

POLICY AND GUIDANCE

The Single Assessment Process: An overview

How many times have you tried contacting an organization for information or perhaps to complain about a service, only to end up being passed from one person to another? This common experience can be very frustrating: we provide full details to one operator and then get passed to another department, only to repeat all the information again.

This frustration is magnified when we are seeking health- and social-care support, perhaps following major illness or severe social pressures, when we may be at crisis point. Some agencies may be uncertain as to who is responsible for which service, resulting in vulnerable people not receiving the help they need and are entitled to.

Most people requiring access to health and social care need an assessment to ascertain their 'eligibility for care' and are dependent upon public sector agencies working effectively together to provide seamless services.

The seamless approach

Unfortunately, seamless and coordinated approaches are not always experienced by service users. Many people find the whole system confusing and baffling, with no clarity about responsibility. This confusion is acute when people are dependent upon several agencies to meet their health- and social-care needs.

Finding your way around the system can be like a maze; you think you have found a route, only to end up down a dead end and have to start again.

Single Assessment Process

To simplify this complexity of systems, the government introduced the Single Assessment Process (SAP), whereby agencies coordinate their approach, share informa-

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Julie Swann explains what you need to know about this guidance and how it will impact on elderly people and the key workers involved in their care.

tion more effectively and avoid duplication.

The SAP for older people was introduced in the *National Service Framework for Older People* (Department of Health, 2001a). This stated:

'Implementation of the Single Assessment Process, in tandem with other person-centred aspects of the National Service Framework for Older People, will lead to a more efficient assessment process and more effective care services for older people.'

The SAP is regularly referred to in other national policy documents, charters and frameworks, such as the White Paper *Valuing People* (Department of Health, 2001b). The Department of Health's (2002a) guidelines required every local authority to have an agreed SAP in place by April 2004.

Aims of the SAP

The *National Service Framework* describes the purpose of the single assessment process 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.'

It states:

'In pursuit of these aims, the Single Assessment Process should ensure that the scale and depth of

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

Key themes of the SAP

The key themes in the SAP illustrate the intentions behind the government's approach to quality care:

1. Person-centred

Establishing the older person's views and wishes by putting the individual centre-stage is critical to the SAP (*Box 1*). Older people are to be treated as individuals with their own distinct needs, which services should be organized around. 'One size fits all' is not appropriate; assessments, like services, are geared around the uniqueness of each. Assessment findings and key issues need to be completed in writing and provided in an appropriate format to the older person.

2. Information management

Information needs to be collected, stored and shared as effectively as possible between agencies, subject to written con-

Box 1.

PERSON-CENTRED CARE REQUIRES MANAGERS AND PROFESSIONALS TO:*

- Listen to older people
- Respect their dignity and privacy
- Recognize individual differences and specific needs, including cultural and religious differences
- Enable older people to make informed choices, involving them in all decisions about their needs and care
- Provide coordinated and integrated service responses
- Involve and support carers whenever necessary.

(*EXTRACTED FROM THE NATIONAL SERVICE FRAMEWORK FOR OLDER PEOPLE, 2001A)

Coordinated services

sent by the service user. There are exceptions to this – for example, in emergencies or if people are cognitively unable – but these situations will be rare.

When details are taken over the telephone, it is also not possible to get prior written consent before details are recorded, but this should be obtained verbally and later in writing at the first available opportunity.

3. Effective use of resources

Professionals should work together in people's best interests and be willing, able and confident to use their judgment. The emphasis is on working collectively as part of a cohesive multidisciplinary team, where work overlaps between many professions. It is important that the different roles of specialist workers (such as therapists, social workers and psychologists) are understood to ensure that appropriate referrals are made.

All processes must be in proportion to individual needs and not be excessive. If needs are complex, one key coordinator of care should be agreed between the agencies.

4. Thorough and accurate assessment

Older people's care needs must be assessed thoroughly and effectively using one procedure, perhaps over several visits. Good assessment processes ensure the best possible care is provided. The level and depth of assessment must be proportionate to the level of need.

5. Avoid duplication

Agencies are required to coordinate their assessment processes in order to avoid service users having to undergo multiple assessments and avoid provision of the same information to many different people from different agencies.

Types of assessment

There are four types of assessment:

- Contact assessment
- Overview assessment
- In-depth/specialist assessment
- Comprehensive assessment.

Although having a framework for assessment is essential, these stages are not complete in themselves and there can be considerable overlap between them.

It is possible for an individual to move between all four stages, but this will be rare. Some will require low-level intervention, while others will have such a range of needs that they will enter the system at a more intense level. The critical issue is that it is based upon individual circumstances and that all agencies operate to the same framework.

Contact assessment

This is the initial contact between an older person and a service. Contact assessment may result in no further action or assessment when dealing with straightforward issues such as requests for information, small assistive equipment and blue badge applications. It may be face-to-face or by telephone.

A first contact may be with a health professional at the GP surgery or in hospital, or with social services. Basic personal information is collected (name, address, date of birth, details of carers), the presenting problem is established and action is taken.

If a health professional is involved, he or she will explore the potential for social-care problems and similarly, social services staff will consider if there could be health implications. In either case, a referral will be made to the appropriate agency. However, referral may be needed to another specialist or an overview assessment may be needed.

Overview assessment

This is generally face to face and provides a more detailed understanding of difficulties and identifies areas of needs. It records the perceptions of the family and carers.

Solutions may involve intensive support or treatment – perhaps a package of care to maintain independence and aid recovery. Issues may not be clear cut or other potential problems may not be identified. Referral to other specialists is often required.

The need for overview assessment may be immediately apparent when basic contact information is collected or specialist assessment of a specific problem may be undertaken first, with the overview assessment providing background later. Overview assessments should be completed by a single professional from either the NHS or from social services.

Many SAP forms will have trigger mechanisms to identify appropriate responses. For example:

- Continence issues: Referral to continence advisor
- Activity of daily living problems: Referral to occupational therapist
- Mobility problem: Referral to a physiotherapist (for a walking appliance and/or treatment) or occupational therapist (for equipment or adaptations)
- Communication difficulties: Referral to a speech and language therapist
- Hearing or visual problems: Referral to a social services sensory impairment team, a GP or an optician.

Triggers help the key worker to identify which other professionals or assessments are needed (*Box 2*).

Specialist assessment

This may follow on from a contact or overview assessment. Specialist assessments explore specific needs in one or more 'domains' (*Box 3*) in depth by the appropriate professional (therapist, doctor, specialist nurse or social worker).

These in-depth assessments cover particular needs – for example, problems with falling, mobility issues, mental health or

Box 2.

ACCREDITED TOOLS THAT CAN BE USED FOR OVERVIEW ASSESSMENT*

- Cambridgeshire Assessment Tool (CAT): The developers of this tool can be contacted at Mark.Howe@cambridgeshire.gov.uk
- EASYcare version 2004: The developers can be contacted at J.Marriott@sheffield.ac.uk
- Functional Assessment of the Care Environment (FACE) for Older People version 3: Contact Piclifford@aol.com
- Minimum Data Set (MDS) for Home Care version 2.3: Contact G.I.Carpenter@ukc.ac.uk
- Northamptonshire Overview Assessment Tool (NOAT): Contact WHoult@northamptonshire.gov.uk
- Standardised Assessment of Elderly People (STEP) in Primary Care in Europe: Contact idris.williams@wgh.mbht.nhs.uk

(*DEPARTMENT OF HEALTH, 2004)

POLICY AND GUIDANCE

sensory impairments. Several specialist assessments may be required on a single area of need. For example, mobility problems may require a GP, nurse, physiotherapist and occupational therapist to ensure a thorough risk analysis is undertaken.

Comprehensive assessment

This assessment is undertaken for complex needs and circumstances, perhaps where intensive, prolonged or complex levels of support are needed, such as for permanent admission to a care home, intermediate care services or intensive packages of care at home.

If all areas in overview assessment are completed and specialist assessments are carried out (as needed), the result is also a comprehensive assessment. When completed, this involves a range of professionals or teams providing specialist assessments in all or most of the 'nine domains' (Box 3). A key worker is nominated to coordinate information.

The carer's assessment

The SAP looks at the carer's support and the need for additional support and services. This may be to help carers continue to care for the older person and may indicate the possible need for a separate carer's assessment, normally carried out by social services.

A carer 'impact assessment' is carried out in private and assesses areas of difficulty in coping with caring. This provides a fuller picture and takes a carer's needs into account under the 1995 and 2000 Carers Acts and the Fair Access to Care Services (Box 4).

Box 3.

DOMAINS OF NEED

Nine domains of need were identified by the Single Assessment Process:

1. **Service users' perspective**
2. **Clinical background**
3. **Social background**
4. **Disease prevention**
5. **Personal care and physical wellbeing**
6. **Senses** (e.g. deafness/blindness)
7. **Mental health and relationships**
8. **Family and friends**
9. **Safety** (risk assessment)

Staff development

The Department of Health (2002b) guidelines recommend that all agencies involved in the SAP receive additional training to complement existing assessment skills. A shared value system across health, social services, housing and other agencies will need to evolve. It is important to understand the local system of care and how older people move through it.

Assessment skills may need to be developed to ensure staff are competent and assessment tools are obtained. Common terminology for care processes, needs and outcomes will have to be identified that are understood by service users.

Many people are potentially engaged in undertaking assessments within the SAP; therefore, interagency staff training is important. Specific training may be required on:

- The older person and the carer, particularly issues relating to ageing and end of life
- Promoting health, independence and safety
- An appreciation of the outcomes that older people and their carers value
- Working with carers.

Some localities have evolved integrated systems, using laptops to input data. This can be done in home or in hospital, thus avoiding staff having to transfer assessments onto a computer later. The older person then knows exactly what information is being shared.

Eventually, assessment information and referrals could be transferred to the com-

Box 4.

WHAT CAN OLDER PEOPLE EXPECT FROM THE SINGLE ASSESSMENT PROCESS?

- To contribute to their assessment
- To participate in problem-solving alternatives by exploring options
- To complete forms as part of the information gathering and make written statements
- To give relevant information, including past problems, key life events, relationships, motivations and beliefs
- To be provided, if needed, with advocates, interpreters or translators
- Agencies working together in joint disciplinary teams

missioning units and a detailed care plan printed out for the service user.

Information on the internet

There are many sources of information, including samples of assessment tools, electronic copies of guidelines, SAP tools and scales. The Centre for Policy on Ageing (www.cpa.org.uk/sap/sap_home.html) was commissioned by the Department of Health to identify learning and development materials to help with staff training sessions when implementing the SAP. Links to other information on SAP is available from this web site.

Conclusion

The SAP is not just about providing a single document for all agencies to use that travels with the individual through his or her contact with the health- and social-care system. The SAP is a fundamental rethink about principles of care.

The SAP places individuals at the heart of the process, empowering them with greater control over their lives. Professionals are required to work in partnership with individuals and be responsive to their changing needs. Service users should suffer fewer frustrating and disempowering experiences in their contact with the complex world of health and care provision. We will all be better equipped to find our way around the maze of care. **NRC**

Department of Health (2001a) *The National Service Framework for Older People*. Department of Health, London

Department of Health (2001b) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. The Stationery Office, London

Department of Health (2002a) *Guidance on the Single Assessment Process for Older People*. Department of Health, London

Department of Health (2002b) *Guidance and Annexes (Jan 02) Annex J – A Strategy for Joint Staff Development*. Department of Health, London

Department of Health (2004) *Single Assessment Process for Older People: Assessment Tools and Accreditation*. The Stationery Office, London

Useful information

- Centre for Policy on Ageing (www.cpa.org.uk/sap/sap_home.html)
- Department of Health (2003) SAP for older people implementation guide for April 2004. www.dh.gov.uk/assetRoot/04/07/03/19/04070319.pdf (accessed 9/11/04)