



North Tyneside Information and Development Events

The Single Assessment Process

The Single Assessment Process (SAP) for older people was first introduced as part of the National Service Framework for Older People. The purpose of the SAP is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively.

To facilitate successful implementation of SAP across North Tyneside, you are invited to take part in one of 8 Information and Development Events, which will bring together health and social care professionals, older people and their carers.

The aim of these events is to:

- Understand the details and context of SAP and identify links with other policies and legislation
- Explore the impact of SAP on current practice and service delivery
- Ensure attendees are informed about local activity and understand future stages of implementation and how they can become involved

The Hadrian Suite

Menzies Silverlink Park Hotel

Coast Road

Newcastle upon Tyne

Thursday 15 April 2004 10.30 – 1.00pm

Thursday 15 April 2004 2.30 – 5.00pm

Tuesday 20 April 2004 10.30 – 1.00pm

Tuesday 20 April 2004 2.30 – 5.00pm

Wednesday 5 May 2004 10.30 – 1.00pm

Wednesday 5 May 2004 2.30 – 5.00pm

Friday 21 May 2004 10.30 – 1.00pm

Friday 21 May 2004 2.30 – 5.00pm

Introduction

This pack has been designed to support the “North Tyneside Information and Development Events” for implementation of The Single Assessment Process (SAP).

Information in the pack will provide background material for the events and will also act as an ongoing source of reference as implementation of SAP progresses in North Tyneside.

Further packs can be obtained from:

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Background to the Single Assessment Process

The Single Assessment Process (SAP) for older people was first introduced in the National Service Framework for Older People. The purpose of the SAP is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively.

The concept of the single assessment process is not new and we can take a look back at the range of legislation for both Health and Social care over the past decade.

The NHS and Community Care Act 1990.

The Act stated that:

- The service user should be central to the assessment process and should not just be assessed for the available services.
- The service user can agree to their carer being part of the assessment process.
- The service user's strengths should be used and will play an active role within their care package
- The service user should be able to exercise choice, and that information should be in a format that they can use.
- The assessment should take into account risk factors and ensure that these are negotiated with the service user.
- The process of assessment should normally include an initial screening.

Better Government for Older People.

The better government for Older People initiative is a national programme covering all public services that older people deal with on a regular basis.

It states that:

- Access to services should be simplified
- Links between services provided for older people by a range of agencies should be improved
- Clear and accessible information on older people's rights should be provided
- Older people should have more influence over services they can access.

Modernising Social Services

This document, published in November 1998, emphasises that:

- Care should be provided to people in a way that promotes their independence and respects their dignity
- People should be able to receive the care they need without their life having to be taken over by social service systems
- The service user should be involved in the services they receive and how they are delivered.

The Health Act 1999

The partnership arrangement in section 31 of the legislation gives powers to statutory organisations to delegate function-led commissioning and integrated provision and pooled funds. They are operational tools intended to be used in a wide range of situations where joint services or resources will help achieve better outcomes for service users.

People want and deserve the best public services, which will protect and improve their health and well being. The partnership arrangements in the Health Act 1999 have been developed to give NHS bodies and local authorities the flexibility to respond effectively either using joint services, or by developing new co-ordinated services. These arrangements build on existing joint working, but offer the opportunity for further innovative approaches to user-focused services.

Regardless of what contribution NHS bodies or local authorities commit to the pool, the collective resources can be used to provide agreed services as set out in the partnership arrangement. This means that the expenditure will be based on needs of the service user and not the level of contributions from each partner.

The NHS Plan 2000

This 10-year plan to improve and modernise health care states:

“The NHS will shape its services around the needs and the preferences of individual patients, their families and their carers. The NHS will work together with others to ensure a seamless service.”

The government recognises that it is crucial for health and social care organisations to be partners, especially in services for older people, mental health service and for people with a physical disability.

Current Health and Social Care Policies Impacting on SAP

Fair Access to Care Services (FACS)

In April 2003 councils with social services' responsibilities implemented a framework for setting eligibility criteria for adult social care. This is based on individuals' needs and associated risks to independence, and includes four bands of eligibility – critical, substantial, moderate and low.

Councils are required to make only one eligibility decision in respect to adults seeking social care support – that is whether they are eligible for help or not. This decision should be made following an assessment of a person's presenting needs and circumstances.

The risk factors are central to the maintenance and promotion of independence and these are in the categories as follows:

- Autonomy and Freedom to make choices
- Health and Safety
- Managing Personal and Other Daily Routines
- Involvement in Family and the Wider Community.

Disability Discrimination Act 1995

The act came into force in 1996 and gave disable people access to areas of employment, goods, services and education.

The definition is someone "with a physical or mental health impairment, which has a substantial and long term effect on his or her ability to carry out day-to-day activities.

The assessor should establish whether the service user is registered disabled. The assessor should not make personal judgement as to whether a service user is disabled. An overview assessment should consider all the identified needs and ensure that care planning will meet those needs.

Assessors should consider whether the services that older people can access are similar to those that the younger disabled people can use, and that there are no barriers (physical, social or personal) that prevent them

accessing any health or social service. (Standard 1 of the National Service Framework for older people, Discrimination and Direct Payments)

Disability in itself should not be considered a problem, unless the service user identifies it as such. But it should be taken into consideration when establishing service provision for the service user and their carer.

Determination of Registered Nursing Care Contribution (RNCC)

Following the Royal Commission Report on Long Term Care, the Department of Health introduces a system of free nursing care wherever it was provided. Before this, there was inequity in that some people were paying for the nursing care they received in nursing homes.

If the assessment indicated the person's needs are best met by admission to a nursing home, a determination of the complexity, predictability and stability of their needs should be undertaken by a registered nurse. The RNCC is then put into high, medium or low banding, and the NHS is responsible for contributing a set amount of funding for the placement in relation to this banding.

Continuing Health and Social Care.

Local health and social care agencies agreed their respective responsibilities for continuing health and social care services in March 2002 and October 2002 Strategic Health Authorities had to agree an overarching policy. Integrated assessments by staff who have a broad understanding of the eligibility criteria and responsibility for local service provision should result in person-centred effective outcomes for service users.

Reimbursement around Hospital Discharge

In order to promote effective joint working in discharge planning, good practice guidance was published in 2003 (Discharge from Hospital: pathway, process and practice), and legislation was passed to allow for the implementation of reimbursement systems around hospital discharge. Integrated and timely assessments where professionals contribute in the most effective way should ensure that the service users receive "the right care in the right place at the right time".

The Carers and Disabled Children Act 2000

For many individuals the help and support of the family members or other carers is essential to remaining independent. Often carers should and need to be involved in assessment and subsequent decisions about the help that is provided. The legislation provides the framework within which their needs can be assessed, focusing on the exact nature of their caring role.

The National Service Framework for Older People

The National Service Framework for Older People, published by the Department of Health in 2001, sets out a 10-year programme for developing and modernising the way the services for older people are commissioned and delivered. It is the first of the National Service frameworks that is only achievable if health and social care organisations work in partnership.

The NSF for Older People has 8 standards.

- 1. Rooting out age discrimination** – the NHS services will provide, regardless of age, on the basis of clinical need alone. Social care services will not use age as an eligibility criteria or policies to restrict access to available services.
- 2. Person-centred care** – NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the **single assessment process**, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.
- 3. Intermediate care** – older people will have access to a range of intermediate care services at home or in designated care settings, to promote their independence. This new layer of care between primary care and specialist services is being developed to help prevent unnecessary hospital admission, support early discharge and reduce or delay the need for long term care.
- 4. General hospital care** – older people's care in hospital should be delivered through appropriate specialist care and by hospital staff who have the right skills to meet their complex needs. Early multi-disciplinary assessment should identify the further care needed and ensure the discharge planning is an ongoing process throughout their hospital stay.

5. Stroke – the NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated by a specialist stroke service and subsequently with their carers participate in a multi-disciplinary programme of secondary care.

6.Falls – the NHS working in partnership with councils takes action to prevent falls and reduce resultant fractures and other injuries in their population of older people. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialist falls service.

7. Mental Health – older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for older people and their carers.

8.The promotion of health – older people wish to remain healthy, active and independent of need for support from the services and their families. The health and well-being of older people should be promoted through a co-ordinated programme of action, led by the NHS with support from councils.

Principles of the Single Assessment Process

- The service user is treated as an individual and their values and beliefs are central to the assessment
- The service user's views are paramount and their strengths should be supported as well as their weaknesses identified.
- The external factors that affect the service user's ability to remain independent should be considered.
- The assessment should be proportionate to the service user's needs.
- The assessment should start from the service user's perspective of their current needs.
- There should be an opportunity for the service user, their carer and the assessor to negotiate the care package, within the constraints of the organisations' ability to deliver
- The service user should have enough information to make informed choices and to be able to refuse services they do not want.
- The service user should see a reduction in the number of assessments they receive.
- When several assessments do have to take place, the service user and/or their carers are not continually asked the same basic questions.
- The carer's needs are recognised and they are considered for assessment in their own right.
- The service user is allowed to accept risks.
- Professionals who are involved in the assessment process share information.
- Staff and organisations should value the process.

Values and Beliefs

The NSF for older people sets out a range of value statements for organisations and staff to consider. It is important that agencies and teams working together to deliver assessments and services should discuss and agree the principles and values underpinning their approach. These value statements should focus on the following issues.

Person Centred Care and Independence:

- Older people should be appropriately informed in clear language about suitable methods of assessment and services and how to access them.
- Their comments should be actively sought on the assessment arrangements and the services provided.
- Their views and wishes should be kept to the fore throughout assessment, planning care and the services provided.
- Assessment should help older people to identify not only their needs but also their strengths and abilities and any external or environmental factors that cause or exacerbate needs.
- The assessment process and services provided enable people to maximise their potential for independence.
- Older people should be involved in decisions about their care and empowered to determine the level of risk they are prepared to take.
- Older people should be given realistic options on how their needs may be met.
- Older people should consent to information that is collected about them and how it will be shared.
- Where individual older people lack capacity to make decisions or give agreement agencies should have a procedure in place to secure the maximum possible participation and safeguard user's interests.
- Professionals should be aware of the age, gender, race, living arrangements, personal relationships, lifestyle choices and the disability of older people and their needs, but not to make assumptions about the impact and be prepared to respond appropriately.

Carers and Family Members:

Agencies should acknowledge the role that many carers and family members play in the care of older people and should be prepared to offer necessary support.

Integrated and responsive services:

- Age of itself should not determine how services are accessed or provided
- Services should be accessed following an assessment that is co-ordinated and straightforward, with duplication kept to a minimum.
- Effective information sharing between professionals, where confidentiality is respected, can be crucial for effective person-centred care.
- Where the service user needs the help of more than one agency, services delivered should be co-ordinated in the best interest of the service user
- The potential for rehabilitation should be explored of the time of assessment and kept under review.

Staff:

- Professionals who work with older people should be properly trained and developed to do so
- Front line staff should be supported with regards to their responsibility for the planning and providing the care for individual older people

Levels of Assessment

Contact

This level of assessment refers to a contact between a service user and health or social care services, where a significant need is first described or suspected. It does not refer to every contact between say, a G.P and service user coming to their surgery. At contact basic personal information is collected, the nature of the presenting problem is established, and the potential presence of wider health and social care needs explored.

Overview

Professionals carry out an overview assessment if, in their judgement, the individual's needs are such that a more rounded assessment should be undertaken. At overview all the domains of the single assessment process, such as personal care and physical well-being, senses and mental health are considered. The need for an overview assessment may be immediately apparent, and should be commenced once personal information has been collected. At other times, contact assessment may have already been

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

Specialist

Specialist assessments offer a way of exploring specific needs, often in detail, and may be indicated by a contact or overview assessment. As a result of a specialist assessment, professionals should be able to confirm the presence, extent, cause and likely development of health conditions, problems or social care needs, and establish links to other conditions, problems and needs.

Comprehensive

A comprehensive assessment may arise in several ways. For example, from the outset, it may be obvious to a doctor or other qualified professional that, based on their professional judgement, a comprehensive assessment involving specialist assessments in all or most of the domains of the single assessment process is needed. In this situation, conducting an overview assessment would be unnecessary and could delay providing the help the service user needs. Comprehensive assessment should also be completed where the levels of support and treatment likely to be offered in intensive or prolonged, including permanent admission to a care home, intermediate care or complex packages at home.

Domains and Sub Domains of SAP

The domains of the assessment process cover all the areas of the service user's life. The overview assessment provides the opportunity to explore all or some of these issues that are impacting on the life and independence of the service user.

Contact

- Personal and demographic information
- Assessment history
- Service user's reason for assessment
- Medical history
- Level of services.

Seeing, hearing and communicating

- Sight

- Hearing
- Communication

Looking after yourself

- Grooming
- Dressing
- Bathing
- Cleaning
- Food preparation
- Oral health
- Self-medication
- Skin problems
- Continence and other aspects of elimination
- Toileting
- Mobility
- Foot care
- Falls
- Access to local facilities

Safety

- Personal safety inside and outside the home
- Harassment
- Discrimination
- Carer support and strength of caring arrangements, including carer's perspective.
- Abuse or neglect

Accommodation

- Housing – location, access, amenities and heating
- Management of finances

Looking after your health

- Exercise pattern
- Breathlessness
- Smoking and drinking history
- History of blood pressure monitoring
- Vaccination history
- History of cancer screening
- Nutrition, diet and fluid intake

Your well being

- Social contacts, relationships, involvement in leisure, hobbies, work and learning
- General health



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- Mental health including reaction to loss and emotional difficulties
- Sleep pattern
- Pain
- Depression

Your Memory

- Memory loss and forgetfulness
- Cognition and dementia

Additional personal information

- Personal fulfilment
- Spiritual fulfilment
- Personal relationships
- Lifestyle choices

Advanced directives

- Power of attorney
- Protection orders

Assessment Skills

It is important for assessors to consider the skills of assessment they may need to deliver the single assessment process.

The sharing of the service user's assessment across agencies will mean that professionals will have to trust the information, be sure how that information was obtained and how accurate and up to date it is. This will become even more important in areas where collective budgets or shared services can be accessed from either health or social care staff. These assessments may be audited under clinical governance.

Some assessment considerations for the single assessment process are:

- Assessment is a **comprehensive** process that identifies an individual's holistic care based on their **potential** whilst considering appropriate risk factors.
- Assessment is a **person-centred** activity with the emphasis on establishing arrears of need to maintain or increase **independence** and **quality of life**.
- Effective comprehensive, person-centred assessment includes both **subjective accounts** (individuals experience) and **objective measurement** (structured instruments)
- The individuals **biography** is central to all assessments



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- A comprehensive assessment gives a clear indication of the type and amount of **care needed** and the most appropriate person to provide it.
- Decisions supporting assessment are made by **objective evidence, service user's preference and professional opinion.**
- The **language of the assessment** should be **understandable** by all who participate in the process and the service user who owns the assessment
- Effective assessment requires **knowledge, skills and expertise** in assessment processes.
- Comprehensive assessments need **time** to undertake effectively
- Effective assessment requires **teamwork**, built on the principle of effective communications, **clarity of role** and **mutual respect and honesty.**
- Inter agency assessments need to be **co-ordinated** from a central point, with a **single point of access** and systems that support effective co-ordination.

Information Sharing and Consent

The sharing of information is essential to effective SAP. The key issues are:

- That the process includes an explanation of the categories of professional with whom the information will be shared – GP, District Nurse, Social Worker, etc., and the service user consents to that sharing.
- That the service user is also invited to agree that the information is shared with carers/family members
- That the Caldicott guardians ensure that sensible management systems are in place to maintain confidentiality in storing and sharing data, e.g., a standard rider referring to confidentiality of information sent by Fax or by email, firewalls to protect confidential data stored electronically

Data Protection

The Data Protection Act provides conditional right to privacy.

Everyone has a right to respect for their private life, their family life, their home and their correspondence.



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There shall be no interference by a public authority with the exercise of this right except in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others.

The eight principles underpinning the Data Protection Act are that the data should be:

1. Processed fairly and lawfully and only in circumstances covered in the act
2. Only used for the purpose for which it has been collected
3. Adequate, relevant and not excessive
4. Accurate and up to date
5. Processed in accordance with the rights of the data subject
6. Subjected to safeguarding against unauthorised or unlawful processing, loss, damage and destruction
7. Not to be transferred outside the European Economic Community area unless comparable protection is available.
8. The usual authority for processing data is the consent of the subject user.

Other categories are:

- Contractual necessity
- Necessary for the exercise of any function conferred by or under an enactment.
- Protection of the vital interests of the data subject
- Function of a public nature exercised in the public interest
- Legitimate interest of the data controller

The Data Protection Act introduces a new category of “sensitive personal data,” which consists of:

- The racial and ethnic origins of the subject
- His or her political opinions
- His or her religious beliefs
- Whether he or she is a member of a trade union
- His or her physical or mental health or condition
- His or her sexual life
- The commission of an offence by him or her
- Proceedings concerning the commission or alleged commission of an offence, the disposal of proceedings and any sentence

Much material gathered in the SAP will therefore be classified as sensitive.

Mental Capacity

Where the service user is mentally incapable of consenting, the provision under the Data Protection Act allowing the processing of data that is necessary to fulfil a statutory function will justify the collection and recording of necessary data for the SAP. Any information required in order to comply with the guidance will be covered.

How to decide if a user has capacity to consent?

The Data Protection Act does not deal with capacity. There is no statutory definition of what constitutes capacity. The Courts divide the decision making into three stages:

1. Comprehending and retaining information
2. Believing the information
3. Weighing the information in the balance to arrive at a choice.

Case law is moving towards a 'presumption of capacity'. The burden of proof falls on the party trying to assert lack of capacity.

Sharing Information with Carers

The principle remains the same in that the service user has to give explicit consent, but there are other conditions that justify sharing.

The requirements to involve carers in the assessment process are enshrined in the Local Authority Act 1970, and therefore assessment and care planning information should, if possible be shared with carers. Where there is a real concern about elder abuse or undue influence then it will be for the assessor to balance the right of the carer and the service user.

Caldicott Guardians

In 1977, the Caldicott Review of Personal Identifiable Information recommended the appointment of Caldicott Guardians to safeguard and govern the use made of confidential material in the NHS. This has now been extended to Social Services by LAC(2000)2 implementing the Caldicott Standards in Social Care. Each council with a social service responsibility must have a Caldicott Guardian in place with responsibility for auditing and organisational aspects of processing personal identifiable data. There are five areas set out in the guidance.



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1. Information given to service users on the proposed use of information about them
2. Staff code of conduct in respect of confidentiality
3. Training and induction
4. Responsibility 'ownership' of information systems, reviews, security, controlling access and risk assessments
5. Protocols for sharing information across agencies.

Consent

Informed consent needs to be sought from the service user for the sharing of information with others who may be involved in their care. The service user should be informed about who are the likely ranges of practitioners who may need this information. Informed consent should also be sought for anonymised information about the service user for the purposes such as research and service planning. Furthermore, the service user should be asked to identify any specific parts of their assessment which they would not wish to be shared or particular agencies or Individuals (including their carers) with whom they would not wish further information to be shared. At each assessment consent to the above should be confirmed.

If the service user is unable to give consent, the assessor should record this and give details, including reasons why information should be shared in the best interests of the service user.

The department of Health has issued more detailed guidance about the points to consider on consent based on English law including what to do when a person is not competent to give consent. There are 12 key points as follows:

1. Before you examine, treat or care for a competent adult patient you must obtain consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is "can this patient understand and weigh up the information needed to make this decision". Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one off event. Patients can change their minds and withdraw consent at any time. If



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there is a doubt, you should always check that the patient still consents to your caring or treating them.

5. Before examining, treating or caring for a child, you must seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent or themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases someone with parental responsibility can give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot override the consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.
6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of a colleague if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.
7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form that they can understand, then their consent may not be valid.
8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals.
9. Consent can be written, oral or non-verbal. A signature on a consent form does not itself prove that consent is valid- the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.
10. Competent adults' patients are entitled to refuse treatment, even where it would be clearly benefit their health. The only exception to the rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse treatment, even if this would be detriment to the foetus.
11. **No One** can give consent on behalf of an adult. However, you may still treat such a patient if the treatment would be in their best interest. "Best interests" go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient may never been competent, relatives,

carers and friends may be best placed to advise on the patients needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while they were competent, that they would refuse treatment in certain circumstances (an 'advanced refusal') and the circumstances arise, you must abide by that refusal.

Clinical Governance and SAP

The main components of the clinical governance are:

- Clear lines of responsibility and accountability
- Quality improvement programmes to maintain and improve clinical care.
- Education and training plans
- Clear policies aimed at managing risk
- Integrated procedures for all professional groups to identify and remedy poor performance.

Links between the single assessment process and clinical governance are considered in more detail below.

Clear lines of responsibility and accountability for the overall quality of clinical governance

The NHS Bill places a duty of quality on Primary Care Trusts and NHS Trusts. Chief Executives and Boards will be responsible for ensuring that this duty is discharged properly.

The single assessment process for some older people will involve assessment and action by assessors from more than one organisation. There must be clear agreement in place about the responsibilities and lines of accountability for the quality of assessment.

It should be clear who has the responsibility for assessing and training needs of existing and new team members of staff in ensuring that receive appropriate initial training and have opportunities to learn from experience and reflection.

A comprehensive programme of quality improvement systems (including clinical audit, supporting and applying evidence based practice,



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implementing clinical standards and guidelines, workforce planning and development)

Processes need to be in place across agencies to monitor:

- Quality and consistency of assessment outcomes
- Record-keeping and the use of standardised tools for contact and overview assessments
- Triggers for referral and action based on evidence –based pathways
- Quality of information collection and transfer.
- Outcomes of assessment in terms of service users experience and promotion of independence and well being.

These processes should be integrated with the overall quality programme locally and where possible, outcomes should be benchmarked against outcomes of quality of single assessment process.

Education and Training

Joint strategies need to be developed that reflect the requirements of single assessment process implementation:

- Define the standards of knowledge and skills which describe fitness for purpose in relation to assessment
- Provide awareness of SAP and its local application for the entire health and social care community
- Provide for the development needs of assessors currently in post
- Identify how new staff members are assured to be fit for purpose/ given training on the local systems of assessment.

Training and development support across the whole system of care:

- Organisational development across the whole system of care
- Staff training in the principles of SAP and local proposals for implementation
- Assessor training in person centred assessment
- Assessor training in the use of specific tools
- Assessor training in the use of assessment software

Clear Policies Aimed at Managing Risk

Risk management systems need to be in place to ensure that the professional s from different agencies undertaking assessments outside their domain of specialist expertise are supported by use of a validated tool, agreed protocols and regular supervision and joint professional working.

Assessments based on untested or non-standardised instruments pose a risk not only to the service user but also to the organisation and assessors concerned. Organisations using locally developed tools should ensure they meet the Department of Health criteria as set out in the National Service Framework for Older People (NSF) and SAP guidance.

Integrated Procedures for all Professional Groups to Identify and Remedy Poor Performance

It is essential that normal procedures for identifying poor performance within the organisation are applied to the single assessment process. In addition, local organisations will need to look at how to identify poor performance across agencies. Robust and clear arrangements must be in place for professional accountability and supervision where there are joint arrangements and team management structures.

Key implications

Older People and Carers

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

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

At all times, older people should expect respect and courtesy from health and social care professionals who are helping them. They should expect assessments of their needs to begin with their perspective, and for their views to be kept to the fore throughout the assessment and subsequent stages of care planning and service delivery. They should expect assessment to focus not only on their needs, but also on the strengths and abilities they can bring to bear in addressing these needs, and for assessment to help them achieve maximum possible independence. Assessment should take account of support older people receive from family members, relatives, friends and neighbours, and whether these carers have needs in their own right.

Older people should feel confident in taking the lead in their own assessment, even helping to filling out some of the official assessment forms if that is appropriate and what they want. To help them do this, where possible agencies should prepare individuals for the assessment, letting them know what issues are to be covered and in what way. Older people should feel confident in requesting and being offered translation, interpretation and advocacy services, or specific communication equipment, to help with their assessment. Health and social care services should ensure



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that translators and interpreters are accredited, and that advocates are both competent and independent of statutory services.

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

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

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

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

Social Workers

Social workers have expertise and experience in working with older people who are experiencing health and social care difficulties. They often have to understand these difficulties in the wider context of the older person's family, social, financial, housing and other circumstances. Social workers also play



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an important role in contributing to, or co-ordinating, assessment and care planning where a number of agencies are involved.

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

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

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

It is likely that social workers will need to take account of all aspects of the single assessment process guidance. An overview of the single assessment process is given in the main guidance, and social workers are recommended to begin their reading here.

Nurses

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

The single assessment process guidance builds on these strengths. Nurses in all settings, like social workers, will contribute to all the four types of assessment, undertake many overview assessments, and play a key part in



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care co-ordination. For many older people, their contact with practice and community nurses will be long-term and important to them.

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

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

It is likely that nurses will need to take account of all aspects of this guidance. An overview of the single assessment process is given in the main guidance, and nurses are recommended to begin their reading here.

GP's

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

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

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

The key implementation issues for GPs are :

Understanding the values underpinning the NSF for Older People and the single assessment process. These can be summarised as person-centred care with involvement of patients and carers in decision making, and a focus on achieving agreed treatment objectives.

Knowing about the stages of assessment. Although GPs may contribute to all types of assessment, GPs will be mostly concerned with contact assessment, Here the use of professional judgement is the only way of deciding whether an assessment should be taken further.

Not treating all contacts with older people who come to their surgeries as occasions for contact assessment as defined in the single assessment process guidance. The full single assessment process is not intended to apply to all older people who have specific needs that can be readily addressed with no wider repercussions

Understanding the uses of tools and scales. In case finding and other proactive health screening purposes, assessment tools and scales are useful in identifying those with a particular problem. In other stages of assessment, they can support professional judgement and can also help ensure that no areas of assessment, needing to be covered, are missed.

Therpaists

Physiotherapists, occupational therapists, speech and language therapists and other therapists, as part of allied health professionals, play a critical role in assessing the needs of older people, and all have expertise and experience in working with older people who are experiencing health and social care difficulties. Too often this contribution is under-recognised.

However, like social workers and nurses, therapists will contribute to all types of assessment described in the detailed single assessment process guidance.

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

needs. In particular therapists are skilled in the assessment of the potential for rehabilitation and independence.

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

It is likely that therapists will need to take account of all aspects of this guidance. An overview of the single assessment process is given in the main guidance, and therapists are recommended to begin their reading here.

Geriatricians and Old Age Psychiatrists

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

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

- Assisting in the selection of assessment tools.
- Identifying one of their number to take a special interest in the assessment process and to act as a focal point for medical involvement in implementation.
- Working with other managers to help ensure that secondary health services are able to support implementation.
- Ensuring that assessments undertaken by other secondary health departments, not primarily associated with care of older people, are aligned to the single assessment process, and there is consistency of assessment across the hospital.
- Ensuring training about assessment procedures is available for hospital doctors, especially specialist registrars, senior house



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officers and those on vocational training schemes, and making related links with primary care teams.

- Stimulating and undertaking research into assessment procedures.
- Linking assessment procedures to clinical governance for geriatricians and old age psychiatrists, their departments and their clinical service networks.

North Tyneside Shared Principles and Objectives of SAP Implementation

Local Implementation Guidance for SAP issued by the Department of Health (2002) offers twelve stages to successful implementation, the first of which is agreeing what older people, service users, carers, professionals and other stakeholders see as the benefits of the single assessment process, and whether they have particular concerns.

The following principles and shared values have been produced and agreed by the North Tyneside Single Assessment Taskforce and incorporate feedback from older people, service users and carers, following consultation exercises during 2003 / 2004.

They provide a basis for project initiation and build upon the partnership commitment from **North Tyneside's Older Person's Strategy Group**.

North Tyneside Older Persons Strategy Group Vision and Objectives

Older People are citizens with talent, experience, knowledge and energy who enrich the lives of all our communities. Together with older people, the public service organisations will develop strategies to enable older people to play a full and active role in our communities.

- To develop a shared vision and agree outcomes that ensure all stakeholders are working together to create a community in which the well being of older people is at the heart of all we do.
- To provide a framework and resources to ensure that older people are active partners in decisions that affect their lives.
- To promote the dignity and independence of older people.
- To ensure that we provide accessible information, support and timely interventions.

North Tyneside Single Assessment Mission Statement

To work together with older people, public and independent sector organisations to ensure that older people receive appropriate, effective and timely responses to their health and social care needs and that resources are used effectively.

North Tyneside Single Assessment Process Objectives and Actions for Implementation

1. Ensure Equity of Service Provision

- Identify an assessment tool that can be used by all professionals. Shared assessment tools are an essential method to assist both professional and older people to access the services they need **and** when they need them
- Provide relevant and accurate signposting information to enable older people and their carers to make informed choices
- Improve the knowledge of professionals and older people so they know what services are available

2. Ensure that Older People are More than just a Statistic

- Talk **to** an older person, not about or at them
- Involve and include the views of carers
- Have co-ordinated assessments, which identify one person who is responsible for coordinating assessments as well as the care provided.
- Develop assessment tools and skills which promote person centred conversation and assessment

3. To promote partnership working across health, social care and voluntary agencies

- Professionals to have confidence in each others judgements and assessment decisions
- Agree assessment terminology and publish this
- Use of Information Technology to improve information sharing, security and ability to access this information outside of normal office hours

4. Avoid delays in service delivery especially around hospital discharge

- Avoid referrals to agencies that may be unnecessary
- To speed up the systems and processes that provide services to older people by sharing information between professional when consent has been given by the older person



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5. Improve the ease with which older people and their carers can access services

- Recognise and ensure that links are made with specialist services such as Learning Disability and Mental Health
- Establish clearer links between health, social care and housing
- Transparent roles and processes that professionals and older people and their carers understand

North Tyneside Agreed Glossary of Terminology

Local Implementation Guidance for SAP states that agencies should review the terminology in local use to describe assessment and other care processes, and agree a common language. They should refer to the definitions contained in this guidance and the NSF for Older People, and to existing national definitions as recorded in the NHS Data Dictionary (www.standards.nhsia.nhs.uk/ds/nhsdddm.htm), the Social Care Core Information Requirements (www.doh.gov.uk/scg/adultcoreimfo/index.htm) and as used in relevant national statistical collections. They should also note that the Information Strategy for Older People (Department of Health, forthcoming) will put in place work to develop and agree national definitions for local use.

The following terminology is in draft form for consultation with all key stakeholders across North Tyneside and was initially agreed in draft form by members of the North Tyneside SAP Taskforce in February 2004.

This consultation is open until 4th June 2004. Comments, corrections and additions are welcomed and should be forwarded to:

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<p>Age Discrimination: Action, which adversely affects the older person because of their chronological age alone. Discrimination can also mean positive discrimination that is action taken to promote the best interests of the older person. But the term age discrimination is generally used in the negative sense in this NSF.</p>
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<p>Assessment: A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.</p>
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<p>Assistive Equipment: Equipment that enables children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible.</p>
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Avoidable Admission: Admission to an acute hospital, which would be unnecessary if alternatives e.g. rapid response services were available.

Best Value: The performance regime for all Local Government services, including Personal Social Services. Councils are required to review all their services over a five-year period and seek continuous improvement in services and related indicators, including both nationally set indicators and ones set locally by the Council. Best Value performance indicators are structured into five domains which together describe all aspects of performance; these are national priorities and strategic objectives, cost and efficiency, effectiveness of service delivery and outcomes, quality of services for users and carers and fair access.

Care Co-ordinator: A practitioner who ensures that the care plan is effectively delivered through:

- taking lead responsibility for ensuring effective communication between the various practitioners/agencies involved with users and carers
- prompting further assessment, care plan and service adjustments
- and ensuring monitoring and review activity takes place

Care Management: A process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, and needs are monitored and re-assessed.

Care Manager: A practitioner who, as part of their role, undertakes Care Management.

Care Package: A combination of services designed to meet a person's assessed needs.

Care Pathway: An agreed and explicit route an individual takes through health and social care services. Agreements between the various professionals involved will typically cover the type of care and treatment, which professionals will be involved and their levels of skills and where treatment or care will take place.

Care Planning: Care planning is a process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

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Care Programme Approach (CPA): The formal process (integrated with Care Management) of assessing needs for services for people with severe mental health problems prior to and after discharge from hospital.

Carer: A person, usually a relative or friend, who provides care on the voluntary basis implicit in relationships between family members.

Chronic Degenerative Disease: A long-standing illness, which contributes to increasing disability, e.g. osteoarthritis, motor neurone disease or Parkinson's disease.

Chronic Illness: A long term or permanently established illness.

Clinical Governance: A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will improve.

Clinicians: Qualified healthcare professionals, including doctors, nurses and the allied health professions e.g. dieticians, podiatrists (chiropodists), occupational therapists, physiotherapists and speech and language therapists.

Cognition; The higher mental processes of the brain and the mind, including memory, thinking, judgement, calculation, visual spatial skills and so on.

Cognitive Impairment: Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dementia.

Commissioning: The process of specifying, securing and monitoring services to meet identified needs. Commissioning is more commonly used to describe the strategic, long-term process by which this takes place as opposed to the short-term, operational, purchasing process.

Community Equipment Services: Community Equipment Services provide the equipment, including assistive technologies, that play a vital role in enabling disabled people of all ages to maintain their health and independence.

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<p>Community Health Services: Health services provided to someone in their own home or in the local community.</p>
<p>Continuing Care Nurse Assessor: Is a registered nurse qualified who will assess you to ensure the appropriate finding and style of care to meet your needs is determined. A nurse assessor will be asked to meet you if you need ongoing care in a care home.</p>
<p>Day Hospital: A hospital where patients receive day care only, continuing to live at home.</p>
<p>Dedicated Ward: A hospital ward that specialises in the care of a particular group of people.</p>
<p>Direct Payments: Cash payments from Social Services in lieu of Community Care Services.</p>
<p>Domiciliary Care: Care provided in an individual's own home.</p>
<p>Elected Member: Someone who is elected to serve on a Council.</p>
<p>Eligibility Criteria: Guidelines to assist Care Managers to reach difficult decisions when determining the allocation of resources in a way that is open, fair and consistent.</p>
<p>Expert Patient Programme: A programme to help people with long-term medical conditions to manage their own health, with specialised support from health care professionals and other agencies.</p>
<p>Free Nursing Care: All nursing care provided by a registered nurse, will be provided free of charge whether in hospital, at home or in a care home.</p>
<p>HAZ Health Action Zone: an initiative bringing together a wide range of agencies with the aim of creating an improvement in health of population in areas which currently experience significantly problems and suffer from inequalities of service. South Shields is a Health Action Zone.</p>
<p>Health Professionals Council: Grouping of clinical professionals who are registered by the Council for Professions Supplementary to Medicine (soon to be the Health Professions Council), for example, physiotherapists, occupational therapists, speech and language therapists, dieticians.</p>

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Health Improvement Programmes (HImPs): HImPs are overarching, strategic documents which set out local health strategies for a health and social care system. They are developed by Health Authorities, working with Local Councils and other key stakeholders, involving local communities.

Home Safety Check: A check made by, for example, an occupational therapist to ensure that an individual is safe and can manage in their own home.

Independent Sector: Includes both private and voluntary organisations.

Intermediate Care: A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long-term residential care; or intensive care at home to prevent unnecessary hospital admission.

Joint Investment Plans (JIPs): Agreed between Health and Local Authorities, JIPs are detailed three-year rolling plans for investment and reshaping of services.

Local Authority Council: Councils are directly elected local bodies, which have a duty to promote the economic, social and environmental well being of their areas. They do this individually and in partnership with other agencies, by commissioning and providing a wide range of local services.

Long-Term Care: Refers to support services provided over a prolonged period of time or on a permanent basis to adults who have difficulties associated with old age, long-term illness or disability. Care may be provided in residential settings such as nursing homes or in people's own homes over a prolonged period of time or on a permanent basis.

Multi-disciplinary: Multi-disciplinary refers to when professionals from different disciplines – such as Social Work, Nursing, Occupational Therapy work together.

Multi-disciplinary Assessment: Multi-disciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.

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National Care Standards Commission: A new, independent national body for the regulation of social care services and private healthcare. The National Care Standards Commission will be legally established this year and will take on its regulatory responsibilities from April 2002.

Nursing Care: The portion of care carried out by a qualified registered nurse. This includes the planning, supervision and or delegation of care.

Older Persons Health Care: This relates to specific health care which is concerned with the diagnosis, treatment and care of the older person i.e. old age medicine, mental health services for older people.

Performance Indicators: Provide a way of comparing performance over time, between similar organisations (for example Health Authorities, Trusts or Councils), or sometimes between different services. They will normally be expressed as rates or percentages to allow comparison.

Personal Social Services (PSS): Personal care services for vulnerable people including those with special needs because of old age or physical disability. Examples of services are residential care homes, home help and social workers who provide help and support for a wide range of people.

Primary Care and Community Health Teams: Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners together with district nurses and health visitors, with administrative support. Primary care teams are now grouped within Primary Care Groups/Trusts, which have responsibility for commissioning specialist services as well as for providing primary care, working closely with Social Services.

Primary Prevention: The prevention of the development of a condition e.g. stroke, by avoidance of the lifestyle factors known to contribute to its development, e.g. smoking. See also secondary prevention.

Protocol: A plan detailing the steps that will be taken in the care or treatment of an individual.

Providers: Organisations, or designated parts of organisations, that provide health or social care services.

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Rapid Response: A service designed to prevent avoidable acute admissions by providing rapid assessment/diagnosis for older people referred from GPs, A & E, NHS Direct or Social Services and (if necessary) rapid access on a 24-hour basis to short-term nursing/therapy support and personal care in the patient's own home, together with appropriate contributions from community equipment services and/or home-based support services.

Rehabilitation: A programme of therapy and re-ablement designed to restore independence and reduce disability –

Residential Care Homes: These may be run by Local Councils or independent organisations. Admission to care homes can be made on a temporary or permanent basis. Care homes are tailored to meet the needs of a group of people with similar problems. Residential Care refers to homes that provide round the clock care for vulnerable adults who can no longer be supported in their own homes. Nursing Care Homes provide 24-hour care for those people who require qualified nursing care to meet their physical care requirements. EMI Residential Care Homes provide qualified psychiatric nursing care to meet the needs of people with ongoing mental health problems. If the person with mental health problems also has physical care requirements then an EMI Nursing Care Home may be recommended. Here qualified psychiatric and general nurses are employed to meet care requirements.

Resuscitation: Immediate cardiopulmonary support for person who has stopped breathing or whose heart has stopped beating effectively.

SaFFS: Service and Financial Frameworks set out the levels of NHS activity and resources to support the local contribution to the national and local priorities set out in the NHS Plan and in Local Health Improvement Programmes.

Secondary Care: Care traditionally provided from a hospital setting in support of the primary care team, e.g. surgery, specialist medical services including old age medicine and mental health services.

Secondary Prevention: Interventions designed to identify and treat factors such as high blood pressure or problems with balance which, unmodified, may lead to more serious problems. See also primary prevention.

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Service User: A person who is receiving health and/or social care services.

Short Breaks (Respite): Are available to carers and clients in a variety of Local Authority or hospital settings providing specialist care to meet the need of the individual. The short break can be from an overnight stay up to a two week stay.

Social Care: Social care is provided by statutory and independent organisations and describes a wide spectrum of activities which support and help people live their daily lives. It can include: intimate personal care, managing finances, adapting housing conditions and help attending leisure pursuits.

Social Services: Social Services are provided by 150 Local Authorities in England through their Social Services Department. Individually and in partnership with other agencies they provide a wide range of care and support for people who are deemed to be in need.

Social Services Inspectorate (SSI): SSI is a professional division within the Department of Health. The inspectorate brings professional and management expertise to:

- providing policy advice with the Department of Health
- managing the Department's links with Councils with Social Services responsibilities and other social care agencies
- inspecting the quality of social care services and
- assessing the performance of Local Councils with Social Services responsibilities including Best Value

Specialist Assessment and Services: An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care e.g. stroke, cardiac care, bereavement counselling, and mental health. This assessment then helps the professional to plan specialist treatment services for the client.

Implementing SAP in North Tyneside Timetable Overview April – December 2004

Action	Timescale	Who
Evaluate and develop awareness raising sessions for everyone involved in SAP	Complete January 2004	North Tyneside SAP Taskforce
Agree principles and aims of SAP in North Tyneside	Draft complete February 2004	North Tyneside SAP Taskforce
Agree shared assessment terminology	Draft complete February 2004	North Tyneside SAP Taskforce
Evaluate and recommend Contact and Overview assessment tool	Complete March 2004	Assessment Tools Project Group
SAP Information and Development Events	April – May 2004	
Develop Client Held File to share basic information	January – May 2004	Client Held File Project Group
Pilot Client Held File	June 2004 Onwards	Pilot sites to be agreed
Work with the Strategic Health Authority to implement information sharing protocols	January 2004 Onwards	All organisations
Identify current assessment processes and systems. Outcomes to be detailed as “Process Maps”	April – May 2004	SAP Taskforce members and representatives from all organisations
Identify and work with services that can implement paper based versions of Contact and Overview assessment tools. Commence assessment tool training	May – December 2004	All organisations
Publish information about SAP principles and standards	June 2004 onwards	All organisations
Commence planning for electronic SAP	July 2004 onwards	All organisations
Collate and agree "Specialist" assessment tools. Link these with Contact and Overview	July 2004 onwards	All organisations

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Contacts

The Department of Health Single Assessment Process website has further information and can be accessed at:

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en>

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The following list acknowledges the support and involvement of representatives from North Tyneside's health and social care community since October 2003 for implementation of SAP.

Name	Role	Involvement
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Alison Lawson	Chief Officer, Carers Centre- North Tyneside	SAP Taskforce
Ann Booth	Community Healthcare Forum	SAP Taskforce. Assessment Tools Project
Audrey Clarke	Older People's Forum -NT	SAP Taskforce
Barbara Kemp	Head Occupational Therapist, North Tyneside Council	SAP Taskforce Assessment Tools Project Client Held File Project
Beverley Bowe	Senior Social Worker, Older People's Service, North Tyneside Council	Assessment Tools Project Client Held File Project
Bill Bell	Project Development Officer North Tyneside Council	Client Held File Project
Derek Curd	Carer Support, Carers Centre –North Tyneside	Assessment Tools Project
Diane Moss	Lead Nurse, Funded Nursing Care Team, North Tyneside Primary Care Trust	SAP Taskforce
Donna Lathaen	Community Physical Disability team, North Tyneside Council	Client Held File Project
Dugald Craig	CPN – Older Person's Support Team, North Tyneside Primary Care Trust	Assessment Tools Project
Duncan Miller	Social Services Trainer, North Tyneside Council	SAP Taskforce Client Held File Project
Gabrielle Sutherland	Social Work student, North Tyneside Council	Assessment Tools Project

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Heather Carmichael	Care Facilitator, Northumbria Healthcare Trust Hospital Social Work Team	SAP Taskforce Assessment Tools Project
Helen Green	Social Worker, Older People's Service, North Tyneside Council	Assessment Tools Project
Hilary Laws	Social Worker, North Tyneside Council	SAP Taskforce
Isobel Larsen	Social Worker Psychiatry of Old Age Service, North Tyneside Council	Assessment Tools Project
Jenette Atherton	Funded Nursing Care Assessor, North Tyneside Primary Care Trust	Assessment Tools Project
Joan Knox	Older People's Forum – North Tyneside	SAP Taskforce
Joanna Cox	Consultant Physician	SAP Taskforce
Joe Mason	Older People's Forum – North Tyneside	Assessment Tools Project
Johanne Mears	Branch Co-ordinator Alzheimer's Society	Client Held File Project SAP Taskforce
Jon Routledge	Unit Leader, Residential & Day Services, Mental Health, North Tyneside Council	SAP Taskforce Assessment Tools Project
Joy Hermeston	Assistant Co-ordinator, North Tyneside Council	SAP Taskforce Assessment Tools Project. Client Held File Project
Karen Redford	Home Care Officer, North Tyneside Council	SAP Taskforce Client Held File Project
Karen Robinson	Team Leader, Cedars, North Tyneside Council	Assessment Tools Project
Lee Ranyard	Funded Nursing Care Assessor, North Tyneside Primary Care Trust	Assessment Tools Project
Lesley Young-Murphy	Assistant Director of Nursing, North Tyneside Primary Care Trust	SAP Taskforce Assessment Tools Project. Client Held File Project.
Lillian Errington	Palliative Care Team North Tyneside Primary Care Trust	SAP Taskforce
Lynne Tweedy	Psychiatry of Old Age Service, Northumbria Healthcare Trust	Client Held File Project.
Marie Baldwin	Team Leader, Intermediate Care at Home Team The Cedars Resource Centre	Assessment Tools Project
Marion Errington	Support Worker Psychiatry of Old Age Service, Northumbria Healthcare Trust	Client Held File Project
Maureen Harwood	Associate Director of Modernisation, Northumbria Healthcare Trust	SAP Taskforce
Milly Dawson	Physiotherapist Older Persons Support Team, North Tyneside PCT	Assessment Tools Project
Nigel Browning	Training Officer North Tyneside Carers Centre	Assessment Tools Project



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Phil Crozier	Funded Nursing Care Assessor, North Tyneside Primary Care Trust	SAP Taskforce Assessment Tools Project
Robert Adams	Manager, Organisational Development Housing, North Tyneside Council	SAP Taskforce
Ruth Liddle	Operational Manager, North Tyneside Primary Care Trust	Assessment Tools Project
Sandra Gray	Head of Care Services, Age Concern	SAP Taskforce Client Held File Project
Sharon Thompson	Liaison Nurse, Psychiatry of Old Age Service, Northumbria Healthcare Trust	SAP Taskforce Assessment Tools Project
Steve Russell	General Manager, Northumbria Healthcare Trust	SAP Taskforce
Su Middleton	Team Manager, Older Peoples Services, North Tyneside Council	Assessment Tools Project
Sue Paton	Manager Community Learning Disability Team, North Tyneside Council	Assessment Tools Project
Val Blacklock	Stroke Discharge Team, North Tyneside Primary Care trust	Assessment Tools Project
Verner Taylor	Team Leader, Medical SW Team, North Tyneside Council	SAP Taskforce
Vic Peart	Social Worker, Review Team, North Tyneside Council	Assessment Tools Project

Evaluation

1. Were you aware of the aims and objectives of the session?

- Before you came? YES / NO
- By the end of the session YES / NO

2. To what extent did the session meet the aims and objectives?

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Not at all completely

3. Please identify the training methods used

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Lecture group work discussion case study other

Comments on the usefulness of these methods with regard to your learning:

4. Do you think any part of the session could be improved or done differently?

5. How well was the group managed during the session?

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Unsatisfactory very good

6. Has the session been beneficial in terms of your understanding of the single assessment process? YES / NO

7. How will SAP implementation change / affect you? Please comment.

8. Any other comments? E.g., future training

Name (optional): _____