demonstrate that neither patient safety, nor clinical responsibility has been neglected.
- Explain the implications of disclosing and not disclosing
 - in order that valid choices can be made, patients must not only know what their options are, but also what the consequences are of making those choices.
 - Where patients insist on restricting how information may be used or shared in ways that compromises the ability to provide them with high quality care, this should be documented within the patient's record. It should also be made clear to the patient that they can change their mind at a later date.

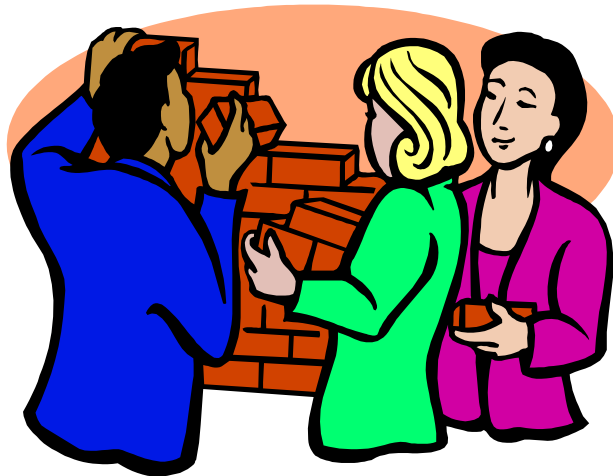
IMPROVE WHEREVER POSSIBLE

- Be aware of the issues surrounding confidentiality, and seek training or support where uncertain in order to deal with them appropriately
 - ignorance is no excuse. Staff must work within their codes of practice, locally produced guidelines, protocols and procedures.
- Report possible breaches or risk of breach
 - if staff identify possible breaches, then they must raise these concerns with their manager or other appropriate colleagues. Staff must be encouraged and supported by management to report organisational systems or procedures that require modifications.
 - There is specific legislation to protect individuals reporting abuses – www.pcaw.co.uk [Public Concern at Work]

MODULE 3

Joint Working – making it work!

UNDERSTANDING ROLES AND RESPONSIBILITIES



Understanding the nature of Assessment

What is Assessment?

Understanding the nature of the Assessment Process is fundamental to the effective implementation of Single Assessment. It is therefore important to consider *Assessment* in a generic way.

1. Assessment is a **comprehensive** process that identifies an individual's holistic care based on their **potentials** whilst considering appropriate risk factors.
2. Assessment is a **person-centred** activity with the emphasis on establishing areas of needs to maintain or increase **independence** and **quality of life**.
3. Effective comprehensive person-centred assessment includes both **subjective accounts** (individual's experience) with **objective measurement** (structured instruments).
4. The individual's **biography** is central to all assessments
5. Decisions supporting assessment are supported by **objective evidence**, **user's preferences** and **professional opinion**.
6. A comprehensive assessment gives a clear indication of the type and amount of **care needed** and the most appropriate person to provide it.
7. The **language of the assessment** should be clear to all who participate in the process and the user who **owns the assessment**.
8. Effective assessment requires **knowledge**, **skills** and **expertise** in assessment processes, including **interpersonal skills**, **communication skills** and skills in **record keeping**.
9. Comprehensive assessment requires teamwork, built on the principle of **effective communication**, **clarity of role** and **mutual respect and honesty**.
10. Inter-agency assessment needs to be **co-ordinated** from a central point, with a **single point of access** and systems that support effective co-ordination (including an IT system).

ASSESSMENT PROCESSES

Exercise

Aim

To ensure everyone is clear about the current level of overlap in processes. This can be looked at in relation to joint working or in relation to the single assessment process.

Time

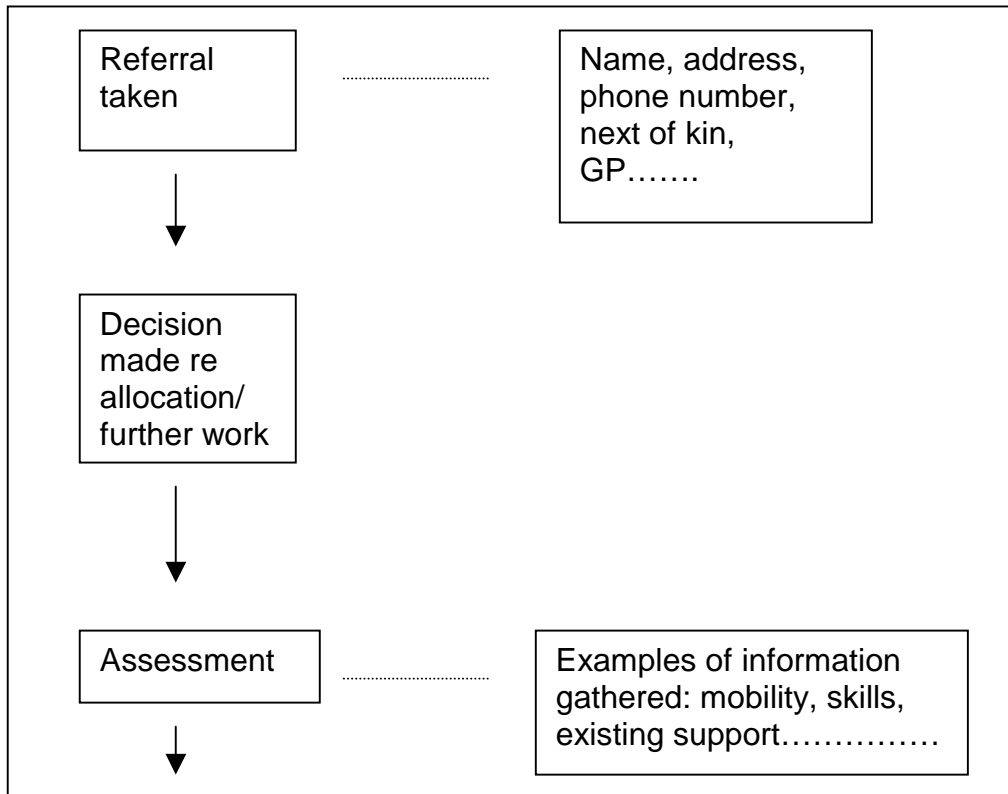
45 minutes

The Activity

1. Organise people into groups within their own agencies. They need to be working in the same system so, for example, if occupational therapists and social workers use separate intake/duty systems you need to ensure they are in separate groups.
2. Give each group a piece of flipchart paper. Make it clear that the information they record will be shared with the wider group (both so they are aware of this, and so it is legible)
3. Ask each group to take 10 minutes to draw a simple flow chart of the process a service user or patient goes through from first contact to end of assessment. Ask them to do this down the left hand side of the paper.
4. Then ask each group to take 15 minutes to list the information gained at each stage on the right hand side.

This is not a full process mapping exercise so it doesn't have to be perfect, and the timescales are not important – people just need to get the essentials down.

Here is an example:



5. Ask the group to stick up their sheets and give them 10 minutes to look at each other's flow charts with the focus on identifying areas of similarity and areas of difference.
6. Bring them back into the large group and do a quick plenary yourself, recording on a flipchart areas of common ground and areas where there are no overlaps.

What makes a good assessment?

Exercise

Acknowledge: Sheffi

Aim

To develop a shared understanding of the principles of a 'good' assessment, focusing on assessments, which can be shared across agencies, and are person-centred.

The Activity

1. Organise participants into groups of four to six. These should be mixed groups with staff from different agencies and professional backgrounds.
2. Provide each group with a facilitator or ask them to nominate a leader and scribe.
3. Ask the groups to answer the question: 'What makes a good assessment?' recording as many thoughts as they have. They should not get into too much detail (such as what information is collected) but look at the broad issues (whether assessments are person-centred, etc). Explain that they will be asked to feed back to the whole group later.

Some issues to start people thinking:

- The use of jargon

- Putting the older person at the centre of the assessment (what does this mean?)
- How will people from another agency or background know what you mean and what areas you have covered?

4. After 30 minutes stop and take feedback from the groups

Current roles and responsibilities

Exercise

Aim

Team Building and joint working

Time

45 minutes minimum

You will need

A4 paper and pens for each person

Flipchart and marker pens for each group

The Activity

- 1. Give out pens and paper and ask everyone to take 10 minutes on their own to list the current key responsibilities of their role. Give a couple of examples to ensure people understand this should include both tasks they may have in common with others and ones that are specific to their role.**
- 2. Organise participants into groups of six to eight, ensuring each group has a good mix of people from all agencies. Each group needs to appoint a facilitator. They also need a flip chart and pens.**
- 3. Give the groups a minimum of 15 minutes to list their responsibilities together and discuss. Warn them that these lists will be posted up later for other groups to share!**

A helpful way of keeping the lists tidy is to divide the flip chart sheet up like this:

	District Nurse	Occupational Therapist
	1	1
	2	2
	3	3
	Care Manager	Speech Therapist
Acknow	1	1
	2	2
	3	3

4. At the end ask the groups to put up their sheets and share the outcomes. The facilitators should be prepared to pull together any themes, such as: things everyone has in common, things that are very much the province of one group, and so on.

SOCIAL CARE

Understanding Eligibility Criteria

FAIR ACCESS TO CARE SERVICES (FACS)

What is Fair Access to Care Services?

Fair Access to Care Services is policy guidance issued by the Government in May 2002 to local authorities, requiring them to draw up eligibility criteria for social care services from April 2003. The guidance provides councils with an eligibility framework for adult social care, for them to use when setting and applying their eligibility criteria.

What have Local Authorities had to do in response to this guidance?

Local authorities already have a legal duty to assess the needs of people with chronic ill health and /or disabilities who appear to need community care services. After assessing these needs the Council must decide whether it is necessary for them to arrange or provide services, and it uses eligibility criteria to help with this decision.

Under Fair Access to Care Services the local authority should assess an individual's presenting needs, and prioritise their eligible needs, based on the risks to a person's independence in both the short and longer- term were help not to be provided.

Once the authority has decided on its eligibility criteria it must meet the needs of people who have been assessed as having eligible needs, and it has to make sure that it meets the needs of people in greatest need before meeting the needs of people with lesser needs.

The authority also has to ensure that it regularly reviews the needs of people receiving social care services arranged or provided by the council to make sure that people are still eligible to receive them and that they are achieving the agreed outcomes. These reviews should include a re-assessment of an individual's needs.

Why have these changes been made?

A fundamental aspect of the guidance is for individual councils to make only one eligibility decision with respect to adults seeking social care support: that is, whether they are eligible for help or not. This decision should be made following an assessment of an individual's **presenting needs**. Councils should not operate eligibility criteria for specific types of assessment; rather, the scale and depth of the assessment should be proportionate to the individual's presenting needs and circumstances. Neither should councils operate eligibility criteria for different services to meet **eligible needs**.

By creating an eligibility framework based on the risk to a person's independence the council will have a method which is straightforward to understand. It will also enable the council to make sure that people with similar needs and circumstances receive similar services no matter where they live in the County or City.

Links to other legislation

- **Health and Social Care**
 - Local health bodies and councils were requested to agree their respective responsibilities for continuing health and social care services by March 2002, as outlined in HSC 2001/015;

LAC (2001)18). Once there is agreement about local responsibilities for NHS care and social care, councils should use the Fair Access to Care guidance.

- Where local health bodies and councils are operating partnership arrangements under section 31 of the Health Act 1999, the FACs guidance should be used by those agencies as a starting point to help them determine joint eligibility.
- **Carers**
 - For many individuals the help and support of family members or other carers is essential to them remaining independent. Often carers should, and need to be, involved in the assessments and subsequent decisions about the help that is provided to the individual. Carers' own needs may be assessed within the framework of 'The Carers and Disabled Children Act 2000': A practitioners guide to carers' assessments' (Department of Health, 2001) where the focus is the carer's needs and the sustainability of the caring role.
- **Rights and discrimination**
 - Consideration should be given with regard to the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Human Rights Act 1998 and the Race Relations (Amendment) Act 2000.

Setting the eligibility criteria (Council's Responsibilities)

In general, councils may provide community care to individual adults with needs arising from physical, sensory, learning or cognitive disabilities and impairments, or from mental health difficulties. In this regard, council's responsibilities to provide services are principally set out in the:

- National Assistance Act 1948
- Health Services and Public Health Act 1968
- Chronically Sick and Disabled Persons Act 1970
- National Health Service Act 1977
- Mental Health Act 1983
- Disabled Persons (Services, Consultation and Representation) Act 1986

Councils should use the eligibility framework set out below to specify their eligibility criteria. In other words, they should use the framework to describe those circumstances that make individuals eligible for help. The framework is based on the impact of needs on factors that are key to maintaining an individual's independence over time. There is no reference to age, gender, ethnic group etc within the framework because as factors they do not threaten independence; however, they may need to be taken into account as needs are assessed and services considered.

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

The Eligibility Criteria Grid

<p>Critical</p> <ul style="list-style-type: none"> • Life is, or will be, threatened; • Significant health problems have developed or will develop; • There is, or will be, little or no choice and control over vital aspects of the immediate environment; • Serious abuse or neglect has occurred or will occur; • There is, or will be, an inability to carry out vital personal care or domestic routines; • Vital involvement in work, education or learning cannot be or will not be sustained; • Vital social support systems and relationships cannot or will not be sustained; • Engagement with vital formal support systems is not being maintained; • A serious risk of harm to self or others exists; • There is an inability to access community facilities
<p>Substantial</p> <ul style="list-style-type: none"> • There is, or will be, only partial choice and control over the immediate environment; • Abuse or neglect has occurred or will occur; • There is, or will be, an inability to carry out the majority of personal care or domestic routines; • Involvement in many aspects of work, education or learning cannot or will not be sustained; • The majority of social support systems and relationships cannot be or will not be sustained; • The majority of family and other social roles and responsibilities cannot or will not be undertaken; • Engagement with vital formal support systems are at risk of not being maintained; • Some risk of harm to self or others, or potential current risk exist; • Ability to access a range of essential community facilities is limited; • There is or will be an inability to carry out essential tasks of daily living
<p>Moderate</p> <ul style="list-style-type: none"> • There is, or will be, an inability to carry out several personal care or domestic duties; • Involvement in several aspects of work, education or learning cannot or will not be sustained; • Several social support systems and relationships cannot or will not be sustained; • Several family and other social roles and responsibilities cannot or will not be undertaken; • Engagement with formal support networks are at some risk of not being maintained; • Ability to access some community facilities is limited
<p>Low</p> <ul style="list-style-type: none"> • There is, or will be, an inability to carry out one or two personal care or domestic routine; • Involvement in one or two aspects of work, education or learning cannot or will not be maintained; • One or two social support systems and relationships cannot or will not be maintained; • One or two family and other social roles and responsibilities cannot or will not be undertaken; • Potential inability to access some community facilities exist; • Absence of formal systems could affect level of independence.

In constructing and using their eligibility criteria, and also determining eligibility for individuals, councils should ensure that the following happen:

- Determine an eligibility threshold based on available resources, so as to ensure that the council can meet needs requiring social care support above the threshold.

(The threshold must be set between the risk categories e.g: between Low and Medium, or between Medium and Substantial, or between Substantial and Critical)

- Assess a person's presenting needs for community care services, and evaluate the risks to their independence.

(The extent of the assessment should be proportionate to the presenting needs and circumstances, and should not fairly discriminate on the grounds of age, gender, ethnic group, religion, disabilities, personal relationships, or living and caring arrangements, or whether a person lives in an urban or rural location).

- Arrange for social care services to be provided to meet eligible needs.

(The determination of eligible needs in individual cases should take account of support from carers, family, friends and neighbours).

- Review the circumstances of all people in receipt of social care services, arranged or provided by the council, or purchased with direct payments, from 7th April 2003.

(Initial reviews should take place within 3 months of help first being provided, or of major changes to current services. Reviews should then be scheduled annually or more often if a person's circumstances appear to warrant it).

- Audit and monitor performance with respect to fair access, and share information with all relevant stakeholders, including service users and elected members.

(While primary responsibility for monitoring Fair Access to Care Services lies with the council, the DOH will check FACS implementation through SSI monitoring and inspection).

Now consider the following case examples, that illustrate how the Eligibility Criteria is used when describing the outcome of a Community Care Assessment, and subsequent delivery of services. Then complete the exercises presented after the examples to assist with a practical understanding and application of FACS.

Example 1

An elderly woman (Mrs A), has been discharged home from hospital following an operation on her hip. She lives alone and finds transferring extremely difficult. Whilst in hospital Mrs A was reluctant to eat and drink enough because she was worried about how she would manage to get on and off the toilet. She is very frail, unable to

care for herself and has lost her confidence in her ability to manage at home. She cannot wash or dress herself without a great deal of assistance and she is unable to prepare meals. She has no close relatives or neighbours able to help with care tasks. She does have a good network of friends visiting socially, and a neighbour who does her shopping and collects her pension.

Mrs A's needs are **Critical** because:-

- there is, or will be, an inability to carry out vital personal care or domestic routines

Likely services provided could include:

- daily home care visits to assist with personal care tasks (toileting, washing, dressing) and to provide breakfast and evening snack
- mobile meals to provide a hot mid-day meal
- a benefits check to ensure she is maximising her entitlements
- an occupational therapy assessment to make it safer for her to move around and minimise the risks in her home environment
- arranging for the housing department to provide a community alarm ('Lifeline') to enable her to call for help easily in case of a fall or other emergency.

Example 2

A man with multiple sclerosis (Mr B) lives with his teenage daughter. His illness is at the stage where he no longer works and is now struggling with personal care. He takes a long time and is exhausted doing things himself. His daughter does all domestic tasks. He has said he does not want help with personal care as he wants to remain independent but her would like some help with domestic tasks to take some pressure off his daughter whom is still at school.

Mr B's needs fall into **Moderate** category because:

- There is, or will be, an inability to carry out several personal care or domestic routines;
- Involvement in several aspects of work, education or learning cannot or will not be sustained.

Likely services provided could be:

- an occupational therapy assessment to look at aids and adaptations that may make his personal care routine easier to manage.
- Welfare rights benefit check to maximise income and give an opportunity to arrange private help with domestic tasks
- Carer's assessment for the young carer or, if relevant, a Child in Need assessment
- Provision of services which are not exclusively concerned with undertaking essential care tasks may be appropriate to support the carer in continuing to provide care.

Example 3

An 88 year old woman (Mrs C) admitted to hospital following a fall, has early stages of dementia and a fractured neck of femur. She has responded well to rehabilitation

in hospital and is being discharged. She requires assistance with all aspects of personal care. Her husband (Mr C) phones to seek help saying he cannot cope with her physical needs as he is only just coping with domestic routines, all of which she did before her fall.

Mrs C's needs fall into the **Substantial** category because:

- There is, or will be, only partial choice and control over the immediate environment;
- There is, or will be, an inability to carry out the majority of personal care or domestic routines;
- The majority of family and other social roles and responsibilities cannot or will not be undertaken.

Likely services provided could be:

- complete a community care assessment and a carers assessment
- refer to HART to maximise Mrs C's personal care skills
- consider occupational therapy equipment and adaptations
- offer Direct Payments for Mr and Mrs C to arrange their own services.
- Benefit check to ensure income is maximised and access to attendance allowance for them to buy in some domestic help
- Consider day care to provide respite and give Mr C a break from caring
- Advise Mr C about carers support groups in his area.

Applying Eligibility Criteria - Exercises

Exercise 1

A man with learning disabilities (Mr D) is homeless and has been for the last 2 years. He presents often at the local office to seek assistance. Several attempts have been made to do an assessment but this has not succeeded because each time he fails to keep the appointment.

Facilitator Response

Mr D would not be eligible for services because the risks fall into the **Low** category: absence of formal systems could affect the level of independence.

The risks appear to be Low as Mr D has been living without support for the last 2 years. Mr D would be given advice and information about housing.

The duty team would want to find out why Mr D presents himself at the office – what help does he need?

The duty worker would aim to complete an initial assessment whilst Mr D is in the office – there may be other issues that become apparent from this, that would require the provision of other services e.g supported housing, day services.

Exercise 2

A woman (Ms E) with severe depression has been responding well to her treatment and to her medication and has now managed to return to her part-time job, which she feels helps her to 'keep going'. She has found out that the firm she works for is closing down and she is to lose her job. She is completely self-caring but the CPN has reported that she has recently stopped taking her medication.

Facilitator Response

Ms E would fall into the **Low** category because there is a risk that:-

- Involvement in one or two aspects of work, education or learning cannot or will not be sustained.

This risk is due to concerns over her not taking her medication and the CPN is responsible for addressing this issue. Within the terms of the current Health and Social Care Protocol Home care packages can only include the prompting and administering of medication as part of visits planned to meet social care needs. Home care services will not be provided where the only need is to administer medication.

Ms E could also be sign-posted to employment services that could assist her in seeking new employment.

Exercise 3

A woman in her 20's who has been profoundly deaf since birth and whose language of communication is BSL, has a progressive visual impairment. She lives alone, having moved away from the family home to live independently in the community. She manages her own care and looks after her home but asks for help with paper work, finances and shopping.

Facilitator Response

Her presenting needs fall into **Low / Moderate** category because:-

- There is or will be an inability to carry out several personal care or domestic routines
- Ability to access some community facilities is limited

However, there is a serious risk to independence and likely increase in the level of need and provision of a minimal amount of support will prevent problems arising. The combination of presenting needs, level of risk and available support indicates eligibility for services.

Services provided could include:-

- Referral to the Centre for deaf for information and assessment
- Referral to the Dual Sensory Impairment Team (at Vista) for assessment for the Guide / Help scheme – for help with mobility, managing shopping as well as assisting with communication with third parties.

Exercise 4

A man in his 50's (Mr. G) has been admitted to hospital after experiencing a stroke, which leaves him with a restricted range of movement and mobility, and loss of vision. He is registered blind after medical assessment. He lives with his wife who works part-time, and with his teenage children who are still at school. He has been self-employed as a builder. He is referred by the hospital for home discharge planning. There are financial problems as he will be unable to return to work and he needs help in adapting to cope at home with personal care and daily living tasks. His family support with domestic and personal care.

Facilitator Response

His needs fall into the **Substantial** category because:-

- There is, or will be, only partial choice and control over the immediate environment
- There is, or will be, an inability to carry out the majority of personal care or domestic duties
- Involvement in many aspects of work, education or learning cannot, or will not, be sustained
- Engagement with vital formal support systems are higher risk of not being maintained
- An inability to access essential community facilities

This level of need would make him eligible for community services. However, because of family support will meet many of the needs, the service provision may be minimal.

Service provided could include:-

- Referral to Vista following medical diagnosis, for initial support, information, advice, equipment, rehabilitation and mobility programme, welfare rights advice and home environment assessment.
- Referral from Vista following environment assessment to social services for OT assessment in respect of adaptations to property.
- Community Care and Carer's Assessment
- Arrangement of support services or provision of Direct Payments if services required.

Exercise 5

Miss D is aged 90 and lives alone. She is incontinent of urine on a daily but unpredictable basis, and also suffers from osteoporosis. She cannot bathe or wash herself and there is no-one to help her. The incontinence, and her inability to cleanse herself following accidents, is acutely distressing to this proud and independent individual. In addition, she has great difficulty in undertaking a range of other personal care and domestic tasks. Unless Miss D is helped with bathing and washing significant physical ill health could develop, and social isolation and depression are also likely.

(Critical)

Exercise 6

Mrs G is aged 81 and lives alone. She is becoming increasingly frail due to chronic arthritis and she is experiencing the early stages of Alzheimer's disease. Currently she manages most personal care tasks as her daughter, who lives nearby, comes in three times a day to help her. The daughter, however, is emigrating in two months and in the build-up to departure can only visit once a week. Without her, Mrs G probably will not be able to fully dress herself, shampoo and set her hair, or take a bath. It is unlikely that she will always remember to take her medication. She needs help to maintain a healthy diet, do heavy housework, and manage her household finances. She is unable to do the weekly shopping alone, and needs reminding to lock the house at night. If Mrs G lacks help both prior to her daughter's departure and afterwards, she could well develop more serious health problems, and her ability to live independently at home will be compromised.

(Substantial)

Exercise 7

Mrs K is aged 77 and lives alone. Since a hip operation a year ago, her mobility has been restricted. She cannot do heavy housework and lacks the confidence to go out of doors to the local shops. Since her husband died five years ago, she becomes agitated when it comes to dealing with her bills and household repairs. Her sister, who lives 20 miles away helps occasionally with these tasks, but her availability is limited by distance and her own family commitments. Otherwise, Mrs K manages other daily routines adequately. Without help in the home and with the shopping, Mrs Ks independence is threatened to a degree. Her sister thinks that weekly help with housework and some confidence building could go a long way to putting things right.

(Moderate)

PARTNERSHIP WORKING ARRANGEMENTS

THE HEALTH ACT FLEXIBILITIES

Background

The Health Act Flexibilities were introduced to make closer partnership working possible. Their purpose is to focus attention on how organisations can respond effectively to the needs of their service users and patients by removing some of the worries over organisational boundaries. There are an increasing number of partnerships already using the flexibilities to meet a range of different service needs which build on existing arrangements for joint working and represent a diversity of options to address local circumstances.

Using the flexibilities is seen as a key test of improved partnerships. Pooled budgets and the delegation of functions are expected to become standard practice for all health and local authorities in the planning, commissioning and delivery of intermediate care and community equipment services.

Partnerships take time, trust, commitment and clarity of objectives and outcomes. Partnerships between NHS bodies and local authorities can have very different structures and dynamics. What should be common to all is the desire to work together to achieve an effective person-centred approach to service delivery and provision.

Who to include

The Health Act Flexibilities can be used for health and all health related services of the local authority. Developing a holistic approach to service user focussed services requires the involvement of a range of functions. Within a local authority, this most often means social services but partnerships can also include housing services, education, transport, leisure and recreation, environmental health etc. Housing and community equipment services for example, are a fundamental component in developing effective intermediate care strategies. They will need to include a range of participants' not just the traditional social care and health representatives.

What to focus on

Currently the partnership flexibilities are being used in a range of services, and a range of client groups, which meet local priorities. These include:

- Intermediate care, winter pressure activity
- Learning disabilities
- Mental health
- CAMHS, speech and language therapy
- Joint equipment services
- Drug and alcohol services.

The main messages

The main messages to make are:

- The flexibilities are problem-solving tools: a means to an end
- They are viewed as a key test of partnership working.
- The principle of proportionality is crucial: the size and complexity of the partnership should match the outcome.
- Not everything has to be new and innovative, partnerships can be small scale and common-sense approaches to service delivery.

Understanding the challenges

There are several re-occurring issues around using the flexibilities that helps to focus people. These include:

- Organisational development and Human resources;
- Understanding the cultures
- Moving beyond social care and health: looking at ways of involving other local government functions
- Understanding the role of the independent sector.

Sources of further information

- Section 31 Guidance: <http://www.doh.gov.uk/jointunit/s31guidance>
- CIPFA guide on pooled budgets: <http://www.cipfa.org.uk/shop>
- Intermediate Care and Community Equipment Circulars: <http://www.doh.gov.uk/coinh.htm>
- Updated notifications list in Portable Document Format: <http://www.doh.gov.uk/notifications.pdf>

APPENDICES

Appendix 1

Leicestershire, Leicester and Rutland Health and Social Care Community

Single Assessment Process – Shared Values and Outcomes

This paper is to advise staff across all professions and agencies of the values that need to underpin Single Assessment Process. It is important that we all consider how we can adapt our practices so that we can together provide a better service to Older People we work for.

The key messages underpinning SAP are that we develop:

- **A person centred approach which also values carers and families**
- **A standardised approach leading to closer joint working**
- **An out come centred approach which is responsive to service users and promotes independence**
- **A culturally sensitive approach**
- **An approach valuing staff**

Single Assessment Process is not a piece of paper it is about how you work. It is about finding ways to ensure the assessments of older people can be streamlined so that it allows a more responsive, joined up and seamless service across professionals and agencies.

To achieve this we need all staff to:

- Put the older person at the centre of their assessment – ask for feedback from people you work with on their experience of the assessment process.
- Consider the care pathway – could this be more joined up?
- Ensure that all assessments contribute to maximising the independence of all older people – challenge any that do not do this.
- Understand the legal aspects of record sharing – make these work for you.
- Explore ways to share information across professionals which will reduce work for others – begin to standardise ways information is recorded.
- Build up a trust in the judgement of other professionals and where possible and appropriate act earlier to meet service user's needs sooner.
- Look for duplication in the system and challenge why this happens.
- Begin to standardise your records in line with the SAP framework.
- Acknowledge the roles informal carers and families play in the lives of Older People.

Purpose of Assessment

Assessment is about collecting information on a person's needs and circumstances and making sense of that information in order to identify eligible needs and decide what support and treatment to provide.

The assessment takes place within a wider process which covering:

- Publishing information
- Case finding (optional)
- Completing assessments – 4 stages
- Deciding on the help to be offered (eligibility)
- Care planning
- Monitoring and review

These are stages that for the past 10 years Social Service Departments have had to work to.

The 4 stages of the assessment described in SAP are:

SAP Description	Purpose
Contact	Where significant needs are first described or suspected. Basic personal information is collected and nature of presenting problems identified.
Overview	A more rounded assessment covering different aspects (domains) of a person's need eg personal care/medical/mental health/services etc.
Specialist	Explores specific needs in detail by a trained or suitably qualified professional like OT/physio/social worker/nurse/consultant etc.
Comprehensive	Is completed when a person's needs are so complex and the level of support and treatment is likely to be prolonged or intensive. A comprehensive assessment is when most of the needs or domains covered in the overview assessment have required a specialist assessment.

When asked, Older People in Leicestershire said:

- They would like to be involved in developing new assessments
- We need to overcome age discrimination on assessments
- We need to make assessments individual
- Need to ensure information is secure, accurate and up to date.
- Build in quicker communications between different services

Appendix 2

LEICESTER, LEICESTERSHIRE AND RUTLAND; HEALTH AND SOCIAL CARE COMMUNITY

SINGLE ASSESSMENT PROCESS

GUIDANCE FOR STAFF

Levels of Assessment

Assessment is a process whereby the actual and potential needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Agencies should not implement these types of assessments as if people progress in an ordered sequence from contact to comprehensive. Practice is usually more complex than that and professional judgement is still required. There are four types of assessment:

Contact Assessment

Purpose

This refers to the first contact between an older person and health and social services, where **basic personal information** is collected and the nature of the presenting problem identified by addressing **seven key issues**. This enables the potential presence of wider health and social care problems to be explored.

This basic personal information must always be collected, on the first contact, checked for accuracy, and updated on any subsequent contact made by a person with an agency covered by this guidance. The updating agency should ensure that where the person is known to other agencies working within this guidance, that the information is made available to them.

Seven Key Issues

These include:

- The nature of the presenting problem
Reasons for referral/ intervention
- The significance of the problem for the older person
How does this affect your life?

- The length of time the problem has been experienced.
- Potential solutions identified by the older person
How can we help?
- Other problems experienced by the older person
- Recent life events or changes relevant to the problem(s)
- The perceptions of family members and carers

It will **NOT** be appropriate for professionals to carry out a contact assessment where presenting problems or requests are straightforward and people have indicated there are no other problems or issues. Such instances include: routine blood tests as carried out by district nurses; treatment of specific minor ailments by GPs; requests for information or advice; provision of disabled persons parking permits. However, where referrals to other agencies are indicated and made, the Single Assessment Summary will be completed and forwarded to the relevant professionals.

It **WILL** be appropriate for professionals to explore for wider health and social care problems where:

- Presenting problems are not clear cut; or
- Other potential problems are identified; or
- Requests for more intensive forms of support or treatment have been made.

In making decisions about the breadth and depth of assessment, professionals will often rely on their judgement. In doing this, they will look for clues that may be given in the ways in which older people describe their problems or how they present at the consultation/ assessment interview. For example, there is evidence of:

- Forgetfulness
- Disorientation
- Tearfulness
- Imbalance or mobility problems
- Sensory problems

- Relationship difficulties

The question about recent unsettling life events, that is part of the seven key issues, may be useful in highlighting events or changes that can lead to, or exacerbate, health and social care problems. Examples include:

- Significant personal loss including bereavement
- The breakdown of caring relationships, and
- Being a victim of burglary or other crime
- Being victims of abuse

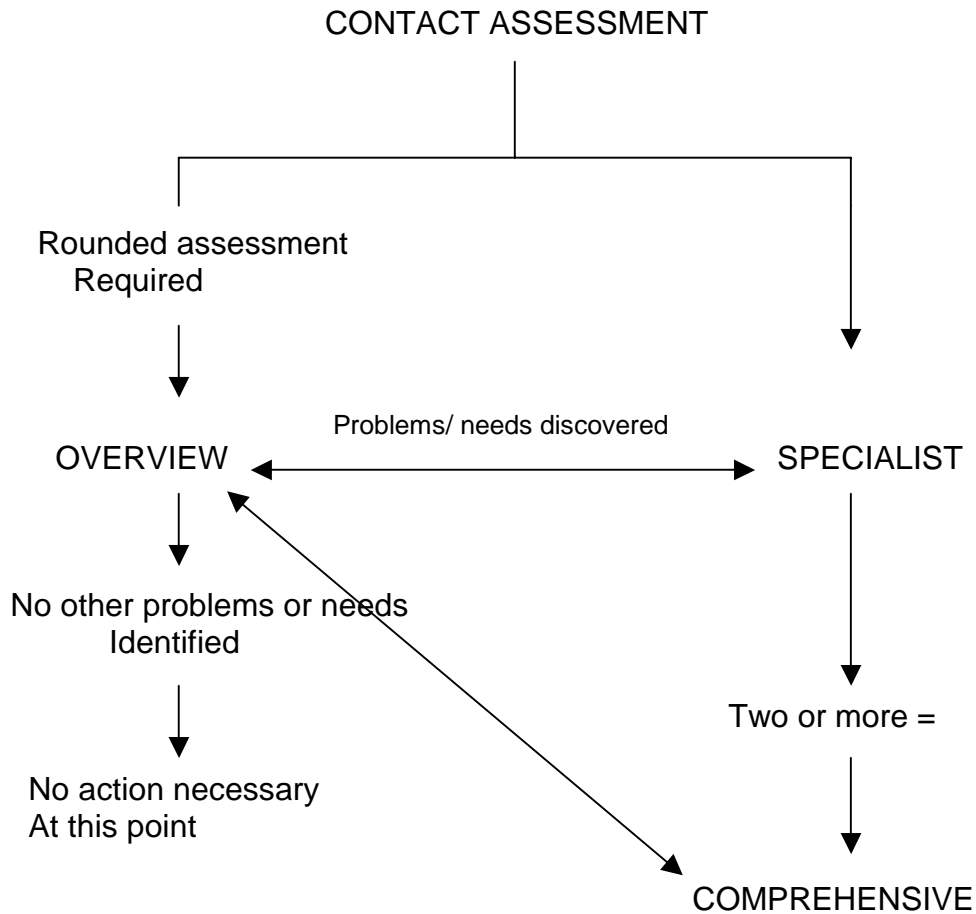
Perceptions of family members and carers are very important. Any type of assessment of an older person's needs should also explore the support and treatment they are already receiving. Where support from carer's is identified, professionals should ascertain the nature of that support, the strength of the caring relationship, and whether the carer requires support and services, either to help them to continue to care for the older person or in their own right.

A separate carers assessment should be considered

On completion of the Contact Assessment, the assessor should consider:

- Provision of a service
- The need for a more rounded assessment, i.e Overview Assessment
- Referral to another agency, Specialist Assessment by an expert in their field ie Occupational therapist, Physiotherapists.
- The need for a Comprehensive Assessment
- No further intervention required.

At this point the SAP can go one of two ways



Overview Assessment

You are expected to carry out an Overview Assessment if, in your judgement, the person's problems are either unclear or such that a more rounded assessment should be undertaken. This should be carried out in the presence of the patient/ service user and if they are unable to indicate their views then it should be identify if the answer is from someone else's perspective.

In some situations a specialist assessment of a specific problem may have been undertaken first, with the overview assessment providing subsequent contextual assessment information.

The Overview has a number of specific areas that it covers and these are called **domains** (*headings*). Where there are areas in each domain that are important, these have also been identified and are called **sub-domains**.

Where the service user indicates that there is not a problem within the domain being considered, it is appropriate for the assessor to move to the next domain. However, where it is obvious to the assessor that there is a problem, they should pursue their assessment in this area having first explained to the service user their reasons for doing so, having sought their co-operation and consent.

When the Overview has been completed you will have:

- Agreed with the person, where they are able, the actions to be taken
- Determined key actions to be taken
- Collected all the assessed needs that will trigger referrals to other agencies
- Assessed the risks associated with the needs identified
- Confidence that you have what you require.

NB: Where there is a strong likelihood of permanent admission to a care home, the receipt of Intermediate Care Services, the provision of intensive services at home, or the provision of health under the Continuing Care Eligibility Criteria, all the domains should be explored, and specialist assessments carried out where necessary.

This equates to a Comprehensive Assessment

Appendix 3

SINGLE ASSESSMENT PROCESS – GLOSSARY

Access Team	The contact point for seeking information about and requesting services from Social Care. May also direct to other services
Advocacy	Process of representing the cause and /or acting on behalf of another person, enabling them to express their opinions
Advocate	A person who speaks for or represents another
Adaptive equipment	Special devices that help people to perform or get around (such as ramps, bars, lower furniture and wheelchair accessories)
Activities of daily living	The everyday things that people do including the things that people do to look after themselves and their home, carry out their work, and leisure activities
Aggregated Data	Anonymised information to be used in research and service planning
Assessment	The process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life are evaluated so that appropriate care can be planned. Assessment identifies problems and includes all relevant view points. It should be a time limited and self-contained piece of work and should culminate in clearly identified needs and objectives for how these needs will be met. It is recognised that needs do not remain static and re-assessment and/ or review recognises these changes
Assessment Beds	Designated beds that will form part of the determination of needs of an older person, where it may be necessary to allow the user and professional staff the opportunity to reflect on future care needs. Usually time limited to an average of six weeks.
Assessment Scale	A set of questions designed to identify the presence and possibly severity of a particular health condition or social care need. Valid scale accurately assesses what it is claimed to assess. Reliable scale when used results in different assessors arriving at similar answers for people with similar needs, or the same assessor

	<p>achieving the same results over time for a particular individual when needs have not changed.</p> <p>Culturally sensitive scale does not unfairly discriminate against people either from minority ethnic communities, or those whose preferred language is not English</p>
Assessment Tool	A collection of questions, scales and personal details to provide comprehensive information on an individual across a range of health and social care needs. An accredited assessment tool is one that has been evaluated against a set of published criteria, by an independent accreditation panel
Assessment summary	A brief statement containing the main points from an assessment
Associate nurse	A nurse who is responsible for meeting a patient's care plans on behalf of the named nurse
Bed Blocking	<p>Term given to older people who are ready to be discharged but whose discharge is delayed unnecessarily because other forms of care are not available.</p> <p>The Community Care (Delayed Discharge) Bill, is intended to prevent bed blocking.</p>
Best Value	The performance regime for all government services
Best Value Reviews	Performance review for local government services, including Personal Social Services, which requires them to review services over a five year period, and seek improvement in services linked to performance indicators such as: national priorities and strategic objectives, cost effectiveness and efficiency, service delivery and outcomes, service quality for users and carers, linked to fair access.
Care Agreement	A contract setting out how a person's assessed needs will be met and what it this will achieve
Care co-ordinator	Practitioner who co-ordinates the various assessments when a person requires the input of a number of professionals. It ensures that assessment and subsequent action is joined up.
Care management	A process which assesses a person's needs, decides which services they are eligible for, produces and introduces care plans, and monitors and re-assesses needs
Care manager	The practitioner responsible for co-ordinating a care package to an individual or group of people

	based on meeting their assessed needs.
Care package	A combination of services designed to meet a person's assessed needs, as part of the care plan arising from the assessment. Can be one or several services, and can be residential and/or community based.
Care pathway	The agreed and explicit route a person takes through health and social care services. It should encompass agreements between respective professionals, to determine when and where, treatment and care will take place.
Care plan	A written statement of service(s) a person can expect to receive following an assessment of need to achieve the desired outcomes identified and providing a review date and other details.
Care Planning	A process based on an assessment of an individual's needs that involves determining the level and type of support to meet the assessed needs, and the objectives and potential outcomes that can be achieved.
Care plan summary	A brief statement containing the main points from a care plan
Carer	<p>Somebody who provides substantial care on a regular basis for another individual aged 18 or over.</p> <p>Carers have the right to have an assessment of their needs in relation to their caring role, even if the person cared for has refused an assessment in their own right, or tuned down the provision of services, provided they would have been eligible for services.</p>
Carer's Assessment	<p>A carer's assessment under the Carers and Disabled Children Act 2000 is carried out at the request of the Carer in order:</p> <ul style="list-style-type: none"> • to determine whether the carer is eligible for support • to determine the support needs of the carer, i.e. what will help the carer in their caring role and help them to maintain their own health and well-being; and • to see if those needs can be met by additional services. <p>Carers have a right to an assessment of their needs, even where the person cared for has refused an assessment, or the provision of community care services, provided the person cared for would be eligible for community care services.</p>

Cascade training	Information that is passed down from one person to another following a structured format.
Case Finding	A process by which people with needs, who are not referred for health or social care help by either themselves or third parties, might be identified by agencies and invited for assessment.
Centralised training	Learning is provided at a specific place
Challenging behaviour	Behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to and use of ordinary community facilities
Client	A person who receives health, social care or voluntary services
Clinician	Those directly involved in the care and treatment of patients, including doctors, dentists, nurses, midwives, health visitors, pharmacists, opticians, chiropodists, radiographers, orthoptists, physiotherapists, dieticians, occupational therapists, medical laboratory technicians, othotics and prosthetics, speech and language therapists and all other health professionals.
Community Care	The provision of services and support to people who need such services to be able to live independently in their own homes, or in homely surroundings (including residential and nursing homes)
Comprehensive Assessment	A comprehensive assessment involves a range of different professionals of specialist teams with relevant skills or knowledge and is carried out where the level of support and treatment likely to be offered is intensive or prolonged, including permanent admission to a care home, intermediate care at home or a substantial package of care at home.
Consent	Permission that is given by an individual for a course of action to be taken.
Contact assessment	The first contact between an older person and a social care or health professional, where information is gathered to explore the older person's problem and whether there are other potential wider needs. Basic personal information is taken and verified.
Continuing care	A general term used to describe the care that people need over an extended period, as a result of a disability, accident or illness, to meet

	<p>both their physical – and mental- health needs. This may involve services from the NHS or social care providers or both. Continuing care can be provided in a range of settings such as hospitals, nursing or residential care homes, or the person’s own home.</p> <p>Both NHS and Social Services have responsibilities for meeting the needs identified.</p>
Daily living tasks	See activities of daily living
Day centre	A place where a person has the opportunity to take part in supervised social activities
Day Care	<p>Provided within centres to which users travel or are transported. Service providers will vary from statutory agencies such as Health or Social Services to the independent and voluntary sector, and may cater for users with high dependency needs in conjunction with home care and residential provision, and be integral to an intermediate care programme.</p> <p>Alternatively day care, particularly within the voluntary sector, may offer social stimulation and be part of a preventative programme aimed at combating a move towards functional dependence, and offering carer relief on a structured basis.</p>
Day hospital	A hospital environment where a person goes for a limited period for medical assessment and treatment
Diagnosis	This is a medical form of assessment that focuses on identifying illness and health conditions, and generating causal hypotheses for them. It results in succinct descriptions such as Alzheimers Disease, Stroke, Parkinsons Disease, etc
Direct payments	Payments made by Social Services that enable users the opportunity of purchasing and organising their own care services as an alternative to having them directly provided by Social Services.
Discharge	Releasing a person from hospital, clinic or a programme of treatment
Domain/ sub domain	Areas of possible need within the Single Assessment Process. Sub-domains relate to components of a domain.
Domiciliary Care	Care provided in a service user’s own home or to a person based at home, e.g. home help, home care.
EasyCare	An accredited assessment tool used in the

	Single Assessment Process
Electronic Social Care Record	<p>The bringing of existing recording practices into an electronic environment, with the application of national standards for managing such records and making them congruent with the NHS Care Records Service</p> <p>It should enable inter-authority transfer of records and enable direct access by service users to their records.</p>
Eligibility Criteria	<p>The criteria used by councils to determine whether a person is eligible for service provision. The criteria will take into account the service user's situation and the resources available.</p> <p>Eligibility covers both whether any service will be offered and, if it is, what service, their volume, and (where relevant) frequency.</p>
Eligible Needs	Those presented needs for which a local authority will provide help because they fall within the local authority's eligibility criteria.
Ethnic origin	A person's racial, religious and cultural background
Expert –patient programme	A programme that helps people with long-term medical conditions to manage their own health, with specialised support from health-care professionals and other agencies
Extracare Housing	A style of housing and care for older people that falls between established patterns of sheltered housing and accommodation, and care provided in more traditional residential care homes.
Fair Access to Care Services (FACS)	<p>The principle that Social Services departments should operate within one eligibility decision for adults seeking social care support. This eligibility criteria is based on a national framework which prioritises risks faced by individuals into four bands, and authorities are expected to adopt these bands in determining their own criteria, with an emphasis on preventative approach to adult social care.</p> <p>Eligibility should be determined following assessment and should support the principle enshrined in the Single Assessment Process.</p>
Formal Carer	A person whose job is to provide personal care and support to a service user.
Health and Social Care Communities	Local health authorities, local councils, NHS Trusts, Primary Care Groups and Trusts and the

	independent sector that provide health and social care services.
Hyperglycaemia	Raised levels of sugar in the blood, as in diabetes
Hypoglycaemia	Low blood sugar in the blood, as in diabetes
Independence	Managing everyday living skills to maximise ability, taking account of the support available and needed.
Independent Sector	Includes both private and voluntary social care providers, who may be contracted to provide services on behalf of Social Services departments.
In-Depth (Specialist) Assessment	The further exploration of assessment domains that have been triggered by Contact or Overview as part of an assessment under Single Assessment Process. This assessment will be carried out by qualified professionals, including specialists, and may require the use of scales. It will result in detailed knowledge and insights about particular problems.
Informal carer	A person such as a friend or relative who provides personal care and support to a person
Initial Contact	This is the date when first contact is received from or on behalf of the service user in relation to the possible need for services, which then becomes a subject of an assessment or re-assessment/ review. The contact may be by way of personal phone call, letter, or other form. It may be direct or through an intermediary. The date of first contact is not necessarily the same date as the screening, though in many local authorities screening will take place on the same day as the contact.
Integrated care pathway	An outline of the care a person with a specific condition or set of symptoms should receive, within a set time, to move through a programme of care
Intermediate care – General definition	A short period of intensive rehabilitation and treatment to help a person's return to home after being in hospital, or to stay in their own home instead of going into long term residential care. It can also be intensive care provided at a person's home to prevent them going into hospital.
Intermediate Care Bed	A specialist service provided within a residential or nursing home, where facilities exist to offer a specific rehabilitation programme and users can access specialist staff such as Occupational Therapists and Physiotherapists and staff within

	<p>the home are trained in re-ablement skills.</p> <p>Users accessing the service would normally have received a multi-agency assessment, and their care plan would clearly indicate the need for a specific residential rehabilitation programme.</p> <p>Specifically designated intermediate care beds would not attract normal charging arrangements and admissions would not normally exceed six weeks.</p>
Joint Funding	Where two or more agencies, usually Health and Social Services agree to share the cost of running a project or service.
Key Holder	A person authorised to keep another person's key
Key Safe	A secure device, with a combination lock, which stores keys outside a person's home, so authorised visitors can get inside.
Key Worker	The professional designated to co-ordinate a person's care.
Learning Disability	Having a significantly reduced ability to understand new or complex information or to learn new skills, or having a reduced ability to cope independently, which started before adulthood and has a lasting effect on the person's development.
Liaison	Communication and contact between groups and individuals
Lifeline System	An emergency telephone alarm system
Local Improvement Finance Trust (LIFT)	NHS LIFT is a private limited company set up by the NHS and private sector under the public, private initiative to fund, replace and furnish Health premises in England.
Long Stay Beds	Beds that provide permanent accommodation to residents whose review has determined this is the most appropriate option for them.
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.
Manual Handling	The various approved techniques used to help a person to move
Monitoring	A regular process of enquiry that checks the progress of the care plan and ensures its suitability for the current needs of the service user.
Multi-Agency	A team or group which is made up of

	representatives from different organisations
Multi-Disciplinary	A team or group which is made up of representatives from several different statutory and/ or non-statutory organisations, who all have different areas of expertise.
Multi-Disciplinary Assessment	An assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information
Named Nurse	A qualified nurse, midwife or health visitor who the person or client knows the name of and responsible for co-ordinating a person's care.
National Care Standards Commission	The national body responsible for the regulation of Social Care Services and private healthcare. This body replaced the Inspection Units previously based within Social Services departments and Health Authorities.
National Service Framework	Set of minimum standards in a series of major care areas (including mental health, diabetes, older people and coronary heart disease) with the aim to drive up performance and decrease geographical variations in service.
Needs	<ul style="list-style-type: none"> • Assessed need refers to the needs of a service user that have been identified as a result of an assessment. • Presenting need refers to needs that are reported by an older person or others on their behalf • Identified needs refers to needs for which treatment or support will be provided by agencies who do not operate eligibility criteria • Eligible needs are needs that councils should meet as they are assessed as falling inside the Council's eligibility criteria, that are set according to the Council's resources.
Occupational Therapist	A specially trained professional who assesses a person's ability to work, look after themselves and perform leisure activities, and then introduces programmes designed to restore, develop and maintain a person's ability.
Off their legs	Temporary inability to walk due to a number of yet unidentified causes.
Osteoporosis	A condition where bones become fragile so that a minor bump or fall can cause a fracture.
Outcome Approach to	An approach that emphasises the relevance of

Assessment	establishing intended outcomes in the assessment process in order to provide clearer links between both assessment and the resulting personal plan of care, and as a basis for clear information to providers.
Out of Hours Service	A specific service to operate outside regular office hours to provide either a direct service where necessary, or offer advice, guidance or re-routing to more appropriate services, where this cannot be provided by the local call centre in their role as initial contact point.
Outcome	The end result of the service provided, which can be used to measure the effectiveness of the service.
Overview Assessment	Assessment that explores all or most of the domains of the Single Assessment Process, which may be able to fully identify and describe assessed needs, or alternatively trigger in-depth/ specialist assessment. It is carried out if the professional involved in the contact assessment believes the individual's needs require a more rounded assessment.
Palliative Care	Defined by the World Health Organisation 'Active total care of patients and their families by a multi-professional team when the patient's disease is no longer responsive to curative treatment'. All patients whose death is anticipated need palliative care. A significant minority of these need some services provided by a specialist palliative care service which provides physical, psychological, social and spiritual support, with a mix of skills, delivered through a multi-professional collaborative team approach.
Patient	A person who receives health or social care services
Performance Assessment Framework	Performance indicators on which Social Services departments are measured as to their efficiency.
Person Centred Approach	An approach to assessment of need that puts the person at the centre of the process and is based on their views and wishes.
Person-Held Records	An individual's health and social care record which is kept by themselves
Personal Activities of Daily Living	The everyday tasks a person must perform to look after themselves
Physiotherapist	Specialist professional trained to use exercise and physical activities to improve a person's activity level.

Plaster of Paris	A plaster cast used to support a bony break
Podiatrist	A specialist in managing problems of the foot and leg (including providing foot care, fitting appliances such as callipers, and adapting footwear).
Postural Hypotension	A fall in blood pressure when rising from a lying to a sitting position, or from a sitting to a standing position)
Pressure Sore	Also known as pressure ulcer, decubitus ulcer or bed sores, these are areas of damage to the skin and underlying tissue due to pressure sheer and friction.
Prioritise	To arrange activity in order of importance
Primary Care Trusts	Free standing statutory bodies that provide primary and community services and commission secondary (hospital) care on behalf of their population. Primary Care Trusts work closely with Social Services departments in developing integrated models of service and service delivery.
Profound and multiple learning disabilities	Severe or wide-ranging intellectual impairment plus sensory and physical disabilities.
Providers	An individual or organisation providing a health or social care service
Psychologist	A specialist professional engaged in the scientific study of the mind.
Public Service Agreements	Agreements between Local Authorities and Government under which Councils get additional funding in return for meeting set targets.
Rapid Response Service	<p>A specific home care service designed to respond at times of crisis to prevent the breakdown of existing care arrangements that, without this intervention, may have led to hospital or institutional care. It is also designed to facilitate early discharge from hospital, particularly from Accident and Emergency departments, and the acute hospital beds.</p> <p>This is time- limited service to allow transfer to mainstream providers, either in-house or independent sector where appropriate. Would provide significant contribution to current needs assessment.</p>
Re-assessment	A re-evaluation of the needs of a service user, prompted by either a scheduled review, or a contact indicating a change in their

	circumstances
Referral	A formal request for an assessment of a person's needs.
Referrer	A person contacting agencies about carrying out an assessment.
Registered Mental Nurse	A nurse who has completed three-year training course on all aspects of providing nursing care to people with mental health problems.
Registered Nursing Care Contributions	An assessment of the determination of need of an older person, that means that they require a level of care requiring the involvement of, and supervision by, a qualified nurse. There are three banding levels that determine the financial contributions that Health will make to the care of the individual.
Rehabilitation Teams	Specialist teams, usually multi-agency and containing a cross section of staff such as Therapists, Care Managers and Home Helps who work with users to promote independence. This work could be both preventative and designed to facilitate hospital discharges, and integrate with both specialist residential or day care provision. Work will be time limited and form part of a user's care plan.
Reliable	Generally speaking, this refers to the trust that can be placed on an assessment tool when used to score the needs of an individual by different assessors, or over time. For an assessment tool to be reliable, there should be evidence of a measurement of reliability of a scale's use in at least one similar population and that this was of an acceptable degree. Reliability refers to the degree of agreement that is achieved between different assessors, using the same scale at around the same time on the same person, or between different times.
Relative	A person who is related to another by blood or by law
Reimbursement/ Delayed Discharges	The Community Care (Delayed Discharges) Bill, relates to the responsibilities of Social Services Departments in making arrangements for the assessment of patients within acute hospitals and organising services to facilitate their discharge. To initiate this process the hospital issues a Section 2 notice, when the following conditions need to be met:- <ul style="list-style-type: none"> • a clinical decision that transfer is appropriate

	<ul style="list-style-type: none"> a multi-disciplinary team decision inclusive of Social Services input which supports the clinical decision and the patient is ready and safe to transfer. <p>A Section 2 notice gives Social Services three days in which to assess and arrange services.</p> <p>A section 3 notice confirms proposed discharge date, and failure of Social Services to organise services to facilitate discharge makes them liable to reimburse the hospital for each day discharge is delayed. The notice under Section 3 gives 24 hours written notice of proposed discharge date.</p>
Residential Accommodation	<p>May take the form of either nursing, or residential care home, that provides 24-hour care to older people, who on assessment have been assessed as no longer being able to be supported at home.</p> <p>Residential accommodation could be either long or short stay.</p>
Respite Care	Designated beds within residential accommodation, available usually on a pre-planned basis to allow a short period of care, often to provide carer relief/ support.
Review	This refers to re-assessment of people's needs and issues, and consideration of the extent to which services are to meet the stated objectives and helping to achieve the desirable outcomes.
Risk Assessment	'Risk' and 'Risk Assessment' in the Single Assessment Process relates to evaluating factors that impact on a person's independence. Key factors include a person's health, their safety and their ability to manage essential daily routines.
Routine Equipment	Equipment that is used so regularly that it is not practical to offer it to outpatients.
Safe Haven	A contact point where incoming faxes that contain information that could identify a person are received in a secure environment.
Safe-haven Procedures	Procedures to be used if no safe-haven fax available. Under these procedures, all details that could identify a person are removed from the document and the person it was sent to is phoned to confirm the service user's details.
Scale	This is a means of identifying the presence and/or severity of a particular problem, such as depression or difficulties with personal care.

Scheduled Review	A review which has been planned in advance
Screening	This is the initial phase with contact when basic data is gathered, along with sufficient indication of the purpose of the contact to determine whether information / advice or a basic service is a relevant response, and / or whether further investigation and assessment are warranted. It is also the stage at which callers who have come inappropriately to the local authority will be filtered out and/ or re-directed.
Self Funding	When a person has sufficient funds and is able to make arrangements for and pay privately for their care services.
Service Provider	An individual or an organisation providing a health or social care service.
Service Provision	A provision of service by a service provider
Service User	This refers to a person who is in receipt of either health or social care services. It includes patients of the NHS
Shared Values	A set of common values drawn from the NHS Plan and the National Service Framework for Older People, which all health and social care systems should work to.
Short-term Community Care	Home Care services provided for a limited period.
Single Assessment Process	Applies to the identification of need in older people and the provision of services from agencies who work together to provide effective and co-ordinated care, as contained in Standard 2 of the National Service Framework for Older People.
Single Assessment Summary	Summary of information drawn from the records in general practice, community health, hospitals, social services and elsewhere.
Social Care	Social Care is provided by statutory and independent organisations and describes a wide spectrum of activities, which support and help people live their daily lives. It can include: intimate personal care, managing finances, adapting housing conditions and helping attending leisure pursuits.
Specialist/ In-depth Assessment	This refers to further exploration of assessment domains that have been triggered by contact or overview assessments. Specialist assessment will usually be carried out by qualified professionals and may require the use of scales. It will result in detailed knowledge and insights about particular needs.

Specialist Transport	Transport provided by specially adapted and equipped vehicles, and with appropriately trained staff, for service users whose health or safety (or the safety of the driver or other people) would be at risk by using other forms of transport.
Step Down Beds	Any beds identified specifically for facilitating hospital discharges. This will form part of a user's ongoing assessment and allow both users and professionals the opportunity to view future care arrangements. Placements would be expected to be time limited, and be integral to a discharge plan.
Supported Discharge	A short-term period of nursing and/ or therapeutic support and sometimes supported by community equipment and/ or housing.
Supporting People	Provides services to a wide range of vulnerable people, and is designed to ensure vulnerable people have the opportunity to live more independently, by developing reliable housing related solutions to complement other care services. The supporting people programme consolidates a number of previous funding sources into one fund administered by Social Services Departments.
Syncope	Unexplained loss of consciousness.
Terminally Ill	Terminal care is an integral part of palliative care but is only one facet of such care. It usually refers to management of patients during the last few days or weeks of life from a point at which it becomes clear that the patient is in a progressive state of decline.
Tool	This is a collection of scales, questions and checklists that have been brought together for assessment purposes. An alternative term for 'tool' is 'instrument'.
Transitional Care	Care provided in a temporary setting
Treatment	To care for medically or surgically; to manage in the use of remedies or appliances; to treat a disease, a wound, or a patient.
Triage	A service/ or mechanism by which a professional prioritises care.
Unmet Needs	Presented needs that are not evaluated as eligible needs or where eligible needs are met but an alternative more appropriate/ desirable service should ideally be available.

Unscheduled Review	An unplanned review arranged in response to notification of a service user's changed needs or circumstances.
Valid	Generally speaking, this refers to a scale actually measuring what it is supposed to measure.
Volunteer	A person who provides a service or gives help free of charge.
Voluntary Agencies	A group of organisations that provide a service or give help to individuals or groups, free of charge.

Appendix 4

SINGLE ASSESSMENT PROCESS – GLOSSARY OF TERMS

ANACHRONYMS AND ABBREVIATIONS

Anachronym/ Abbreviation	Definition
↑	Upstairs or increase
↓	Downstairs or decrease
↔	Level
/c	With
>	More than
<	Less than
#	Fracture (bony break)
/12	Months
/52	Weeks
/7	Days
6/12	Six months
6/52	Six weeks
6/7	Six days
A	Past or present alcohol dependence
Abdo	Abdomen
A&E	Accident and Emergency Department
ADL ————— (Activities of daily living)	The everyday things that people do including the things that people do to look after themselves and their home, carry out their work, and leisure activities
AF	Atrial fibrillation – a rapid chaotic beating of the heart muscle
A/F	Artificial Feeding
AIDS	Acquired Immune Deficiency Syndrome – a virus that destroys a subgroup of lymphocytes, resulting in reduced immunity
AK	Above the knee
AKA	Leg amputated above the knee or/ also known as
am	Morning
Appt	Appointment
AX ————— (Assessment)	The process of identifying a person's needs and how they affect their ability, independence and quality of life
ASW	Approved social worker – a trained social worker with an extra qualification in mental health
A&O	Activity organiser
BD	Twice a day

BK	Below the knee
BKA	Leg amputated below the knee
BM	Blood sugar monitoring
BMI	Body Mass Index
BNO	The person has not had their bowels open
BO	The person has opened their bowels
BP	Blood pressure
B/N	Bank nurse – a nurse who is not employed by the area in which they are working
BNA	British Nursing Association – an employment agency for nurses
BNF	British National Formulary – the reference book for all British drugs
B/F	Breast Feeding
C/O	Complained of or/ care of
C1	Cervical of the spine – the neck section of the backbone
Ca	Cancer – malignant tumour caused by abnormal and uncontrolled division of cells which then invade and destroy the surrounding tissue
CABG	Coronary Artery Bypass Graft – an operation to improve blood flow to the heart and so reduce the risk of a heart attack
CAH	Care provided at home
Ch/Pro	Child Protection Register
CCD	Child Contact Document
CPA	Care Programme Approach (see main glossary)
CT	Computerised Tomography (Head scan)
CCF	Congestive Cardiac Failure
CMHT	Community Mental Health Team
CMT	The Care Management Team
CNS	The Central nervous system – the brain and spinal cord
CofE	Church of England
CONS	A Consultant – fully trained specialist in a branch of medicine who accepts total responsibility for patient care
COPD	Chronic obstructive pulmonary disease – a disorder of the lungs
CP	Cerebral palsy – a non-progressive disorder of movement resulting from damage to the brain before, during or immediately after birth. There can also be an associated learning disability
CPN	Community Psychiatric Nurse – a nurse providing specialist psychiatric domiciliary care
CPR	Cardiopulmonary Resuscitation
CT	Computerised Tomography – scan providing sectional view
CRT	Community Rehabilitation Teams
CVA	Cerebral vascular accident – rupture of diseased vessels or clot in the brain, causing a stroke
CVS	Cardiovascular system – the circulation of blood around

	the body
CXR	Chest X-Ray
DR	Doctor
D&V	Diarrhoea and vomiting
DSS	Department of Social Security
DHS	Dynamic –hip screw – a prosthesis used to repair a fractured or damaged leg bone
DLA	Disability Living Allowance
DM	Diabetes mellitus – diabetes – a disease characterised by high levels of blood sugar
DN	District nurse – nurse providing care in the community setting
DNA	Did not attend (when a patient misses an appointment)
DNAR	Do Not Attempt Resuscitation
DOA	Date of admission – date person added to caseload
DOB	Date of birth
DPA	Data protection Act
DSC	Disablement Services Centre
DU	Duodenal ulcer – an ulcer in the small part of the intestine
DVT	Deep vein thrombosis – obstruction of a vein by a blood clot
DXT	Deep x-ray treatment – electromagnetic radiation
ECG	Electrocardiogram – a recording of the electrical activity of the heart
ECT	Electroconvulsive therapy –a treatment for severe depression
EDD	Expected Delivery Date
EEG	Electro encephalogram – a recording of the electrical activity of the brain
eg	For Example
EH	Environmental Health
EMH	Elderly Mental Health – the person is elderly and has mental health problems
EMI	Elderly mentally ill – the person is elderly and is mentally ill
EMW	Early morning wakening
EN	Enrolled nurse
ENT	Ear Nose and Throat
EPDS	Edinburgh Post Natal Depression Score
FACS	Fair Access to Care Services (see main glossary)
F/U	Follow up
FBC	Full blood count – the number of blood cells in a known volume of blood
FOB	Faecal occult bloods – exploring the presence of blood in a person’s stool (faeces)
FH	Family history
FSTF	Freestanding toilet frame – an item of equipment to assist people in getting on and off the toilet

FWB	Fully weight bearing – a person is able to weight bear unaided on a joint or limb
GCS	Glasgow coma scale – used to estimate a patient’s level of consciousness after a head injury
GI	Gastrointestinal – relating to the stomach and intestine
GU	Genito-urinary – relating to the reproductive and excretory systems
Gr	Gram
GP	General practitioner
GH	Glenfield Hospital
Hb	Haemoglobin
HCA	Healthcare assistant
H.C	Head Circumference
Hemi	Hemiplegia – paralysis of one side of the body
HIV	Human immune deficiency virus
HI	Head injury
HImP	Health Improvement Programme
HNPU	Has not passed urine
HO	House officer – a hospital based doctor, or/ history of
HADS	Hamilton Anxiety and Depression Scale
Ht	Height
HV	Health visitor – a trained nurse with a specialist qualification in health promotion
Hx	History
ICU	Intensive Care Unit
IDDM	Insulin Dependent diabetes mellitus – type 1 diabetes. Person needs regular injections of insulin
IM	Intra-muscular – within a muscle
IMMS	Immunisation
IV	Intravenous – within a vein
IADL	Instrumental Activities of Daily Living
<u>ICP</u> (Integrated Care Pathway)	An outline of the care a person with a specific condition or set of symptoms should receive, within a set time, to move through a programme of care
<u>IC</u> Intermediate Care	A short period of intensive rehabilitation and treatment to help a person’s return to home after being in hospital, or to stay in their own home instead of going into long term residential care. It can also be intensive care provided at a person’s home to prevent them going into hospital
IP	In- patient
IRW	Industrial Rehabilitation Workshop
ISQ	In status quo – condition unaltered
IT	Information Technology
ITU	Intensive Therapy Unit
Jt	Joint
KA	Known as – preferred name
KG	Kilogram

L	Left
L1	Lumbar area of the spine – the section of the spine that forms the lower back
LA	Local Authority
LBP	Lower back pain
LD	Learning Disability
Learning Disability	Having a significantly reduced ability to understand new or complex information or to learn new skills, or having a reduced ability to cope independently, which started before adulthood and has a lasting effect on the person's development.
LDP	Local Delivery Plan
LHS	Left hand side
LIB	Local Implementation Board
LIFT	Local Improvement Finance Trust
LFT	Liver function test
LGH	Leicester General Hospital
LRI	Leicester Royal Infirmary
LL	Lower limb (leg)
LPT	Leicestershire Partnership Trust
LSP	Local Strategic Partnership <i>or</i> Local Service provider
LVF	Left ventricular failure – the left ventricle of the heart is failing to pump efficiently
Miscellaneous	1/12 1 month 1/52 1 week 1/7 1 day @ at % percentage
MAU	Medical Admissions Unit
Mane	In the morning
MAP	Major Assessment Point
MCP	Metacarpal phalangeal – bones of the finger
MD	Medical Director Or Muscular Dystrophy – disease where the muscles become weak and wasted
MDT	Multi – disciplinary Team – a team made up of people from various professional backgrounds to co-ordinate and manage an individual service users care.
ME	Medical Examiner Or Myalgic encephalomyelopathy – a condition characterised by extreme disabling fatigue
MHA	Mental Health Act
Mcg	Microgram – unit of treatment dosage
Mg	Milligram – unit of treatment dosage
MI	Myocardial Infarction – death of a portion of the heart

	muscles which causes a heart attack.
MmHg	Millimetres of mercury – unit of pressure measurement
Mmol	Millimoles – unit of liquid volume
MND	Motor Neurone Disease – a progressive degenerative disease affecting voluntary movement
MOW	Meals on Wheels
MI	Millilitre – unit of fluid measurement
Mg	Milligram – Unit of treatment dosage
MOAI	Mono Amine Oxidase Inhibitor
MRI	Magnetic resonance imaging scan – a diagnostic technique used to produce images of the body's tissues
MRSA	Methicillin-resistant Staphylococcus Aureus – a type of infection which is resistant to the treatment by antibiotics.
MS	Multiple Sclerosis – a chronic disease of the nervous system which affects the movement of sufferers.
MSU	Mid Stream Urine – sample of urine captured during the process of urinating.
MW	Midwife
NA	Nursing Auxillary – untrained member of the nursing workforce
NAD	No abnormalities detected.
N/A	Not Applicable
NAI	Non-accidental injury
NEB	Nebuliser – equipment used to deliver vapourised medication for patients with lung problems
NFA	No further action or appointment is needed.
NG	Nasogastric tube – tube passing down the patients nose and into the stomach as either a drainage instrument or as a means of feeding.
NIDDM	Non-Insulin Dependent Diabetes Mellitus – type ii diabetes usually occurring in older age. Usually controlled by appropriate diet.
NN	Nursery Nurse
Nocte	At night
NOF	Neck of femur – section of the thigh bone which is most commonly fractures in old age.
NOK	Next of Kin
NSF	National Service Framework
NWB	Non-weight Bearing – unable to stand or place weight on the joint.
O/A	On Admission – when a person goes into any type of care setting
O/E	On Examination – when a person is examined
OA	Osteoarthritis – degenerative disease of the joints due to wear and tear.
OBS	Observations – the monitoring of a patients vital signs

OD	Once per day medications <i>or</i> Overdose
ON	Once a night
OP or OPD	Out-patients
O2	Oxygen
OPA	Out-patient Appointment
OT	Occupational Therapist (see main glossary)
OTA	Occupational Therapy Assistant – unqualified assistant who works along side the occupational therapist.
OTTI	Occupational Therapy Technical Instructor – trained specialist occupational therapy assistant.
PAC	Pressure Area Care – assessment, prevention and treatment to ensure skin integrity (tissue viability)
PCT	Primary Care Trust
PD	Parkinson’s Disease <i>or</i> Physical Disability
PE	Pulmonary Embolism – obstruction of the pulmonary artery or one of its branches, usually by a blood clot.
PEG	Percutaneous Endoscopic Gastrostomy – feeding tube placed directly into the stomach, through the wall of the abdomen for regular liquid feeds.
PT	Physiotherapist (see main glossary)
pm	Afternoon
PN	Practice Nurse – a qualified nurse based in a GP Practice
PO	Orally – medication to be delivered by mouth
POD	Podiatrist (see main glossary)
POP	Plaster of Paris – cast for supporting a bony break.
PR	Per Rectum – via the rectum
PRN	Pre-Ro Nata (As required) – Treatment prescribed as or when necessary.
PROF	Professor
PTA	Physiotherapy Assistant – person employed to help a physiotherapist
PU	Passed Urine – a person has passed urine
PWB	Partial Weight Bearing – a person is able to partially weight bear on a joint or limb and they may use aids or adaptations
PV	Per Vagina – via the vagina
QDS	Four times per day
R	Right
RA	Rheumatoid Arthritis – disease affecting the lining of the joints causing them to be painful, swollen and stiff.
RAP	Referrals, Assessments and Packages of Care
RC	Roman Catholic
Rehab	Rehabilitation
REG	Registrar – now replaced by a specialist registrar.
RESP	Respirations – a measure of the breathing pattern of a person
RIP	Rest In Peace
RMN	Registered Mental Nurse (see main Glossary)

RN	Registered Nurse
ROM	Range of Movement – how far a person’s joints can move.
RSCN	Registered Sick Children’s Nurse
RTA	Road Traffic Accident
RTS	Raised Toilet Seat
Rx	Treatment
S/a	Same Address
SENCO	Special Educations Needs Co-ordinator
SEN	State Enrolled Nurse
SN	Staff Nurse
S/N	School Nurse
SAH	Subarachnoid Haemorrhage – sudden bleeding into the subarachnoid space surrounding the brain.
SALT	Speech and Language Therapist (see main glossary)
SAP	Single Assessment Process (see main glossary)
SHint	School Health Interview
ST/N	Student Nurse
S/B	Seen By
SC&H	Social Care and Health
SH	Social History
SHO	Senior House Officer
SHV	Specialist Health Visitor
SHVA	Specialist HV Assistant
SMI	School Medical Interview
SLR	Straight Leg Raise – an exercise used in physiotherapy
SMO	School Medical Officer
SNA	School Nurse Assistant
SNR	Special Needs Register
SOB	Short of Breath
SOBOE	Short of Breath on Exertion
SR	Specialist Registrar – following on from a senior house officer, a doctor with continued experience can apply for the post of specialist registrar, in a chosen specialty, within a hospital.
SS	Social Services
STM	Short term Memory
SW	Social Worker
TB	Tuberculosis
TDS	Three times a day
THR	Total Hip Replacement
TIA	Transient Ischaemic Attack – temporary disruption of blood flow to the brain, causes symptoms similar to stroke but patients recover within 24 hours.
TEDS	Thrombo Embolic Deterrant Stockings
TENS	Transcutaneous Electrical Nerve Stimulation
TEMP	Temperature recording
TFT	Thyroid Function Test
TTO	To Take Out

Leicester, Leicestershire and Rutland; Health and Social Care Community
Single Assessment Training Package

TKR	Total Knee Replacement
TLC	Tender Loving Care
TPR	Temperature/Pulse/Respirations
TURP	Transurethral resection of the prostate
U&E	Urea and Electrolytes
UTI	Urinary Tract Infection
Vaccs	Vaccinations
VB	Venous Blood
VP	Venepuncture
V/A	Visual Acuity
WC	Toilet
WE	Weekend
Wf	Walking Frame
Wt	Weight
WR	Ward Round
WRVS	Womens Royal Voluntary Service
XR	Xray
Zf	Zimmer Frame