THE SINGLE ASSESSMENT PROCESS
GUIDANCE FOR LOCAL IMPLEMENTATION

Introduction

1. This guidance sets out how the single assessment process described in the National Service Framework (NSF) for Older People (Department of Health, 2001) should be implemented locally from April 2002. It is issued to councils with social services responsibilities under section 7(1) of the Local Authority Social Services Act 1970.

2. Local implementation of the single assessment process by health and social care systems will promote better care services and better outcomes for older people, and more effective use of professional resources. In particular, 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. The single assessment process also provides information to support the determination of the Registered Nursing Care Contribution for residents in care homes which provide nursing care. The guidance fully supports the principle of informed consent with regard to information on older people's needs and circumstances that may be collected and shared. These purposes are set out more fully as "Key attributes of the single assessment process" in Annex A.

3. This guidance does not recommend the use of a single assessment tool. Rather it provides a rigorous framework that will lead to convergence of assessment methods and results over time irrespective of the tools chosen for local use.

Who should use this guidance

4. The guidance is directed at staff working in the following settings :

- GP surgeries
- Community health services
- Hospitals including Accident and Emergency and Outpatients departments, Medical Assessment Units (including Old Age Psychiatry Units), and wards and other locations where older people are cared for.
- Other NHS facilities including walk-in centres, day hospitals, community rehabilitation teams and community mental health teams.
- Social services offices and access points.
- Care Direct (where locally established).

5. Annex B sets out general implications of this guidance for older people, carers and professionals. Specific implications are given separately for : older people,

social workers; nurses; therapists; GPs and geriatricians and old age psychiatrists. (Annex B gives details.)

Implementation - approach

6. The Government is committed to a single national assessment framework, which will result in convergence of local assessment procedures, outputs and outcomes over time. Local agencies will therefore be required to demonstrate that their agreed approach to assessment complies with the NSF for Older People and this guidance. Annex C sets out the criteria that will have to be met before agencies and localities can be certain that their agreed approach to assessment is compliant. It also includes a detailed timetable.

7. The criteria emphasise that while different localities may opt for different tools or approaches to assessment, their assessment systems should be capable of generating a single assessment summary comprising sets of standardised assessment information.

8. The criteria and timetable for implementation recognise that implementation in many localities may need to be incremental. This is because, despite good joint assessment systems in some areas, and excellent aspects of assessment in many other areas, most assessment systems in current practice fall short of the requirements of the NSF for Older People and this guidance.

Implementation - responsibilities

9. Local implementation should be based on the geographical areas used for implementing the NSF for Older People as a whole (for example, Local Strategic Partnerships). Where there are overlapping boundaries and impending changes to boundaries, local agencies should agree solutions that put the interests of service users first. Within an implementation area, chief officers in each health and social care organisation should take responsibility for implementation, assisted by the clinical practice champions required by the NSF for Older People.

10. GPs, and staff who work directly with them, have an important role to play in the operation of the single assessment process. They may wish to become involved in the process of implementation through their local Primary Care Trust.

Implementation - process

11. Health and social services should involve local stakeholders, including older people, service users, carers, providers, other local statutory agencies such as housing, and local voluntary and community organisations, in implementation.

12. Project plans for implementation should be based on the following 12 steps.

(I) Agree purpose and outcomes

With reference to the "Key attributes" in Annex A, local agencies should agree what they want to achieve through local implementation of the single assessment process. In helping them to do this, they should :

- Ask older people, service users, carers, professionals and other stakeholders what they see as the benefits of the single assessment process, and whether they have particular concerns.
- Identify, and build on, current good practice in their locality.

In thinking through the benefits, agencies should recognise that many frail older people will have numerous separate assessments per year with the majority of the information being repeated on each assessment. The single assessment process will help to minimise this unnecessary duplication, while allowing a full assessment to be built up over time. It will also reduce paperwork by providing a single assessment summary (preferably based on electronic records) for health and social care. It should also facilitate information sharing with other agencies such as housing. Of course, the collection and sharing of assessment information must be based on older people's informed consent.

(II) Agree shared values

Agencies in localities should agree the shared values that will underpin their joint approach to assessment and care planning. Annex D offers a guide based on the principles of the NHS Plan and the NSF for Older People. Agencies will need to be aware that some principles underpinning the values in Annex D, such as the need to gain consent before sharing confidential information between agencies, are required by law whereas others permit greater flexibility.

The process by which agencies arrive at shared values can often be as important as the values themselves. In discussing shared values, agencies and professionals should attempt to appreciate each other's roles, the resources at their disposal, and the constraints under which they operate.

(III) Agree terminology

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 (see the NHS data dictionary website), the Social Care Information Requirements 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.

(IV) Map care processes

Agencies should identify how older people currently move through the system, from point of access to delivery of a service. As part of this, they should map current systems of assessment and care planning. They should identify duplication and omission, and the potential for a more integrated approach with a view to reducing work for professionals. They should ensure local care and assessment systems align with the single assessment process described in : Standard Two of the NSF for Older People; the requirements, care pathways and services models of other standards; and this guidance. They should use their maps to describe the involvement of independent providers.

In addition, when mapping care processes, agencies should clearly identify which professionals need to see information about individuals seeking or receiving treatment or services, how they will use the information, and related safeguards for individuals.

(V) Estimate the types and numbers of older people needing assessment

Within a locality, the different agencies should estimate the types and numbers of older people who will approach them for help and the type of assessment they receive. Existing data collections such as the Department of Health's "Referrals, Assessment and Packages of Care for Adults" may be used to generate estimates. The estimates will help agencies to design their assessment systems in the first place, and monitor and review them over time. As a guide, it may be anticipated that across all agencies in a locality a relatively small proportion of older people, in the region of 20% of all referrals, would receive a comprehensive assessment. In individual agencies, the proportions will differ markedly. Primary care teams may expect to lead on very few comprehensive assessments. Social services departments may expect between 20 and 30% of cases, where they have the lead, to require a comprehensive assessment. In an Old Age Psychiatry Unit the proportion may approach 100%.

(VI) Agree the stages of assessment and care management

Agencies should agree the stages of assessment care planning, review and other aspects of care management.

These stages should cover :

- Publishing information about services
- Completing assessment – the four types :
  - Contact assessment, including the collection of basic personal information
  - Overview assessment
  - Specialist assessments
  - Comprehensive assessment
- Evaluating assessment information
- Deciding what help should be offered, including eligibility decisions
- Care planning
- Monitoring

- Review

In addition, agencies may wish to take a pro-active approach to identifying needs among individual older people, who are not in touch with health and social services. "Case-finding" of this kind can play an important part in preventive strategies and health promotion.

The Department is aware that these stages already feature prominently in the structures and processes of many NHS bodies and councils. Because of this, in many areas, implementation should not involve radical change.

The early parts of the assessment process described in this guidance may replace or build on the content of a normal consultation with a GP or an initial approach to other professionals. However, the full process is not intended to apply to older people who have specific needs that can be readily addressed, with no wider repercussions. In this regard, agencies should pay particular attention to contact assessment, and they should be wary of perceiving and recording every contact as requiring a contact assessment. To do so would create unnecessary bureaucracy for older people and professionals alike.

During assessment, care planning and subsequent processes, the older person's account of their needs and their views and wishes must be at the centre of all decisions that are made. The strengths and abilities that individuals can bring to bear on their needs and circumstances should also be acknowledged and taken into account, together with external or environmental factors that may have precipitated or exacerbated their needs. They should be informed about, and consent to, the assessment process and related information on their needs and circumstances which may be collected and shared. Key decisions and issues on assessment, eligibility and service provision should be put in writing, or other appropriate formats, and a copy given to the older person.

Annex E contains detailed guidance for each stage of assessment and care management.

(VII) Agree the link between medical diagnosis and assessment

Agencies should reach an understanding of how medical diagnosis fits within the single assessment process. Medical diagnosis is the identification of a specific health condition, how it arose and its likely course. As such medical diagnosis can be seen as distinct from the assessment of wider health and social care needs. However, the inter-related nature of specific health conditions (such as stroke or a fractured neck of femur) with social, physical and mental health needs makes separation in practice unhelpful.

(VIII) Agree the domains and sub-domains of assessment

Agencies should agree the domains and sub-domains of the overview assessment. Local agencies may add to, or sub-divide, the domains and sub-domains already provided in the NSF for Older People (see the boxes in Annexes F and H.) However, they should not delete any.

(IX) Agree assessment approaches, tools and scales

In each locality, agencies should work to, or adopt, a common approach to assessment. Their approach should emphasise that assessment involves the collection **and** evaluation of information. In particular, agencies should agree the assessment tool or approach they will use for overview assessment.

Currently, it is not possible to identify any existing assessment tool which adequately covers all the domains and sub-domains in the NSF for Older People, or is sufficiently person-centred and meets other requirements. Therefore, there is no one tool that can be prescribed for national use. Instead, the Department has developed rigorous criteria (see Annex C) against which local agencies should evaluate current or proposed approaches to assessment, in order to help them identify changes they may need to make so that their assessment systems comply with the Department's requirements.

Examples of assessment tools, developed either for national or local use, are given on the internet under Tools and Scales. While none of these tools yet fully comply with the requirements of the NSF for Older People and this guidance, they provide a useful starting point for localities that wish to start from scratch or replace their current systems.

As well as agreeing assessment tools, agencies should agree the assessment scales that will be used in the locality in support of professional judgement. It is important that scales are valid, reliable, and culturally sensitive. Assessment scales and questions that the Department of Health recommends can also be found in Tools and Scales.

(X) Agree joint working arrangements

Agencies should agree joint working arrangements for assessment and care planning, and protocols for the involvement of professionals in these processes. The protocols should specify which professionals from which agencies should co-ordinate assessment and care planning in what circumstances. Likewise, it will be important for agencies to emphasise the leading or prominent role that geriatricians and old age psychiatrists may make to comprehensive assessment. Agencies are asked to be particularly clear about joint working arrangements when admissions to care homes for older people, or other forms of intensive or prolonged care, are likely. They should also be clear about gaining consent for collecting and sharing information in relation to both assessment and care planning.

In reaching these local agreements, agencies should look to their statutory duties. These are summarised in Annex E under "Legal matters".

Where more than one agency is involved in assessing needs or planning care, those agencies should explain to services users which agency is responsible for what aspect of care. This will be useful if individuals need to complain about or comment on services.

The single assessment process applies to health and social care. Yet, as acknowledged in the domains of the overview assessment, these agencies must be prepared to address the full range of needs older people may experience, including those relating to housing and finances. In these instances, it could be essential for professionals from housing, benefits and others agencies to be involved.

See Annexes G and H for more details.

(XI) Agree a single assessment summary

It is essential that local agencies work to an agreed single assessment summary for the collection of information on older people who are assessed, whether or not they go on to receive services. This is the most critical step towards a single assessment process. When undertaking this work they should refer to the Information Strategy for Older People and liaise with their Local Information Strategy communities so that, in time, a virtual single assessment summary can be constructed from electronic records.

The three components of the single assessment summary, covering basic personal information, needs and health, and a summary of the care plan are given in Annex I. When agreeing their single assessment summaries, localities may add to these information items, but should not delete any.

In addition, agencies should agree how the information identified for their single assessment summary is to be collected, stored and shared, with due regard to the Data Protection Act 1998, Caldicott requirements and informed consent. Annex I gives further details.

(XII) Implement a joint staff development strategy

Agencies should agree and implement a joint staff development strategy. This will be part of a co-ordinated approach to staff development that follows from the implementation of the NHS plan and other related health and social care current policy initiatives. It will determine the arrangements for ensuring that organisations and staff are competent to introduce and operate the single assessment process over time. Effective arrangements will include ongoing programmes for multi-disciplinary groups of staff that will support professional practice, and cover issues of organisational change; knowledge of old age and related health and social care conditions; multi-disciplinary working; and assessment skills and techniques.

See Annex J for more details.

Summary timetable

13. Between April and June 2002 agencies in all localities should have reviewed how their assessment systems compare with the criteria of Annex C, and should put in place action plans to address the most serious difficulties. Further reviews are required by April 2003 and April 2004 to address remaining difficulties, accompanied by revised action plans in 2003 if necessary. Reports of these reviews are required by the Department of Health, and the first review is due in September 2002.

14. By April 2004, where localities cannot **fully** meet the Annex C criteria they will have to implement action agreed with the Department of Health to ensure compliance by April 2005. If the criteria are not met in April 2004, because of difficulties with overview assessment tools, localities may be asked to adopt one of the assessment systems that the Department will then have accredited.

15. To ensure that local systems are fit for purpose over time, localities should regularly review the operation of the single assessment process after April 2005. The reviews should specifically ensure that the interests of all stakeholders continue to be addressed, and the system is delivering a person-centred and standardised approach.

16. Agencies should be satisfied that their assessment information is good enough to help determine the Registered Nursing Care Contribution for people admitted to care homes which provide nursing care. (See Annex H.)

17. The Department of Health will take a close interest in the implementation of the single assessment process. In addition to the reports and action plans that should be sent to the Department, routine monitoring will play an important role.

Relationship to other NSF standards, service models and care pathways

18. The guidance applies to all older people. In implementing it agencies should refer to the standards in the NSF for Older People for intermediate care (Standard Three), general hospital care (Standard Four), stroke (Standard Five), falls (Standard Six), and mental health in older people (Standard Seven). All these standards include specific details on assessment, care management, team working and care co-ordination, and training and education. In particular, the standards for stroke, falls and mental health include service models and care pathways that provide the context in which the single assessment process should operate.

The over 75s health check

19. The guidance provided here does not affect the obligations of GPs to offer a health check, on at least an annual basis, to all people aged 75 and over who are on their practice lists. This remains an important term of service for GPs.

20. Further guidance on the over 75s health check and the relationship to the single assessment process will be issued by 2003, based on the results of further research. Meanwhile, GPs may find it helpful to review and develop the way in which they approach and administer the over 75s health check in the light of the domains of the single assessment process and this guidance, while continuing to fulfil their contractual obligations. In addition, over 75s health checks can be an important method of case finding.

Housing and other services

21. This guidance does not formally extend to housing authorities or other statutory agencies. Yet for many older people, services such as housing, benefits and transport can make important contributions to promoting independence and well-being. Where possible, local NHS bodies and councils are encouraged to engage these wider interests as they implement the single assessment process and other aspects of the NSF for Older People.

22. Specifically, this guidance is formally sent to housing authorities so that they are aware of the implications for them, and to encourage greater collaboration between local NHS and social services agencies and housing in the care of older people. This will enable these agencies to set joint standards and targets for service delivery, including assessment, under local "Better care, higher standards" charters.

National Assessment Working Group

23. To help the Department develop this guidance, a National Assessment Working Group was established in April 2001. The group will continue to be consulted during the implementation phase of the single assessment process.

Copies and enquiries

24. This guidance can be accessed on the internet at the SAP website. Developments in assessment tools and recommended scales can be accessed at this website by clicking on Tools and Scales.

25. Further copies of the guidance may be obtained from the Department of Health, PO Box 777, London SE1 6XH, Tel 0870 155 5455 or Fax 01623 724 524.

26. Enquiries about this guidance, apart from requests for copies, can be made to :

Department of Health (SAP)
Older Peoples Services CC3
Area 221
Wellington House
133 – 155 Waterloo Road
London SE1 8UG