



**A Joint Protocol for Delivering
The Single Assessment Process
For Older People
In
Sutton**

Developed in Partnership with:

*London Borough of Sutton Community Services
Sutton and Merton Primary Care Trust
Epsom and St. Helier Hospital Trust
Sutton Older Persons Mental Health Team
Age Concern User and Carer Group*



About This Document

Purpose:

This document aims to set out the responsibilities that each agency need to adopt in order to deliver the Single Assessment Process in the London Borough of Sutton. It is envisaged that it will provide guidance for an efficient and effective delivery of services which will meet the expectations of local people and that of the National Service Framework for Older People

Contributors:

The content of this document is a result of work that has been carried out by a range of people in the development of the Single Assessment framework, who are committed to the ethos of improving services for older people. This includes professionals from health, social and voluntary sectors as well as users and carers. Acknowledgement is needed of the extra work this has entailed for many people.

Using the Document:

It is expected that this document and its contents will be used as a reference for practitioners who are working with older people and their carers. As the single assessment process is continuous and will develop over time, the contents of this document may change. The aim would be to reflect the changes in working practice as they arise.

Terminology:

An agreed Glossary of Terms, which are used in this document, are found in Appendix 1. The terms 'older person', 'patient' and 'service user' will be interchangeable while describing the processes.

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INTRODUCTION

The Single Assessment Process (SAP) has its origins in Standard Two of the National Service Framework for Older People, which is identified as Person Centred Care. The aim is as follows:

To ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries

This protocol addresses the way in which we will ensure that the needs of the most vulnerable are understood and managed. It is envisaged, as agencies work to it, that it will improve communication between agencies, deliver more co-ordinated care, identify and acknowledge more clearly the needs of users and carers before making decisions about what they are going to do to assist them.

Implications for Professional Practice

There are significant implications for professional practice and attitudes to bring about these changes, which need to be managed. This will be mainly addressed by a joint training strategy which will contain a vision for continuous development, as well as through the organisational structures for support and supervision of professionals as defined by each agency.

The implementation of the single assessment process will be monitored and action taken where necessary to change or improve the approach.

It is intended that this Protocol will act as a professional guide and support the process.

Current Organisational Structures

This Protocol is developed to address the Single Assessment process within the current organisational arrangements in Sutton and in so doing reflects the way in which health and social care practitioners, working in the field of older people, currently work together, as well as giving scope for further development of roles and responsibilities, as outlined in the Department of Health SAP guidance.

It is recognised that other working arrangements would enhance the process. These could include creation of joint teams, co-location of workers, or creation of pooled budgets for resource allocation. A main area of development for all organisations will be the ability to share information across IT systems.

As this Protocol is integrated into practice it is envisaged that boundary issues and how they affect collaborative working will be brought into focus. This will in turn inform strategic organisational developments.

AIMS AND OBJECTIVES

The following will be the main aims of the Single Assessment in Sutton:

- That **older people** are afforded respect, dignity and choice during their 'journey' through the health and social care services.
- That the approach is **person centred** by ensuring that the views and wishes of the user and carer are central to the assessment and the decision making process
- That approach between agencies is **collaborative** and that the contribution of all health and social care disciplines are integrated into one assessment and care plan
- That the **outcomes** of intervention are clear, by identifying how service delivery will improve the well being and circumstances of the individual
- That the **risks** to the individual are clearly identified and agreed action, with the user and carer, taken to reduce those risks
- That **independence** is promoted, where ever relevant, to improve the well being of users.
- That **care plans** will reflect the commitment of collaboration between multiple agencies and users and carers, in order to make a difference to peoples lives.
- That **information** is shared in such a way that it is relevant, with consent, meets confidentiality criteria and avoids duplication.
- That **unmet need** can be identified and in turn inform the needs of local service development
- That **service provision** can be monitored in order to improve service delivery and working with the provider sectors.

SHARED VALUES

The following are the agreed shared values, which will underpin practice and the joint approach to assessment and care planning:

1. Age will not determine how services are accessed and provided.
2. Older people and their carers will be appropriately informed, in clear language and suitable methods, of assessment and services and how to use them. Their comments on assessment arrangements and services will be actively sought.
3. Older people will be fully involved, where possible, in the assessment and care planning process. Their views and wishes will be kept at the fore front of the assessment and they will be given opportunity to identify their needs, to recognise their strengths and abilities and any external or environmental factors that cause or exacerbate those needs.
4. The informal carers' contribution to the care of the older person will be acknowledged with an offer of an assessment in their own right.
5. The assessment process and services that are provided will enable people to maximise their potential for independence. This will include the potential for rehabilitation, which will be kept under review.
6. Older people will be involved in decisions regarding their care, and empowered to determine the level of risk they are prepared to take.
7. Older people will be given realistic options for how their eligible needs may be met.
8. Access to services will be offered via an assessment that is co-ordinated, straightforward and avoids duplication.
9. Where an older person requires the help of more than one agency, service delivery will be co-ordinated in the best interests of the older person.
10. The promotion of health and well - being will be as important as reacting and responding to needs as and when they arise.
11. Consent will be sought from older people on what information that is collected on them may be shared. Sharing of that information will respect the confidentiality of the older person and aim to promote effective person-centred care.
12. Where individual people lack capacity to make decisions or give their agreement, Vulnerable Adults guidelines will be a reference point in order to secure the maximum possible participation and safeguard the older person's interests.

13. All professionals will be aware of, but not make assumptions about, the impact of age, gender, race, living arrangements, personal relationships, lifestyle choices and disability on older people and their needs.

Valuing Staff

1. Professionals who work with older people will be properly trained and developed to do so.
2. Front line professionals should be supported to take responsibility for planning and providing care for individual older people.

ASSESSMENTS

A person will be exposed to different levels and types of assessments during their 'journey' through the health and social care system. The aim of the single assessment process is to make the journey as smooth and effective as much as is possible. By identifying the correct level of assessment that is required, when a person approaches an agency for help and assistance, time will be saved and services delivered more effectively and efficiently.

When a person is undergoing an assessment for the first time, they may not fully understand the process. It is therefore necessary to ensure that they have full information of who the person is that is assessing them and what the purpose is.

An assessment is only as good as the quality of the information contained within it. It needs to be remembered that the person who is undergoing the assessment is the best qualified to give all the necessary information about their circumstances. It is vital, therefore, that they and their informal caring network are consulted and are central to the whole process. Their opinions should always be sought, where possible and documented.

The sharing of the results of any assessments undertaken with other disciplines will facilitate a broader understanding of a person's circumstances and therefore a better planned service provision and delivery.

Good collaboration with other disciplines means that there should be respect and acknowledgement of their expertise and knowledge. Accepting each others opinions and assessments will facilitate greater understanding and foster improved working relationships.

Four Levels of Assessment

There are four levels of assessment that can be drawn on when working with older people; these are named as **Contact, Overview, Specialist and Comprehensive** assessments. A person will not be exposed to all of these during their 'journey' through the care system and there is reliance on professional judgement as to which one will be used at what stage.

A fuller definition of these assessments can be found in the 'Agreed Terminology' document. (Appendix 1) However the following are some key elements within the whole process:

- At the stage of **Contact assessment**, all core details should be obtained regarding the individual and correctly documented. This will need to be updated at each contact with a department as necessary. It is at this stage that it will be determined if a person may need intervention of one or more agencies, through sensitive questioning of their immediate circumstances. This information, in accordance with the Information Sharing Protocol, will be shared with other disciplines as necessary, thus reducing the need for users and carers to give information more than once.

- If further, fuller exploration of a person's circumstances is needed then an **Overview assessment** may be required. This contains domains of an older person's life that are relevant and may trigger requests for assessments to other agencies. The person who is responsible for completing this assessment, engaging other professionals as required and drawing up the care plan is the **care co-ordinator** or **key worker**. (For fuller definition of 'Care Co-ordinator' please refer to 'Agreed Terminology' in the Appendix)

For the purpose of this current Protocol, Care Managers, District Nurses and Intermediate Care Practitioners will be regarded as potential Care Co-ordinators. This does not preclude therapists becoming agreed Care Co-ordinators, however this would have to be agreed within the expressed parameters of that person's discipline.

- **Specialist assessments** are such by the virtue of the fact that there is expertise in a given area, whether it be in the health or social fields. These contributions should be sought as appropriate and in agreement with users and carers.
- When a person has more complex needs then a **comprehensive assessment** may be required. This would contain a collection of specialist assessments, which would address all the domains of the Overview.
- In order to ensure that a care plan is working and effective, **monitoring** and **reviewing** of the care should be carried out by the Care Co-ordinator or another person as agreed by all parties, including the user and carer.
- Professionals need to be able to share relevant information therefore a **Summary of Needs** and **Care Plan** will be completed. This will help in identifying any unmet need.
- It is important to ensure that the consent for sharing information between agencies has been sought from the user. This can be obtained by the use of an **Agreement Form**, which the user should be invited to sign when the assessment process begins.

CONTACT ASSESSMENT AND WHEN TO USE IT

Older People come into the care services by a variety of ways. This could be either through a routine visit to a GP or via an emergency that needs either, or both, the intervention of health and social services.

In Sutton, health care would be initially be accessed by GP, District Nurse, Intermediate Care Practitioner or via Accident and Emergency and Medical Assessment Unit at the Hospital Trust. Social care would be accessed via the Adult Care Management teams, in the area in which the person lives, and also via voluntary organisations.

This may be the first contact a person will have with a complex organisation at a vulnerable time. The response from the practitioner, who receives the first call, will define the quality of the outcome for the older person and their carer and indicate the type of resources needed to meet the presenting need.

Therefore the following information should be gathered at the contact/referral stage:

- Establish whether the older person has agreed to the referral and understands and agrees to the reason for it. In the cases of incapacity, the person's representative should be informed that a referral has been made.
- Complete the core detail information on the Contact form (see Appendix 2) as fully as possible at this stage. This would give vital information to other agencies which could potentially become involved, reduce time and the need for the older person, or their representative, to repeat the information. (Where an agency has the facility to input this information straight into a computer system, please ensure all the appropriate fields are completed)
- Document an outline of a person's circumstances and any health conditions that may have led to their present difficulty.
- Clarify how the person sees the difficulties that they are experiencing, how they have coped so far and what they would like to happen to alleviate the situation.
- Establish if there is a family member or other person from their informal network is helping out. Clarify what tasks they perform and how that person is coping both mentally and physically. In the case of an older person's representative being the carer and making the first contact, enquire whether the person is agreeable to maintaining the care in the short term until support is provided if the older person's circumstances demonstrate eligible need.
- Establish if any other agencies have already been contacted or are involved.
- Agree what the next steps will be with the older person and/or the representative.
- If a referral comes via a GP or other 3rd party, contact the referrer and inform them that contact has been made with the older person and what action has been taken.
- If the decision is made to refer on to another agency, send a copy of the core detail information, including current health circumstances, with a clear indication of what is required, to the appropriate person. This could be sent by fax or by e-mail if the facility is available. Document on the case notes the date the referral was sent.

- Any information being transferred to another agency should have a consent to share form signed and dated by the user (or representative where agreed)

Organisational Criteria

Social Services work within the framework of Fair Access to Care Services. This is a set of criteria, which determines a person's level of eligible need and what will be the organisational response. Other agencies not operating within this system would benefit from familiarising themselves with the criteria, especially when considering a referral to social services. This would ensure that the referral is appropriate and save time both for the referring agency and the older person themselves.

Similarly, access to some health provision, for example Intermediate Care, operate under criterion and so the same principles apply.

It is recommended that, where possible, that negotiation and flexibility in individual circumstances keeps the best interests of the older person at the forefront and ensures a smooth delivery of response and service.

Future training arrangements should reflect the multi-agency approach of SAP, with emphasis on clearer understanding of practitioners different roles and responsibilities.

OVERVIEW ASSESSMENT AND WHEN TO USE IT

The information collected at contact assessment may have been sufficient to *signpost* a person on to other services straight away. Therefore, the contact core details, with reason for referral, should be sent to the relevant agency.

However, the professional who is dealing with the person may, in their judgement, decide that the older person would benefit from a more rounded, or holistic assessment. For this purpose, the overview assessment would be completed. The identified Care Co-ordinator would start this process.

It is important that the user feels they are central to the assessment and that their views are sought at each stage. Explanation of the benefits of assessing and identifying their needs should be given, including taking a preventative approach and promotion of independence.

There are certain domains that have to be covered when assessing for health and social care and it is for the practitioner to judge when it will be necessary to complete some of these or all of them. In short, the overview assessment supports professional judgement does not replace it. An example of the domains to be covered in assessment can be found in Appendix 3.

What is an Overview assessment?

The overview is an assessment *tool*. Basically this means it is a collection of scales, questions and checklists brought together for specific assessment purposes to enable the professional to make judgements relating to care needs.

When to complete an Overview Assessment

Completion of the overview should be guided by the professionals own judgement, taking into account the service user's wishes and any indications of wider need that have been triggered at the contact stage, or during discussion with the person.

For those older people for whom this may be the first episode of care assessment, and whose circumstances demonstrate that they may need the intervention of and/or health and social services, then a full overview assessment would be beneficial.

For those older people already in receipt of care services, the timescale for the review of the care will have been agreed. If at this time a re-assessment is indicated, use of the overview would prove useful in revisiting the areas of social and health care needs to identify what, if any changes have taken places since the original assessment.

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

Understanding the *triggers or sign posts* that may lead to further assessment can help professionals make decisions about what domains they should explore. For example, if it is established that a person is incontinent of urine, further assessment of mobility, medication and access to the toilet should be carried out.

It is important to know who to refer to for a particular assessment or service. Agencies in Sutton have reached agreement on triggers for referral and these can be found in Appendix 4.

Where a person requires a high level of intervention at home or placement in permanent care then all of the domains should be considered. Where existing specialist assessments do not give the full picture, then the remaining information can be gathered by use of the overview. This constitutes a comprehensive assessment.

In reaching decisions on individual cases, professionals may wish to err on the side of caution and apply all the domains. This is because there is considerable evidence that many treatable health conditions and other needs go undetected or mis-diagnosed.

The overview assessment helps to identify the varied specialist roles that different practitioners work within and enhance a worker's understanding of these roles and expertise.

SPECIALIST ASSESSMENT

Each practitioner has expertise within their own field, whether it be health or social care. An older person may demonstrate a need which would benefit from an assessment ground in specific knowledge. Where practitioners feel the older person would benefit from such expertise then referral to a specialist in that field would be made with the following guidelines:

- The older person agrees to the assessment and understands what it entails.
- The core details of the person and clear request for reason for referral are sent to the appropriate agency.
- When the referral is received by the agency, response should be given that the referral has been received and timescales indicated when the assessment will take place.
- If the person's life or safety is at risk then the timescale for response should be immediate and joint agreement what first steps need to be taken to minimise any risks. This may involve an agreed joint visit and assessment by relevant agencies.
- Some requests may be for information or for an opinion only. The older person must understand what is to be shared and give consent where possible and practicable.
- The specialist assessor will use the diagnostic tools they feel are appropriate to support their professional judgement. The outcome of their assessment, the evaluation of the risks involved and the suggestion for service delivery, will be shared with the care co-ordinator and explained clearly to the older person.
- The specialist will be responsible for ensuring that the service recommended is delivered in the appropriate way, in discussion with the care co-ordinator and the older person and their family or informal carers.
- The service delivery through specialist involvement will be reflected in the care plan.
- Where appropriate and with consultation with the older person, the assessment and service recommendation may be placed in the User Held Record if one is in place in the older person's home.

COMPREHENSIVE ASSESSMENT AND WHEN TO USE IT

What is a Comprehensive Assessment?

A comprehensive assessment is an in-depth assessment of an individual's physical, emotional, social and cultural needs and risks. It constitutes a collection of specialist assessments from relevant disciplines and other information gathered, which encompass the health and social care needs of an older person.

When to Complete a Comprehensive Assessment

The assessment *process* is similar whether you are undertaking an overview assessment or a comprehensive assessment. The difference is in the *focus* and *depth* of the assessment.

If an individual has complex needs with an expected high level of prolonged support, then a comprehensive assessment should be undertaken. Examples of this are permanent admission to a care home, intermediate care services, or substantial packages of care at home.

A comprehensive assessment by a care co-ordinator should include

- The client and carer's perspectives
- The care co-ordinator's professional assessment of the individual's needs.
- A synthesis of the information gained from the views of the client and/or carer, the specialist assessments
- Ensure that all the domains of the Single Assessment have been covered. (If supplementary information is needed to provide a complete picture of the person's needs and circumstances, the relevant sections of the overview assessment may be used for this purpose)
- Any disagreements between the assessor and the user and/or carer, and other agencies, with regard to the assessment.

MULTI-AGENCY CARE PLANNING

The care plan will outline the response agreed to meet the identified needs of the older person.

Where a care plan involves the contribution of several agencies, then care planning must be joint and in consultation with the potential service user and their representatives.

In these instances the designated Care Co-ordinator should ensure:

- The service user and their representatives are clear on what care is to be given, by whom, how this will be delivered and at what time.
- Where possible and practicable that a choice is given regarding the timing of care delivery.
- Agencies work together to provide the service in the most flexible way that suits the individual person.
- Each agency has contributed to the care plan and that the objectives and expected outcomes are clear.
- Cultural and gender sensitivities are incorporated.
- It is agreed by all parties, including the service user.
- The service user and appropriate, identified and agreed persons receive a copy of the care plan including a daily timetable of care delivery.
- The older person and their representatives have the contact details for each agency.
- A contingency plan has been agreed in case of emergencies.
- All involved agencies and the service user report any concerns or issues regarding the care and care plan to the care co-ordinator or identified agency.
- After 4-6 weeks an initial review is carried out to evaluate that the objectives of the care plan are being met. At this stage, or before if circumstances dictate, adjustments are to be made to ensure the care remains relevant to the situation.
- Agreement, with the service user and their representatives, to be reached regarding on-going monitoring and reviewing and change in care co-ordinator if appropriate.

SUMMARY DOCUMENT

The Single Assessment Summary is the means by which case information on an individual older person is stored and shared, subject to consent and confidentiality, among health and social care professionals. It draws on information collected during the assessment process but also covers care planning information including support and services that are being provided.

The information in the Summary may be built up over time as an older person's needs change.

The Care Co-ordinator will be responsible for instigating the Summary.

Where a person has further episodes of care, the current agency involved takes responsibility for updating the Summary

All agencies should ensure that the designated Care Co-ordinator has a record of their current involvement and what needs have been assessed.

The information gathered will be stored in the organisation's internal client/patient case files. Ideally this will be on IT systems where possible.

Until appropriate IT systems are in place to facilitate sharing of information across agencies, other methods of transfer should be used, such as fax or e-mail.

When there is an agreement to change the Care Co-ordinator, the Summary should be updated and a copy passed to the new Care Co-ordinator. Where possible, this would be at a hand-over meeting with the service user and their representatives present.

When a new Care Co-ordinator takes over responsibility for the supporting the service user, they should ensure that the current Summary information is put into their client/patient file system, where it can be updated.

THE CARE CO-ORDINATOR OR KEY WORKER

The care co-ordinator, or key worker, is the person who will be responsible for instigating the overview assessment with the older person, collating the specialist assessments as well as co-ordinating the agreed care service, or services. They will be the main contact for the older person, their family and other professionals, ensuring the care delivered is appropriate and timely through the agreed monitoring and reviewing systems.

When an older person presents as needing both significant health and social care intervention, agreement should be reached by the appropriate professionals as to who should be the care co-ordinator.

The following can be considered when making the decision:

- For people whose needs are clinically unstable or complex, such as those needing immediate intermediate care services, an intermediate care practitioner is best placed to be the care co-ordinator.
- For people whose needs are socially complex, where family and social relationships give cause for concern, where abuse, or suspicion of abuse, may be present and where permanent care has been agreed as the care delivery, a care manager should be take on this role.
- Additionally, if the health need is paramount with no immediate indication of immediate social care intervention, a district nurse or therapist may complete the overview to acquire a more rounded picture of the older person's circumstances. If further assessments from other agencies are required as a result of completing the overview, then agreement should be made as to who will be the care co-ordinator. For example, in the case of terminal illness, social care may be providing some support additional to the intensive health provision. In these instances the district nurse would be the person best placed to co-ordinate the care.

In all circumstances the professionals working as the care co-ordinator should feel competent to do so. Appendix 5 lists some competencies which will support this important role and to which all professionals should aspire.

ROLE OF THE CARE CO-ORDINATOR OR KEY WORKER

When carrying out an assessment the care co-ordinator has the following responsibilities:

- To ensure that the older person understands why they are having an assessment and how that will benefit them.
- Ensure that the older person's perspective and that of their informal carers is central to the process of assessment and that their opinions are documented.
- Through use of the domains in the overview assessment, identify the range of needs that an older person may have and which of those needs should be assessed by a specialist.
- When referring to another agency provide the following information:
 - The older person has agreed to the referral
 - The views and concerns about the referral
 - The core detail information
 - Clear reason for request for their involvement
 - Other relevant information that will provide clear context for a specialist intervention.

- Be responsible for producing a multi-agency care plan, which reflects the involvement of all providing service delivery, including a daily timetable of services.
- Be responsible for completing, sharing and holding the Summary document in accordance with the guidance and information sharing protocols.
- Be responsible for monitoring the care provided and reviewing the care plan in the first four weeks to ensure it is delivering on the agreed outcomes. Any concerns, voiced by the older person or their representatives, regarding its implementation and progress should be addressed in a multi-agency forum, where that is appropriate.
- If appropriate, the care co-ordinator will consider placing a health and social care record folder in the older person's home. This would be in consultation with the older person and their representatives and in accordance with the laid down procedure. (Appendix 6)

Changing the Care Co-ordinator/Key Worker

The older person's needs may change over time and so it would be appropriate for the care co-ordinator who has the most involvement at any given time to take forward the care plan. For example, if a person has acute health needs, then the Intermediate care professional would co-ordinate the care for the first 6 weeks, through the integrated specialist team.

If the care plan is stable, then this may need to be monitored only. The complexity of the situation and consideration of the long term risks will determine who is appropriate to carry this out. When a person requires more social care input, then it would be appropriate for a care manager to become the key worker.

Some older people who have on-going care, which is stable, may not need the regular involvement of a care co-ordinator as they are able, with the support of family and friends, to monitor the care plan themselves. However, they should have their care regularly reviewed at yearly intervals to ensure the care continues to be appropriate to their need.

If there is not active involvement with a care co-ordinator, an older person and their representatives should be given clear information about who they should contact in the case of needing advice on their care package.

At all times, where the care co-ordinator/key worker is to be changed, this must be done in consultation with the service user and their representative.

JOINT WORKING

Sutton has a good history of positive working relationships between health and social care practitioners. The joint working arrangements at Bawtree House, the new integrated specialist team in intermediate care and the prevention initiatives with Age Concern demonstrate a commitment to partnership working to the benefit of older people. Strong links between district nurses, care managers and community psychiatric nurses have been built up through initiatives such as the multi-agency co-ordinating groups and the care management link to district nurses.

In order to progress a key objective of improving and delivering on the quality of service we give to older people, we need to take the whole systems approach and build on our joint working arrangements. In order to facilitate this the following should be built into practice:

- When a person presents with an acute health or social care need and an urgent assessment is required from another discipline, consider the value of arranging a joint visit to the service user. This will ensure that health and social care needs are addressed at the same time, service provision and by whom can be agreed and agreement on who will be responsible for co-ordinating the case in the immediate to short term can be reached.
- For social services this could be built into the Duty system and applied where practicable.
- Where there is to be a hand over from one agency to another, for example if care is required following an intermediate care episode, then a joint visit would be beneficial for both practitioners and service users.
- If a request has been made for a specialist assessment, there may be value in a joint visit with the specialist.
- Where the service user has the input of several services, installation of a health and social care record in the home would be beneficial.
- When considering joint working, practitioners should look beyond the statutory health and social service agencies only. The voluntary sector provides key services and information to older people, who would benefit from improved links and communication across all sectors.

SINGLE ASSESSMENT IN EPSOM AND ST HELIER TRUST

The principles of single assessment should apply to people in hospital in the following way:

- The older person should always be central to decisions regarding their care and treatment.
- The ward multi-disciplinary meetings are the forums for co-ordinating specialist assessments, and making decisions on care required on discharge from hospital.
- Ward staff complete the Contact assessment form which includes a check list to highlight which domains of the Overview assessment the agreed Care Co-ordinator needs to assess in more depth. (See Appendix 7 for sample of Epsom and St. Helier Contact Form)
- The multi-disciplinary records held by the hospital on each patient will contain the Contact core details and the specialist assessments so giving a comprehensive picture of the person's circumstances and needs.
- Use of the Contact assessment and re-imburement notification facilitate the appropriate level and timing of assessment and discharge.
- In the event where post discharge is to be exclusively provided by health, the intermediate care team or community nursing then the relevant practitioner will be the Care Co-ordinator.
- Appropriate use of the Timely Discharge Protocol will lead to stable and effective discharge planning and choice for the service user.

INFORMATION SHARING

The key to this protocol being successful, and for improvement of services, is the need to share information quickly, efficiently and appropriately.

The electronic solution will eventually be introduced and be the means by which people will be able to access appropriate information on service users.

Information should be shared having acquired the agreement of the service user where possible and practicable. This will be in accordance with the agreed Information Sharing Protocol and within the parameters of the data protection act.

The first stage of sharing information is to gain consent from the user about what is to be shared and with whom. Currently there is opportunity on all paper based forms for the older person (or their representative where agreed) to sign and give consent.

When sharing information practitioners need to ensure that **all** the relevant details are completed on the appropriate forms (and/or the internal IT systems) and agree how that information is best shared.

Each agency will store core details and the assessments on their internal IT systems under client records.

Where implemented, the health and social user held record is a central place for all information to be held and should be kept up-dated.

Vital, core information, can be placed in a service user's home using the 'Message in a Bottle' initiative.

APPENDIX 1

Agreed Glossary of Terms	
Term	Description
Age Discrimination	Action which can adversely affect an older person because of their age. Discrimination can also mean positive discrimination that is action taken to promote the best interests of the older person.
Assessments	The process whereby the needs of the individual are identified and their impact on independence, daily functioning and quality of life are evaluated, so that appropriate action can be planned. Assessment involves both professionals and those with problems thinking through different explanations for how problems have arisen, and how different problems interact with one another
TYPES OF ASSESSMENT	
Holistic Assessment	There is a need for the assessment to take a broad view of a person's assessed needs within the context of their social and family networks.
Multidisciplinary Assessment	Multidisciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information
Single Assessment Process (SAP) <i>(See also PERSON CENTRED APPROACH)</i>	The single assessment process for older people applies to health and social care services. It recognises that many older people have health and social care needs, and that agencies need to work together so that assessment and subsequent care planning are effective and co-ordinated. There are 4 types of assessment which includes
Contact Assessment	This refers to a first contact between an older person and professionals and establishing the nature of the presenting problem and whether or not there are potential wider health and social care needs as part of the Single Assessment Process. Basic personal information will be collected, or verified if previously collected, at contact assessment
Overview Assessment	This refers to situations where all or most of the domains of the single assessment process are explored. Overview assessment may be able to fully identify and describe assessed needs; if not, should include or trigger where in-depth assessment is required.
Specialist Assessment	Specialist assessment offers a way of exploring specific needs, often in detail, and may be indicated by a contact or overview assessment. As a result of a

	<p>specialist assessment, professionals should be able to confirm the presence, extent, cause and likely development of a health condition or problem or social care need, and establish links to other conditions, problems and needs.</p>
Comprehensive Assessment	<p>A comprehensive assessment may arise in several ways:</p> <ul style="list-style-type: none"> • Where professional judgement identifies 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 • At initial contact there could be less certainty and an overview assessment may be carried out to explore areas of concern. When all the domains of an overview assessment have been surveyed, and specialist assessments carried out in most or all of them, the result is a comprehensive assessment. • Where the level of support and treatment likely to be offered is intensive and prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home.
Carers Assessment	<p>A carer's assessment is carried out at the request of the carer in order to determine eligibility for support, the support needs of the carer and to see if those needs can be met by social or other services.</p>
Risk Assessment	<p>Evaluation of risk that result from the assessment of the individual's, and others, needs. This evaluation should take full account of the likely outcome if help were not to be provided. Consideration to be given to how needs and risks may change over time and what the impact this would have on a person's independence both in the immediate and longer term.</p> <p>Risk assessment involves the professional and individual exploring the individual needs which could include moving and handling, mental health, risk of neglect or self harm, skin care.</p>
Care Management	<p>A process whereby an individual's needs are</p>

	identified and assessed, eligibility for services is determined, care plans are drafted and implemented, and needs are monitored and re-assessed.
Care Coordinator	<p>A name given to a person who is responsible for co-ordinating, monitoring and reviewing the care of an individual. This is usually a professional member of staff working in specific health or social services and could be one of the following:</p> <ul style="list-style-type: none"> • A professional working in mental health services, who has been named and allocated as a care coordinator to a patient currently the subject of a care programme approach. • A care manager or social worker working in a social services department, who is the named worker for assessing and planning for the needs of a service user. • An intermediate care practitioner working in health services who is responsible for assessing and planning for the needs of a patient/service user
Care Planning	Care planning involves users and professionals discussing the support and treatment that can best meet identified/eligible needs and achieve agreed goals.
Care Plan	A Care Plan is the record for all older people who receive services. Details of the care plan should be in proportion to the assessed/eligible needs and service provision
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	A multi-agency agreement for an explicit route an individual (service user) takes through health and social care services. Agreements between the various professional involved will typically cover the type of care and treatment, which professional will be involved and their levels of skills, and where treatment or care will take place.
Care Programme Approach	The formal process of assessing needs for services for people with severe mental health problems prior to and after discharge from hospital.

Carer	Defined in the Carers and Disabled Children's Act 2000 as 'Carers (aged 16 and over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over'. It is a matter of professional practice to identify the impact of the caring role on the carer in light of the carer's age, general health, employment status, interests and other commitments. Key factors relevant in deciding the impact of the caring role on the carer are the sustainability of the caring role and the extent of risk to the sustainability of that role.
Electronic Social Care Record	A comprehensive social care record encompassing all relevant information about the assessed needs, services and expected outcomes for an individual, accessible in electronic form.
Ethnicity	The ethnic categorisation of individuals. The DoH uses the 2001 Census classifications for all statistical collection.
Health Care Professional	A type of person who is professionally qualified to practice the delivery of health care services and is contracted to or provides healthcare for a particular organisation or health care provider.
Intermediate Care	A short period (normally no longer than six weeks) of intensive rehabilitation, nursing care and treatment to enable patients to return home following hospitalisation, known as Early Supportive Discharge. Also, prevention of admission to permanent care can be facilitated by providing care in intermediate care beds or in the person's own home.
Mental Health Care Team (Community)	A team of professionals delivering specialist mental health services, including secondary and self-referral services, for adult and elderly patients. This includes the care or assessment of adult and elderly patients with drug or alcohol dependence but excludes child and adolescent psychiatry patients and patients with learning disabilities. The team can be multidisciplinary and may contain members who are employees of the health care provider or be employees of another NHS or non-NHS organisation.
Needs: <u>Presenting Need</u>	Those needs that are reported by older people or others on their behalf. The needs of a service user that have been identified

<u>Eligible Need</u>	as the result of an assessment, subject to the eligibility criteria. Eligible needs are needs that councils should meet as they are assessed as falling inside the councils eligibility criteria, that are set according to a council's resources.
Person Centred Approach	<p>The older person seeking help from health and social services experiences a single assessment process where:</p> <ul style="list-style-type: none"> • Information about needs is given once, no matter that the assessment and subsequent care planning and service delivery involves a number of professionals and agencies <p>Professionals work together in the best interests of the older person (as defined by the older person or those close to them)</p>
Reviews	A review is an examination of the assessed needs of a service user needs and services (the care plan where it exists) at or by a predetermined date. A further defining characteristic of a review is that it is about both the needs and service provision for the individual service user.
Service User/Patient/Client	An individual who is in receipt of either health services or social care services.

APPENDIX 2

SUTTON LOCALITY SINGLE ASSESSMENT CONTACT AND REFERRAL FORM

Referred by:	Assessor:
PARIS No:	NHS No:

BASIC PERSONAL DETAILS

Forenames:	Family Name:	Title: Mr/Mrs/Ms/Miss	
Permanent Address:		Date of Birth:	
Post Code:			
Tel No:	Fax No:	E-mail:	
Marital Status: Married/Single/widowed/Divorced/ Lives with Partner (circle as reported)	Gender: MALE / FEMALE	Lives Alone: Yes/No	Religion:
Present Whereabouts (If not at home address)			How long at this address?

ETHNICITY

(users view)

White UK	White Irish	White Other	Black UK	Black African	White/Black Caribbean	Black Other	White/Asian	Other Mixed
Tamil	Pakistani	Bangladeshi	Chinese	Indian	Other Asian	Not Stated		Other
Person's first language:				Interpreter Required?		Yes/no		
Communication Needs: Needs Interpreter/Lip Reading/Makatan/BSL Signer/Specialist Equipment Required								
Person's Occupation (where applicable)								

SIGNIFICANT CONTACTS

Others Involved

Person most close to older person (Next of Kin if appropriate)		Relationship:	
Family name:		Forenames	
Address:		Postcode:	
Telephone No:		Date of Birth:	
Main family or other carer (if different from person most close to older person)			
Family Name:			
Address:		Postcode;	
Telephone No:		Date of Birth:	

HEALTH DETAILS

Name of GP:		Practice:	
Referral Code:		Practice Code:	
Telephone No:		Email Address:	
Last Seen:			
Name of Dentist:		Practice:	
Telephone No:		Email Address:	
Hospital Consultant:		Last Seen:	
Relevant Medical History including any admissions within the last 12 months:			
Any Allergies?			
When was the last over 75 check completed? (if appropriate)			
Current Medications:			
How Administered? (please circle) Self/dosset box/blister pack/med. boxes/ help of another/other way (state):			
Other professionals currently involved:		Contact details	
(please list contact details)			
Care Co-ordinator			
CPN			
Physiotherapist			
Occupational Therapist			
Advocate			

Any Other	
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DISABILITY REGISTRATION

(PLEASE CIRCLE)

Physically Disabled	Blind	Dual Sensory Loss	Partially Sighted
Learning Dis. Mild/Moderate/Severe		Hard of Hearing/Deaf	Deaf without Speech

HOUSING INFORMATION

Housing Type:	Bed-sit	Maisonette	House	Bungalow	Caravan
	Nursing Home	Residential Home	Homeless	Flat	Sheltered
	Other (Please State)				
Housing Tenure	Owner	Lodger	Council Tenant	Private Tenant	Housing Association
Landlord Name and Address: (if applicable)			Sheltered Housing Officer Name:		
			Contact Number:		
Access to Personal Alarm system? Yes/No					
Access Arrangements: Entry System/Key Holder/Can get to the door (if key holder please insert name and tel. No.): External Stairs/Internal Stairs/Level Access/Ramp Access					
Hazards:					
Any Pets? Yes/No. (if yes please insert type and name):					

CURRENT SITUATION AND REFERRAL DETAILS

Please take down details of the referral purpose and current circumstances ensuring the following are included:
Please describe the current problem.
How has this affected the normal ability to cope? (i.e. what cant they do now which they could do before)
How have they managed so far? (including who has helped them)
Has there been any other problems or recent major life experiences, which has affected the quality of life? (eg recent bereavement/moving house)
Who else has been approached to help?

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SUMMMARY OF WHO CONTACTED AND REASON

Agency referred to/contacted	Date	Reason
District Nurse		
Intermediate Care Co-ordinator		
Incontinence Advisor		
GP		
CPN		
Social Services		
Sheltered Housing Officer		
Voluntary Sector (including service type eg vol. Bureau/day service/transport)		
Occupational Therapist		
Meals on Wheels		
Other		

APPENDIX 3

Domains of Overview Assessment

<p><u>Clinical background</u></p> <ul style="list-style-type: none"> ❑ History of medical conditions and diagnoses ❑ History of falls ❑ Medication use and ability to self-medicate <p><u>Disease prevention</u></p> <ul style="list-style-type: none"> ❑ History of blood pressure monitoring ❑ Nutrition, diet and fluids ❑ Vaccination history ❑ Drinking and smoking history ❑ Exercise pattern ❑ History of cervical and breast screening <p><u>Personal care and physical well-being</u></p> <ul style="list-style-type: none"> ❑ Personal hygiene, including washing, bathing, toileting and grooming ❑ Dressing ❑ Pain ❑ Oral health ❑ Foot-care ❑ Tissue viability ❑ Mobility ❑ Contenance and other aspects of elimination ❑ Sleeping patterns 	<p><u>Senses</u></p> <ul style="list-style-type: none"> ❑ Sight ❑ Hearing ❑ Communication <p><u>Mental health</u></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><u>Relationships</u></p> <ul style="list-style-type: none"> ❑ Social contacts, relationships, and involvement in leisure, hobbies, work, and learning ❑ Carer support and strength of caring arrangements, including the carer's perspective <p><u>Safety</u></p> <ul style="list-style-type: none"> ❑ Abuse and neglect ❑ Other aspects of personal safety ❑ Public safety <p><u>Immediate environment and resources</u></p> <ul style="list-style-type: none"> ❑ Care of the home and managing daily tasks such as food preparation, cleaning and shopping ❑ Housing – location, access, amenities and heating ❑ Level and management of finances
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APPENDIX 4

'Triggers for referrals to key services'

This section contains suggested 'triggers' for referring to key local agencies who can be viewed as 'specialists' in their own fields. In some cases the triggers may be derived from the agency's formal 'eligibility criteria' These triggers are only intended to serve as a guide for referrals, they are not intended to replace one-to-one discussion with the agency/individual/service concerned, which should always take place if the referrer is unsure whether the referral is appropriate.

Triggers for the involvement of a Care Manager (Sutton)

Referral to social services should be made when:

- A person is in need of assistance with activities of daily living.
- A person is socially isolated
- A person is at risk of self neglect or harm
- A person is in need of specialist services and/or registration for the sensory impaired
- A person is in need of access to emergency contact with relevant agencies by the installation of appropriate equipment (Safecall)
- A person is in need of assistance, support and advice with regard to housing issues
- Where Adult Abuse has been identified and investigation is needed
- Existing care arrangements cannot continue
- Where the needs of informal carers indicate a Carers Assessment would be valuable.
- Where consideration is being given to permanent care

Triggering a Referral to Primary Care

Primary Care provides a spectrum of health services from a variety of professionals including family doctors, dentists, pharmacists, district nurses, therapists and health visitors. Within a general practice setting there may be access to nurse specialists and nurse practitioners, who may also carry out health assessments. Triggers that would prompt a referral to general practice would include:

- Non-urgent, urgent and acute medical conditions, where emergency services are not required(ie 999). This could include rapid weight loss, sustained loss of appetite and difficulty in swallowing, persistent pain, deterioration in mobility, a temperature, an apparent infection, change in bladder or bowel habits eg going to the toilet more frequently or urgently, or having pain when passing urine or a change in the patient's mental state or behaviour.
- Access to domiciliary physiotherapy
- A variety of specialist services, for example advice re weight loss, assistance to stop smoking etc. (each General Practice may have their own specialist service.)
- Referral to a Consultant, in secondary general, or mental health medicine, when further specialist expertise is sought.

- Referral for wheelchair service (if no involvement from a physiotherapist)
- Referrals should be made for an annual medication review if a person is over 75 and this has not occurred, or if they are taking 4 or more medicines, which have not been reviewed for 6 months.

Triggering the involvement of the PCT Community Nursing Service

District Nurses also receive referrals from the GP, but can receive direct referrals for assessment on the following:

- Apparent skin breakdown
- Dressing of wounds
- Continence/Incontinence problems (including catheter problems)
- Deterioration in mobility (if known to the District Nurse, otherwise to the GP)
- Carer's health is breaking down
- Person complains of, or has a history of, falls (if known to District Nurse, otherwise to the GP)
- Refusing to take medication or taking medication inappropriately
- Person is experiencing difficulty with positioning.

Triggering the Involvement of the Sutton Mental Health Services for Older People

A person who presents with mental health needs should be referred to the GP in the first instance. The GP will decide if the person needs to have further investigations and assessments under a secondary care consultant. Therefore referral to the Trust should only occur when:

- A. the person is an open case to the Mental Health Team and
- B. any sudden, unexplained change in his/her mental state presenting with signs of extra confusion, delirium, mood changes, aggression, inappropriate behaviour or paranoid behaviour, has no underlying physical cause eg. Urinary tract infection.

Triggering the Involvement of the Intermediate Care Teams

The intermediate care teams will receive referrals from a GP, however direct referrals can be made when:

- The person has clear rehabilitation needs and potential to reach the goal of increased independence
- The person is in hospital or in an Accident and Emergency Department/Medical Assessment unit and could carry on their rehabilitation/recovery at home
- To prevent an inappropriate acute admission for patients who could be safely cared for at home or in intermediate care beds.
- If the person meets the specific clinical (or other) criteria of the relevant intermediate care services in Sutton

Triggering the Involvement of the Local Authority Occupational Therapy Services

- The individual has a permanent illness, injury or deformity which substantially affects his/her ability to carry out activities of daily living (as stated in the National Assistance Act 1948 and Chronically Sick and Disabled Persons Act 1970).
- The priority of the O.T. service is to make sure that people can cope with practical living skills like toileting, getting in and out of bed or a chair, washing, dressing, cooking and eating.
- Following assessment, OT's can recommend various techniques and items of specialist equipment to help with practical living skills.
- Small adaptations may be recommended. These include grab rails, stair rails, shallow steps and low gradient ramps.
- If the person is an owner-occupier or private tenant, advice or financial assistance may be available under the Disabled Facilities Grant Scheme for large adaptations such as showers, complex ramps and stair lifts. These grants are subject to a financial assessment.
- If the person is a Council tenant, they may be eligible for large adaptations following an O.T. assessment.
- The Rapid Response Service facilitates timely intervention for professional referrals where there is an urgent need and potential risk to client/carer has been identified.
- Also included in the Rapid Response Service is the fast-tracking of equipment and adaptations. Assessments with recommendations are accepted from therapists, and are actioned directly to support hospital discharges and prevent admissions.

Triggering the involvement of the Domiciliary Physiotherapy Service

A referral to the domiciliary physiotherapy service should be made (via general practice or Hospital Consultant) if the person has a disability which would be most suitably treated at home. Examples of the service offered are:

- Mobility assessment with provision of standard walking frames and sticks if required
- Support after hospital discharge.
- Assessment following visits to A&E
- Treatment for all neurological conditions in either acute intervention or long-term management stages.
- Acute back/neck pain advice and treatment, and provision of corset and collars
- Wheelchair assessment
- Assessment and advice for frail elderly people to promote independence at home

Triggering the involvement of the Voluntary Sector

A referral to the Voluntary Sector should be made when service provision is being considered in the following areas:

- Assistance with shopping, transport and befriending, housework
- Advice on general and specific services for older people
- Advice on security and safety
- Advice on keeping well and keeping warm
- Support on discharge from hospital
- Advice and support in prevention of falls
- Provision of environmental checks and smaller items of equipment
- Access to advice and advocacy for older people
- Access to projects that prevent social isolation
- Benefits claims – assessments to include disability benefits, housing & council tax benefits, MIG, from October Pension Credit - this is a home visiting service
- Access to charity funding in the case of financial hardship
- Access to Handyperson Service for small household maintenance jobs

APPENDIX 5

KEY COMPETENCIES OF THE CARE CO-ORDINATOR OR KEY WORKER

- ❖ Able to work with patients/service users and their carers in a user centred way, eliciting their views on all issues and securing their engagement in the assessment process.
- ❖ Able to work in outcome focussed ways, able to specify issues to address and agree appropriate objectives in addressing them.
- ❖ Able to carry out assessments of need in their own area of expertise.
- ❖ Able to identify which of the full range of domains in the Single Assessment process are relevant to each individual.
- ❖ Knowledge of areas of expertise of all other specialists/agencies relevant to care of older people
- ❖ Able to engage specialists constructively and appropriately.
- ❖ Able to support specialists to summarise their work in outcome focussed ways.
- ❖ Able to integrate the various specialist contributions into a single plan.
- ❖ Able to use IT systems effectively.

APPENDIX 6

USER HELD RECORD PROCEDURE

Title

The record to be called 'Social and Care Record'

Format

The record will be:

- Hard back folder to be in bold colour so easily identifiable
- Colour coded plastic dividers, one for each participating agency.
- User friendly, easy to work through, with sections being clearly marked.

Content

- a. The first insert will be a list of involved agencies with names and contact numbers and availability, including out of hours contact numbers. This needs to be kept up to date to reflect the changing circumstances of the individual.
- b. The first contact section will be the current shared referral form used by community services and community health trust. This will maintain consistency and avoid production of a further referral form.
- c. The person's assessments and care plans will be filed in individual sections to reflect the agencies involved. This could include:
 - district nurse assessment and nursing plan ie the patient specific assessment for the current specific condition
 - care management care plan
 - the intermediate care assessment and care plan
 - the occupational therapy action plan and equipment issued to client
 - in the case of 'sensitive' information being held (ie CPN involvement) only basic details of who is involved and current intervention will be documented.
- d. Sections to be made available for the individual care delivery agencies including independent and in-house services. To be more specific in content than 'all care given'. An example may be where the person is diabetic and timing of meals is stated. This is crucial to effective maintenance and treatment. Emphasis to be put on recording specific changes or unusual episodes in order to give a clearer monitoring picture.
- e. A section to be provided for users and carers to make comments
- f. A section to be provided for comments from Sheltered Housing Officers.
- g. A section to be provided for 'Other'

Process for Contributors

- a. For the purposes of this pilot, the responsibility for setting up the user record will be, in the first instance, with the sheltered housing officer. This does not eliminate the request from a care manager or district nurse if they feel a person would benefit from having the record in the home. They would then adopt the responsibilities as outlined for sheltered housing officers. (If this is the case, the Project Manager for the Single Assessment needs to be informed for monitoring and evaluation purposes)
- b. Clear agreement needs to be made with contributing agencies, regarding who will hold any records that may be removed in the up-dating process. In the case of independent agencies records, reference to be made to the commissioner of the care in the first instance.

- c. All agencies involved will have their own section; this would include the voluntary sector as well as informal carers. In the case of meals-on-wheels any concerns could be recorded in the 'Other' section. However, it is not envisaged this will replace the need to take direct action by contacting the appropriate person should the need dictate.
- d. In order to ensure that all involved are aware of the service and treatment being received, each agency will take responsibility to sign they have read the record.
- e. The co-ordinator would be responsible for informing the GP that the record is in place and invite them to read and sign when a visit made
- f. The co-ordinator will take responsibility to ensure the record is up-dated after 3 months. This could take place at the time of case review, with all agencies agreeing to amend where necessary.
- g. Each agency to take responsibility for alerting the co-ordinator when there may be a need for a review of the care.

Additional Responsibilities

The original procedure will be used with appropriate amendments.

The roles and responsibilities will be as follows:

- a. Identifying a suitable candidate for the scheme
- b. Discuss the use of the Record with the user and carer ensuring they fully understand its purpose and seeking agreement for participation in the scheme
- c. Being responsible for placing the record in the users home.
- d. Alerting the agencies which are currently involved with the user of the existence of the Record and requesting that current care plans are placed into the care folder
- e. Working with the user and other agencies to maintain the folder so that it remains up to date and relevant.
- f. Supplying "message in a bottle" equipment, facilitate completion of information sheet and ensuring that the bottle is placed in the users fridge and alert stickers are in position.