

**West Midlands Regional Single Assessment Process Group**

**THE SINGLE ASSESSMENT PROCESS AND  
CROSS BOUNDARY WORKING**

**West Midlands SAP Cross Boundary Project sponsored by**

**ADSS West Midlands - Older Peoples Network**

**Department of Health - Health and Social Care Change Agent Team**

## THE SINGLE ASSESSMENT PROCESS AND CROSS BOUNDARY WORKING

The ADSS West Midlands Regional Single Assessment Process Group commissioned this project in May 2004 with funding from the Department of Health Health and Social Care Change Agent Team to address issues of consistency and compatibility of working arrangements and information sharing across geographical boundaries with respect to the Single Assessment Process.

The aims of the project were: to map cross boundary issues by type and location, to draw on this information to work towards agreeing the principles of cross boundary working, and to produce a model protocol to build on and complement existing Information Sharing Protocols. The project was intended to be flexible to respond to local issues and circumstances, and it was hoped the outcome or product would be applicable across a wider audience.

The West Midlands region comprises 3 Strategic Health Authorities, 14 Local Authorities, 30 Primary Care Trusts and 20 Acute Trusts. It is a mixture of densely populated urban areas with closely overlapping boundaries and services and more sparsely populated rural areas where many people in border areas receive services from outside their own locality. The assumption behind the Cross Boundary Project is that, in an area like the West Midlands with significant cross border patient flows, co-ordination and consistency across geographical areas is essential if older people are to receive good quality assessment and care regardless of where they live and from where their services are provided.

The aim of the Single Assessment Process, delivering person centred care (National Service Framework for Older People, Standard 2), is *“to ensure that older people’s needs are assessed and evaluated fully, with professionals sharing information appropriately and not repeating assessments already carried out by others. This requires a high degree of mutual trust, robust systems for information-sharing, and a clear understanding of respective roles and responsibilities.”*<sup>1</sup> Although simple in concept, implementing the Single Assessment Process is an enormous task, and the effort involved should not be underestimated.

The Department of Health has provided the framework for a standardised approach which should improve the quality of assessments and decision making for older people everywhere, but how local organisations implement SAP has been left to localities to decide. The introduction of electronic care records through the National Programme for IT will require a far greater degree of standardisation than at present exists.

The W Midlands Regional SAP Group has aimed to promote a common approach to the Single Assessment Process in the region by sharing information and endorsing best practice. The Cross Boundary Project has aimed to support this, by mapping how the Single Assessment Process has been implemented in the West Midlands,

---

<sup>1</sup> Department of Health: Changing Times – Improving Services for Older People. Report on the work of the Health and Social Care Change Agent Team 2003/4. p.8

describing some of the implications for cross boundary working arising from this, and by identifying some aspects of good practice which could become the basis for a regional model.

This report outlines the findings of the mapping exercise, suggests in a Good Practice Guide for Cross Boundary Working steps which localities can practically take to move towards greater commonality, and sets out the elements of a formal Agreement on Cross Boundary Working and Information Sharing which could be adopted by organisations responsible for implementing the Single Assessment Process in the West Midlands.

## **The Project Findings**

### **Methodology**

Discussions took place with the lead officers for SAP in each locality, visits were made to a number of sites to talk to practitioners involved in using the Single Assessment Process, and SAP documentation from around the region was collected, compared and evaluated against Department of Health guidelines. This work, which was carried out between May and July 2004, was supplemented by information from the June Audit of progress on implementation, and a follow up questionnaire to lead officers specifically asking about cross boundary issues and how these were being addressed. It was clear from all of this that there was a strong commitment to the principles of the Single Assessment Process across the region and a very great deal of work going on in each locality to implement SAP successfully, but the outcome was extremely varied.

Sharing the findings from this Project through the West Midlands regional group has enabled localities to identify gaps and differences, and begin to address these. Single Assessment processes in most localities are continuing to evolve. As a result, some of the detailed examples based on the situation in June and July 2004 will already have been amended.

### **Assessment tools and documentation**

The absence of a single agreed national assessment tool and the Department of Health's decision to allow organisations the freedom to develop local solutions meant that all localities except one (Birmingham) had opted to develop their own assessment format and documentation, rather than use a nationally accredited assessment tool. The result was very considerable variation. Most areas had worked hard to develop SAP systems that worked for them, often involving professional staff and older people in the process. Organisations were all starting from a different base, and took pragmatic decisions to build on what already existed, with a resulting wealth of variation in systems and documentation across the region (Figure 1)<sup>2</sup>.

---

<sup>2</sup> This information, and that which follows, is based mainly on the SAP documentation in use in July 2004. Some documentation and systems have been amended or developed since then.

<b>Locality</b>	<b>Assessment Documentation</b>	<b>Format</b>
<b>Birmingham</b>	Birmingham Single Assessment System, based on EasyCare	Paper, carbonated. Contact Assessment can be completed in Word.
<b>Coventry</b>	Home grown (piloted EasyCare and rejected it)	Paper.
<b>Dudley</b>	Based on DH Current Summary Record	Paper, carbonated.
<b>Hereford</b>	Homegrown, using existing forms	Paper. Possibly developing interim electronic solution with ODPM funding
<b>Sandwell</b>	Homegrown, using existing forms	Paper (will be carbonated). Can be completed on Swift by Social Inclusion & Health
<b>Shropshire</b>	Home grown. Developed with Older Peoples Forum	Paper. Can be completed as Word document.
<b>Solihull</b>	Home grown using existing processes.	Paper forms, which will feed electronic record. National pilot for interim electronic solution
<b>Stoke &amp; Staffs</b>	Based on Worcestershire documentation	Paper forms. Can be printed from one hospital system. Contact Assessment built into electronic social care record.
<b>Telford &amp; Wrekin</b>	Home grown	Paper.
<b>Walsall</b>	Home grown	Paper. Can be completed on screen as Word document.
<b>Warwickshire</b>	Home grown. Trialled EasyCare and rejected it.	Paper, carbonated. SSD system CareFirst can print Contact Ass.
<b>Wolverhampton</b>	Home grown. Trialled EasyCare and rejected it.	Electronic system – Fusion. Fed by paper forms.
<b>Worcestershire</b>	Home grown.	Paper initially. Interim electronic solution being developed.

**Figure 1. SAP systems in use**

The approach used in devising home grown assessment tools and documentation differed widely. Some areas, for instance Shropshire, had deliberately aimed to produce something short and basic (seven pages in all for Contact and Overview Assessments, including Consent and Care Plan). At the opposite end of the scale, Warwickshire's Overview Assessment at 22 pages long, and Birmingham's at 31 pages, were clearly very different documents from Shropshire's. Some of the variations in documentation will be described in more detail below.

Most areas were using paper based systems. This usually involved completion of a paper form by hand, photocopying or using a carbon copy to give a copy to the service user or to pass the information on to another professional. A number of

Social Services' electronic record systems, for example Staffordshire, Warwickshire, Sandwell and Dudley, had been adapted to produce the completed Contact Assessment in printed form, or to use the hand written form to input the information onto their system, but none of these could link electronically with Health systems. Similarly, in some areas the Contact Assessment form had been devised as a Word document so that it could be completed on screen and then printed off or emailed (for instance, Birmingham, Walsall) but this capacity was limited in Shropshire by lack of access to PCs.

In many areas the documentation was still undergoing revisions and amendments in the light of implementation experience. A number of localities had made the deliberate decision to start with something simple, with a view to ongoing development. In general, localities recognised that implementation was likely to be a long term process, requiring considerable changes over time in culture and working practices.

A number of areas were considering how to link information held electronically in different organisations' systems. The interim electronic solution being developed in Worcestershire is intended to draw information from four different systems, but, like the Wolverhampton system, may not have the capacity to send information back. Generally electronic systems were still in the very early stages of development.

### **Person Held Records**

The Department of Health recognises that until the National Programme for IT is in a position to deliver an integrated electronic recording and referral system for the Single Assessment Process, organisations will need to rely on paper based systems to exchange information. The Department suggests that an interim solution to information sharing pending electronic systems becoming available could be a joint health and social care record held by the service user<sup>3</sup>. This has the added advantage of empowering the service user by giving them the most up to date information about themselves and putting them in control of who has access to it.

A majority of localities in the region had decided to implement Person Held Records as an integral part of delivering person centred care through the Single Assessment Process. Many localities had decided to adopt the same type and colour of folder for the PHR as a neighbouring authority, although the content might differ, to make it easily recognisable. The expectation was that the Ambulance Service would be able to locate the record in an older person's house and bring it with the patient to hospital, or the person themselves would be encouraged to bring it with them when attending outpatients.

The following table (Figure 2) shows that there is no common standard for Person Held Records in the region. Most localities were using a large, robust plastic coated ring binder to contain the documentation, which looked official and would be easily recognisable by the service user and visitors. Shropshire and Telford and Wrekin

---

<sup>3</sup> Department of Health: Draft Guidance on Person Held Records, shortly to appear on SAP website.

had deliberately gone for a smaller flexible folder, in response to the request from older people consulted for something easy to tuck into a handbag or coat pocket.

Locality	PHR	Format	Content
<b>Birmingham</b>	Yes	Yellow ring binder (same as Solihull)	Instructions for service user. Table of contents, dividers for agencies' own documentation. Sheet to note sections removed. Pocket for leaflets.
<b>Coventry</b>	Yes	Orange ring binder (same as Warwickshire)	Table of contents, dividers. Sections for Contact & Overview, various specialist assessments, discharge summary, care plan and Reviews.
<b>Dudley</b>	Yes	Purple ring binder	Instructions for reader (professional). Sections for leaflets and assessment forms, plus coloured dividers representing notes sections for different professional groups.
<b>Hereford</b>	No		
<b>Sandwell</b>	Yes	Yellow ring binder (same as Birmingham & Solihull)	Table of contents, dividers. Sections for assessments, care plan, nursing and other professional records. Communication sheet, useful telephone numbers, and documents removed from the file.
<b>Shropshire</b>	Yes	Yellow A5 folder (same as Telford & Wrekin)	Assessment Summary – the Contact & Overview (A4) folded into single pocket of A5 folder.
<b>Solihull</b>	Yes	Yellow ring binder (same as Birmingham)	Instructions for service users. Table of contents, dividers. Care Co-ordinator's details. List of tel. nos. Section for own use. Pocket for leaflets.
<b>Stoke &amp; Staffs</b>	Yes	Yellow ring binder	Instructions for service users. Dividers, assessment forms, communication sheets.
<b>Telford &amp; Wrekin</b>	Yes	Yellow A5 folder (same as Shropshire)	Assessment Summary – the Contact & overview (A4) folded into single pocket of A5 folder.
<b>Walsall</b>	No		
<b>Warwickshire</b>	Yes	Orange folder (same as Coventry)	Table of contents, dividers. Sections reflect different sections of Overview Assessment, plus Reviews.
<b>Wolverhampton</b>	No		
<b>Worcestershire</b>	Yes	Red folder	No dividers or guidance on content.

**Figure 2. Person Held Records**

While further work can be suggested to bring the content closer together, the investment already made by many localities in purchasing and publicising special folders means that it is unlikely to be possible to adopt a standard folder at this stage. It might make sense, however, for any locality considering developing Person Held Records to choose yellow/orange for the cover.

For most areas the introduction of Person Held Records had been too recent for any systematic evaluation of their use and usefulness. There was anecdotal evidence from Telford & Wrekin that some older people had taken them out with them to social activities and compared notes. At one Birmingham Hospital the physiotherapists had found it extremely helpful when people brought their records to their follow up appointments in outpatients.

In most areas the Ambulance Service had been alerted when Patient Held Records were introduced, and one area was sending the Ambulance Service details of all patients issued with a folder. It was not known how this information was being used or how useful it was. Sandwell is going to use a yellow sticker on the older person's telephone to alert professionals to the existence of the Person Held Record. Dudley was using numbered files to keep track of who had been issued with one, and had set up a database of recipients which health and social care professionals could access.

### Contact Assessment

The Department of Health Guidance states that the Contact Assessment *"refers to a contact between an older person and health and social services where significant needs are first described or suspected.....At contact assessment basic personal information is collected and the nature of the presenting problem is established and the potential presence of wider health and social care needs is explored."*<sup>4</sup> The guidance lists the basic personal information which should be collected and outlines the key issues to be addressed in establishing the nature of the needs faced by the older person.

In implementing the Single Assessment Process organisations in the West Midlands had by and large followed the guidelines for the Contact Assessment, but there was still considerable variation (Figure 3).

Locality	No of pages	Personal demographics	Others involved	Perception of needs	Other information
Birmingham	4	Accommodation and household details, religion, occupation, in Overview modules.	GP, next of kin, main carer, emergency contact. Hospital	Reason for referral, practitioner observation, other needs or factors.	Has consent form been completed? Continuing Health Care Ass? Includes Sec 2

<sup>4</sup> Department of Health: Single Assessment Process - Guidance for Local Implementation. Annex E - Stages of Assessment. January 2002

			admissions. Referrer's details	Person's own perspective in Overview.	Notification
<b>Coventry</b>	2	Omits NHS number, alternative names, occupation, accommodation type & tenure.	GP, next of kin, others in household, hospital admissions. Lists other professionals	Reason for referral, significant medical conditions. Person's own perspective in Overview.	Interagency referral form. Includes services usually received.
<b>Dudley</b>	2 + 1	Omits occupation.	GP, next of kin, main carer, advocate, emergency contact, Care Co-ordinator.	No information on needs or reason for referral.	Includes separate sheet for recording confidential information
<b>Hereford</b>	2	Omits post codes	GP, dentist, referrer, significant contacts, professional involved & services, hospital admissions.	Disabilities or health. Reason for contact – presenting difficulty, own perspective. Own preferred solutions.	Includes Action Taken. Includes Consent to Information Sharing.
<b>Sandwell</b>	2	All included.	GP, dentist, next of kin, main carer, emergency contact.	Source & reason for initial contact, other agencies involved.	Requires signature of service user, but not consent to information sharing.
<b>Shropshire</b>	1	Omits gender, alternative name, occupation, interpreter needed and access/hazards. Accommodation details in Overview.	GP, next of kin and main carer.	Current needs & issues, Reason for assessment, History of medical conditions & diagnoses, Allergies, Medication. Equipment, Hospital admission (all small text boxes)	Integrated into SAP Summary/ Overview Assessment
<b>Solihull</b>	? 3	All included, plus Primary Client Type.	GP, Main carer, other personal relationships, other professionals involved .	Reason for referral, Assessed person's perspective.	Integrated with Overview into Registration, Assessment & Referral form.
<b>Stoke &amp; Staffs</b>	2	All included.	GP, Significant contacts, Professionals involved or	Health, Communication needs, Person's own description of	Includes Consent to Sharing Information. Includes Action Taken, and

			services provided	needs, Reason for referral, Risks.	space for Additional comments
<b>Telford &amp; Wrekin</b>	2	Omits temporary address and alternative name, occupation, access/hazards.	GP, dentist, next of kin, main carer, other professionals involved, hospital admissions	Reason for referral, clients perspective of current need, comments/ additional information.	Continuing Health Care assessed? Level of assessment required, allocation details. Includes warden, alarm.
<b>Walsall</b>	5	Omits NHS number	Referrer's details, GP, Nearest Relative, Emergency contact, Main carer.	Brief description of reason for contact, Diagnosis, Practitioner's observations, Other needs, other factors.	Includes Action Taken, Agreed next steps, Consent to Information Sharing, Benefits info.
<b>Warwickshire</b>	2	All included	GP, Care Co-ordinator, Significant other, Main carer, Emergency contact, Advocate	My needs & problems, Practitioners perspective – Presenting problem, reason for referral.	Consent to Share Information obtained? Restrictions?
<b>Wolverhampton</b>	4	Omits gender	Omits GP. Includes Emergency contacts, Carers, Next of Kin.	Reason for Referral	Includes CareLink, Minicom or Key Safe?
<b>Worcestershire</b>	2	Omits access/ hazards	GP, Significant contacts – Family, Professionals	Reason for contact (person's own perspective), Health, Nature of presenting problem (Views of referrer or assessor), Action, other comments.	Includes Consent to Information Sharing, Sec 2 notification, service user's email address.

**Figure 3. Contact Assessments**

Most localities had kept the Contact Assessment to two pages, and all asked for the basic demographic information specified by the Department of Health, with one or two omissions. These included the person's NHS number (two localities), gender (two localities), accommodation details (three localities, although two included this information in the Overview Assessment), occupation (five localities), religion, interpreter needed and post codes. Basic identifying information such as NHS number and post codes will become particularly important with the introduction of the national electronic care record through the National Programme for IT.

Three localities omitted information on safety or access issues for professionals visiting. Most localities asked for details of a range of contacts, personal and professional, although one omitted most of these, including GP details, from the Contact Assessment and included them instead on the Overview Assessment.

Most areas were intending to use the Contact Assessment as a basic referral form between health and social care agencies, with some localities already using it for all referrals between health and social care professionals, but one locality's form did not include any information on needs or the reason for the contact. In two places the Contact Assessment included the Section 2 notification for hospital discharge and reimbursement, and two checked whether an assessment for Continuing Health Care had been carried out. A space for service users to sign consent to information sharing was included on the Contact Assessment in four localities, and a further two had a space on their form to indicate whether consent had been obtained.

### Overview Assessment

The Department of Health guidance refers to the Overview Assessment as “a more rounded assessment, (in which) all or some of the domains of the single assessment process, such as personal care and physical well-being, senses and mental health are explored”<sup>5</sup>. The domains and sub-domains are set out in the guidance, but the type of information to be collected under each heading is not specified. As a result, the variation in Overview assessments across the region is considerable (Figure 4).

Locality	No of pages	Domains	Type of information	Care Plan	Other
Birmingham	29	All domains covered except Clinical Background. No diagnosis. Relies on person's own perception of their health – Module 2 How are you doing?	Very detailed. Tick boxes (Yes/No or No difficulty/ Some difficulty/ Unable, and Comments space.	Services received plus Action Plan. No objectives.	
Coventry	10	Omits Senses and Safety. Clinical background mainly free text.	Tick boxes for subdomains, e.g. Normal diet/Restricted diet, plus Comments Spaces.	Separate Care Plan. Overall Aim, Needs – Objectives – Services.	Records info from 3 separate dates. Also Update section.
Dudley	13	Omits Safety.	Mainly free text with detailed prompts. Use DH codes 1-4 for Individual Needs.	Lists services with DH codes 1-4. No timetable	

<sup>5</sup> Department of Health: Single Assessment Process – Guidance for Local Implementation. Annex E – Stages of assessment. January 2002

<b>Hereford</b>	7	All domains covered except Relationships but not all sub-domains.	Tick box and comments e.g. Manages independently/ Needs help.	No Care Plan, only Action to result from assessment, and by whom.	
<b>Sandwell</b>	7	All domains covered, but some in very little detail.	Mainly free text, some tick boxes in section on Accommodation and Environment.	Separate Care Plans - Residential & Non-residential.	Person signs to say agree with assessment
<b>Shropshire</b>	6	Omits Safety. Few sub – domains e.g. only Allergies for Disease Prevention.	Some sections tick boxes e.g. Food: Normal/ Soft/ Puree/ Cold swallow. Others free text e.g. Mental Health.	Lists Needs & Action. Summary Care Plan included, no objectives or list of services.	
<b>Solihull</b>	4	All domains covered, and most sub-domains, except Diagnosis.	Mainly tick boxes with DH Codes 1-4, plus Notes boxes. Some free text sections with prompts e.g. other Clinical Information, Risks to Independence.	No Care Plan, no list of services.	Next Steps includes suggestions for getting help elsewhere.
<b>Stoke &amp; Staffs</b>	4	All domains covered, but not all sub-domains e.g. general question: Health promotion issues addressed?	Mainly - Do you have difficulty with...? YES/NO (box), and Comments (text)	Service provision – Agreed outcome - Review date. No list of services or timetable.	
<b>Telford &amp; Wrekin</b>	14	All domains covered.	Separate sections to most questions for: Response/ Carers comments/ Assessors comments, plus a-d codes (Needs help/ Manages with current help/ No difficulty/ Not assessed)	Summary of needs identified and proposed outcomes. Summary Care Plan (timetable) included.	Prompts throughout – Consider request for assessment by/ referral to...
<b>Walsall</b>	3	Omits Clinical detail, Disease Prevention, Safety. No sub-domains.	ADL -Free text space, no prompts, and code boxes. Summary of Eligible Needs: Health/ Personal Care/	No care plan or list of services received	Prompts for Direct Payments

			Family/Carer – small free text space and tick: Critical/ Substantial/ Moderate/Low		
<b>Warwickshire</b>	24	All domains and sub-domains covered.	Very detailed factual information e.g. date, location and details of falls, action taken. Tick box and comments.	Includes Care Plan – Overarching, specific and timetable.	R - Referral prompts throughout.
<b>Wolverhampton</b>	13	Omits Safety. Not all sub-domains covered.	Mainly tick boxes, with comments.	No Care Plan. Lists current services, but not action as result of assessment.	Person signs to agree assessment. Demographic update form.
<b>Worcestershire</b>	5	Omits Disease Prevention Senses, and many sub-domains.	Mainly free text, with some prompts. Space for Action Taken after each section.	No care plan or list of services.	Name & date of person completing each section.

**Figure 4. Overview Assessments**

Overview Assessment forms in the region vary in length from 3 pages to 29 pages and the approach taken similarly shows wide variation. Only one, Birmingham's Single Assessment System, is based on a nationally accredited tool (EasyCare). Some clearly show their provenance by being particularly health or social care biased, for instance by detailing type of catheter, or conversely by omitting clinical detail but including information about direct payments. Some of the variation is down to localities having incorporated information in their assessment forms which was previously collected on internal forms and which various professionals still considered essential. In some places this has been the trade-off for bringing different professionals on board and agreeing to discard their own forms.

A major difference in approach is shown in the way questions are framed and information recorded. Some assessment formats are commendably person centred, with an emphasis on the older person describing their own needs in their own way (for instance "In general, would you say your health is Excellent/Very Good/Good/Fair/Poor?" Birmingham Module 2, Question 1; or "Do you have any concerns about your health? Yes/No/Comments" Staffordshire and Stoke). The problem with this approach is that unless there is somewhere else to record the diagnosis this vital piece of information could be missed. In Birmingham and Staffs/Stoke, for instance, this means that practitioners needed to be careful to include the diagnosis under Reason for Referral in the Contact Assessment. As a result, Birmingham has amended the Contact Assessment to ask for diagnosis explicitly.

Similarly, asking “Has your blood pressure been checked recently? Yes/No/Comments” (Birmingham Module 6 Question 8) without also prompting for the most recent blood pressure reading to be recorded, means that if this information is relevant it will have to be sought elsewhere, for instance from the medical notes. This undermines the value of the Single Assessment Process and creates potential problems for producing the Current Summary Record (see later).

The factual approach adopted from the DH guidance, for instance by Dudley, which asks for Diagnosis and Diagnosis Date, and Blood Pressure and Blood Pressure Observation Date, still means that this information will have to be sought elsewhere by, for instance, a social worker completing the assessment with an older person. The difference is that, whoever provides it, bringing together this information and copying it into the record makes the Single Assessment Process documentation a truly joint record containing the essential information about a person with health and social care needs.

Some localities’ forms only ask for very general information such as Medical History (free text) with or without specific prompts, and it may be more difficult in these circumstances to ensure that the essential information is captured. Most localities used a combination of tick boxes with space for free text comments. Generally speaking, systems using free text without associated codes or tick boxes are less likely to produce standardised information and may be more difficult to convert to an electronic record.

Even when closely following the specified domains and sub-domains, most localities do not use the Department of Health’s specified codes against the items in the Assessment of Individual Needs section. This is also true of EasyCare, one of the nationally accredited tools examined for comparison. The Department of Health’s specified codes for Individual Needs – 1. *Need being addressed* / 2. *Need not being addressed* / 3. *No current need* / 4. *Not known* – are only used by Dudley and Solihull, perhaps because they do not seem particularly helpful. Many localities instead use their own breakdowns, such as “*Without help/ With help/ Completely unable*”. While useful locally, the lack of a standard system for coding responses will be problematic for sharing information with other systems.

Finally, it was not always clear from the forms in use in some localities who had completed or contributed to the assessment, or why an assessment had been required. Similarly, only one or two systems indicated clear processes for updating the information. Worcestershire ensures each section has a name and a date beside it. Coventry allows space for information from three different assessment dates and includes a final section “Record of Development of Assessment” which records further or reassessments undertaken and where the records are kept. Birmingham similarly includes a schedule of assessment modules undertaken, with dates for subsequent assessments. The EasyCare system includes special update forms.

### **Ability to produce the Current Summary Record**

The Department of Health states that the Current Summary Record (formerly the Single Assessment Summary) should be “*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*<sup>6</sup>. As such, the Current Summary Record is a key element in the Single Assessment Process.

The Guidance sets out the required information which should be brought together into the Current Summary Record, using the most up to date information available. The sections of the Current Summary Record detailed by the Department of Health are Person demographics, Others involved, Older person's perspective of current needs, Clinical background, Disease prevention, Assessment of individual needs, Evaluation of needs and risks, Summary of Current Care Plan, Additional personal information and Administrative details.

Ultimately, the plan is for the Current Summary Record to be generated electronically by systems developed as part of the National Programme for IT. In the absence of an electronic system, the Department of Health suggests that a paper version of the Current Summary Record should at least consist of the Contact Assessment, Overview Assessment and summarised information from any specialist assessments, together with the Care Plan. The means of sharing this information could be the Patient Held Record. For this project, locally developed Person Held Records were evaluated to see how far local systems are capable of generating the required information for the Current Summary. For those localities which have not developed a Person Held Record, their current SAP documentation was used.

At the time of this survey, no area was using documentation which fully met the requirements of the Current Summary Record, and this included EasyCare. There were many differences, and difficulties, around Evaluation of Needs and Risks, with no locality following the Department of Health's framework, once again perhaps because it is not particularly helpful. But this section, together with the Care Plan, lies at the heart of the Single Assessment Process, in that together they demonstrate how assessment information is used to evaluate a person's circumstances and lead to the delivery of appropriate care. Some localities have Action Plans or Action Taken as a result of the assessment, but not necessarily tied into an overall Care Plan.

Warwickshire was using the prompt "R" with suggestions throughout the assessment form whenever the response to a particular question suggests the need for referral elsewhere (although these have been removed in the most recent version because of practitioners' and managers' fears of raising service users' expectations through inappropriate referrals). Telford and Wrekin have similar suggestions for additional assessments or referral for particular services included on the assessment form. In other localities the SAP process does not necessarily guide the assessor to what to do as a result of the needs identified. EasyCare contains suggestions in the accompanying guide for assessors.

Not all sets of documentation included a joint care plan at all. Of those that did, not all followed the Department of Health guidance, which states that the Summary of

---

<sup>6</sup> Department of Health: Current Summary Record (formerly known as the Single Assessment Summary) Introductory Note p.1

the current Care Plan should contain the Objectives of the Care Plan, How support and services address current needs and risks, the Support and services received, including a weekly timetable of care, and Benefits received.

A list of Support and Services Received is included by the Department of Health with the Care Plan in the Current Summary Record. The specified codes for each item are: *1. Support/service currently provided / 2. Support/service pending / 3. Support/service not currently provided / 4. Not known.* These codes are used only by Dudley. The result of not using the specified codes is that for some localities it is not immediately clear from their documentation whether the person was already receiving the service at the time of the assessment, or will be provided with the service as a result of the assessment. Others do not list services received at all. EasyCare clarifies this by including the list of services received in the basic information collected as part of the Contact Assessment.

### **Consent to share information**

All localities demonstrated their commitment to obtaining the service user's consent to share assessment information obtained. A number of localities such as Shropshire and Hereford included a section on either the Contact or Overview assessment documentation for the service user to sign their consent to share the information contained and, if they wished, to specify with whom it could be shared or any exclusions. Others used a separate form, which in Coventry's case ran to 4 pages. Birmingham and Solihull had a separate form, but whether consent had been obtained or not was flagged on their assessment forms. This would seem to be a sensible solution once the move to electronic systems is made, as it is likely there will still need to be a process for obtaining the service user's signature on paper and indicating on the electronic record that this has been obtained.

### **Progress on implementation**

As well as the differences in assessment tools and documentation, there was considerable variation around the region in how localities were setting about implementing the Single Assessment Process, and how much progress they had made with this. The Department of Health had expected all areas to be implementing the Single Assessment Process for older people by April 2004. In the June 2004 audit, in which each locality had to report their progress on implementing SAP to their Strategic Health Authority, nine out of the thirteen areas evaluated their progress as "Adequate", with only two (Solihull and Telford and Wrekin) assessing their progress as "Good".

This apparent consistency masked wide variations. For instance some areas, such as Walsall, were still at the stage of agreeing the final version of the documentation they would be using for SAP. Other areas were in the process of running a few pilot sites or early implementation sites to test out the documentation and processes and the training requirements (Hereford, Staffordshire, Warwickshire) with other sites scheduled for implementation as training was delivered.

Birmingham had implemented the Single Assessment Process throughout every quadrant of the city, but the system was mainly being used only by social workers and nurses, not, for instance, by occupational therapists. Conversely Wolverhampton had implemented a fully integrated electronic system involving professionals from a social work team, a GP practice, a District Nursing team and a medical assessment ward, but only covering one small part of the city. Many areas were struggling to engage staff from Acute Trusts, and only Shropshire and Wolverhampton appeared to have had any success at all in involving GPs.

Formal agreements to share information between agencies had been signed, or were in the process of being signed, in most localities. The Department of Health recommends an overarching agreement on information sharing between organisations, with a lower level agreement specific to the Single Assessment Process<sup>7</sup>. In the West Midlands most localities were using the Information Sharing Agreement developed by Solihull as a template.

In all areas the amount of work being undertaken to implement the Single Assessment Process was considerable. Most places had appointed a specific lead or dedicated project worker to take forward the necessary work, and those areas without dedicated personnel certainly found progress harder to achieve. Yet in all areas there was still a very great deal to be done. In many places, organisations were not yet thinking beyond the “front end” of the process, the actual assessment and recording of need. Insufficient thought had been given to the link with care pathways, how appropriate care would be delivered, the role of Care Coordination and how information would be updated.

The selection of particular units to champion SAP meant that the burden of implementation in some areas was falling disproportionately on some staff, and implementation was still too limited for many staff (or older people) to experience the benefits. For instance, piloting the system in a Medical Assessment Unit in one area meant that nursing staff were completing Contact and Overview Assessments for most patients who were transferring on to other units and services, but rarely benefited from receiving similar information about patients who were admitted to their unit, because implementation had not yet reached community services. Where staff had experienced good information recording and sharing, for instance physiotherapists finding patients coming for follow up out patient appointments with completed discharge assessment and care plan in their Patient Held Record, the benefits were immediately obvious.

In many places there was little evidence of systematic review and evaluation of the impact of implementing the Single Assessment Process, particularly the impact on older people themselves, and most areas did not have systems in place to monitor what was happening. In Dudley, using numbered folders had proved very beneficial, for example they were able to compare the number of discharges from particular units with the number of SAP folders issued, uncover significant discrepancies and target the reasons.

---

<sup>7</sup> Department of Health: Information Sharing Protocols – Briefing Note. July 2004

## Implications for cross boundary working

In the Cross Boundary Project it had been the intention to identify examples of the particular problems localities were experiencing with the Single Assessment Process when working across geographical boundaries, and try to establish what worked best in overcoming these. In the event, implementation was not sufficiently advanced in most localities in the region to provide this information in any detail. It was also the case that not all areas within the West Midlands were equally affected by cross border patient flows. For some localities it was not a major issue, while for others it was adding considerable complexity to their local SAP implementation.

The most common examples of cross border flows cited were:

- A patient from one locality receiving treatment from a hospital in another locality
- A patient from one locality registered with a GP in another locality
- The reverse, with GPs and hospitals in one locality treating patients from another locality
- Primary Care Trusts' and Social Services Departments' administrative boundaries not aligned, with Primary Care Trusts' responsibilities to patients registered with particular GPs, and Social Services responsible for people living within their geographical boundaries

In some places it was not uncommon to have a patient living in one locality, registered with a GP in another area, and receiving hospital treatment in a third area. It is also important to note that not all cross boundary flows were reciprocal, and this could create imbalance and disadvantage for organisations and localities.

Across the region the project found great variation and diversity between areas: different levels and types of resources; different processes, in the routes people are expected to take to access care services; different assessment tools and documentation; different IT systems, unable to pass information between them; a proliferation of home grown solutions; and differences in progress on implementing SAP. There was considerable potential here for frustration, duplication, lack of clarity and consistency and lack of trust.

This situation is not new, it has not been created by the Single Assessment Process, but SAP has the potential to highlight the differences. The extent to which cross boundary issues were affecting successful SAP implementation was largely determined by the quality of existing interagency relationships and the success or otherwise of cross boundary working on other issues, for example reimbursement or funding for nursing care. The Single Assessment Process should not be seen in isolation. Localities which had already established good working relations with neighbouring authorities were finding it easier to reach agreements on SAP. Similarly, while the project focused deliberately on geographical boundaries, it was clear that localities found these easier to deal with if they had already addressed issues to do with organisational boundaries.

On the whole, problems with differing formats and documentation did not yet appear to be a major issue, because implementation generally was not far enough advanced to throw these up and because agreements in principle to accept one another's documentation were relatively easy to achieve. As implementation progressed it was thought likely that more problems would occur. Also it was not clear in what way the early development of electronic solutions would affect the issues. There was a general concern that, without a co-ordinated approach, the problems inherent in IT systems "talking" to one another would exacerbate cross boundary working.

Some localities were attempting to anticipate and head off potential problems with neighbours by adopting a similar approach. Stoke and Staffordshire had appointed a joint SAP lead. Others, such as Coventry and Warwickshire, Birmingham and Solihull, Shropshire and Telford and Wrekin, had met with their closest neighbours and common folders for Person Held Records was one of the outcomes.

On a wider scale, the West Midlands Regional SAP Group brings together SAP leads from across the region to share information, discuss good practice and adopt a common approach to issues which arise. As well as the regional group, two out of the three Strategic Health Authorities also held joint SAP meetings to share information on implementation issues.

## **Conclusions**

Undertaking this exercise has revealed a very great range of differences across the region in the way the Single Assessment Process is being implemented. As well as having the potential to cause difficulties in working across geographical boundaries, these differences are likely to be problematic when it comes to implementing the National Programme for IT in the region. Organisations in the region have agreed to work together with the local service provider to develop a common IT solution and ensure that the needs of the Single Assessment Process are met within this.

The exercise has also highlighted some of the practice issues for individual systems as well as for the region, and has identified some problems with the current Department of Health guidance, which will hopefully be updated. While a strong commitment to good working practices throughout the Single Assessment Process will go a long way to helping overcome cross boundary problems in the region, it seems clear that it would also be helpful to move towards greater standardisation and convergence between individual systems in the region over time.

The following Good Practice Guide sets out suggestions for practical measures localities can take to improve cross boundary working, and includes practical recommendations for achieving greater standardisation and commonality in the region. It is followed by a more formal Agreement which organisations can sign up to, which promotes a common approach to SAP in the region and sets out some "good behaviour" rules for more effective cross boundary working.

**Angela Nicholls**  
**October 2004**