

**GUIDANCE ON SINGLE SHARED
ASSESSMENT OF COMMUNITY CARE
NEEDS**

Scottish Executive



SCOTTISH EXECUTIVE

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29 November 2001

Dear Colleague

SINGLE SHARED ASSESSMENT OF COMMUNITY CARE NEEDS

Introduction

1. This circular provides guidance to local authorities, NHSScotland and housing agencies on the steps necessary to improve results for people who use services through introducing Single, Shared Assessment, initially for older people from 1 April 2002. The guidance is issued under section 5 of the Social Work (Scotland) Act 1968. Further practical advice to support these arrangements will follow.
2. Single, Shared Assessment is one of the key parts of the Executive's strategy to improve the results for people using community care services. This includes people needing housing support. The recent introduction of joint resourcing and joint service management from April 2002, for example, will provide a more holistic approach to the financing, management and delivery of services. Complementing that, Single, Shared Assessment redesigns the assessment system, takes a more holistic approach to assessment, with benefits for people who use services, for agencies and for professionals. More particularly, it will streamline systems and speed up the delivery of services. In short, it will mean shorter routes to services, and faster passage along these routes.
3. This guidance stems from the Joint Future Group's (JFG) recommendations on Single, Shared Assessment. Some areas have already begun to implement them. This guidance will reinforce and support their progress, and provide a new lead to those areas not so far advanced. The

principles of Single, Shared Assessment, though developed in community care, can apply equally to other needs, such as young people at or coming to the transition to adult services.

4. The detailed guidance (in the Annex attached) is in 4 parts, as follows:

- Part 1: What we mean by Single, Shared Assessment.
- Part 2: The key steps necessary for implementation in April 2002.
- Part 3: Minimum standards checklists for the assessment process and assessment tools, and the core dataset.
- Part 4: Technical developments (Resource Use Measure (RUM), information systems and the Carenap assessment tool).

Context

5. Comprehensive guidance on assessments generally was issued in 1992¹. Further guidance, specifically on integrating assessments and the care of older people, was issued in 1998². Both dealt extensively with the purpose of assessment, who should assess and the efficiency of the arrangements. They remain in place as the baseline for assessment generally, but some aspects, e.g. managing confidentiality, have been overtaken.

6. There is widespread recognition that assessment needs to move on. To reinvigorate and refocus assessment, the JFG recommended introducing Single, Shared Assessment. It takes assessment to a new level, building on the continuity of skill available. It recognises the lead responsibility of social work within local authorities but also that effective partnerships and engagement of both health and housing professionals are essential to achieve the holistic approach that Ministers want. The Minister for Health and Community Care announced her intention to implement Single, Shared Assessment in both the Executive's response to the Royal Commission on Long Term Care and in *Our National Health: A plan for action, a plan for change*. The Executive's response to the report of the Joint Future Group deferred its commencement until April 2002.

7. Single, Shared Assessment is also an integral part of wider policy developments. The Executive is committed to introducing free personal care and free nursing care for older people from April 2002. Single, Shared Assessment will determine their needs, and help identify services which count as 'personal care' or 'nursing care' for these purposes. And as part of the Executive's improved support for carers, measures in the Community Care and Health Bill now before Parliament will provide independent assessment for carers. The Single, Shared Assessment principles and model should apply equally to them. And the measures in the Bill on joint working apply to, amongst other things, assessment arrangements.

8. It also applies to people with housing needs. Housing professionals in local authorities will usually assess them and be the lead assessor. Providers generally (including housing providers) can contribute to the lead assessor's full understanding of the person being assessed under Single, Shared Assessment. When "Supporting People" comes into effect in 2003, housing support needs will be

¹ SWSG 11/91 – Assessment and Care Management

² SWSG 10/98 – Community Care needs of Frail Older People – Integrating professional Assessments and Care Arrangements.

included. And in the drugs field, the Effective Interventions Unit will incorporate Single, Shared Assessment in its proposals for greater integration generally.

Scope of Single, Shared Assessments

9. Single, Shared Assessment will apply to all care groups. Ministers expect Single, Shared Assessment to start for older people in April 2002. In the course of 2002-03 it should be applied more widely to the rest of community care, including people with drug and alcohol problems. Local authorities, NHSScotland, and housing agencies should therefore work through the key steps set out in Part 2 of the Annex to meet these expectations. The Single, Shared Assessment Team that is part of the Joint Future Unit (JFU) will support and monitor implementation.

Benefits

10. Single, Shared Assessment is one part of the assessment and care management framework. The expected benefits from Single, Shared Assessment are trailed in paragraph 2 above, and set out more fully in Part 1: paragraph 5 of the Annex.

Implementation

11. This guidance supports agencies to implement Single, Shared Assessment. By way of summary, the key steps fall into 3 main categories, as follows:

<u>Joint Working</u>	<u>Single, Shared Assessment Process</u>	<u>Information Sharing</u>
<ul style="list-style-type: none"> • Involve stakeholders. • Agree purpose and results. • Agree underpinning values. • Agree roles, responsibilities and accountabilities. • Agree a plan for joint staff training and development. • Agree common terminology • Identify change leaders 	<ul style="list-style-type: none"> • Map and agree the process. • Agree the Single, Shared Assessment tool. • Agree the use of the assessment tool. • Agree the links to other assessment inputs and intensive care management. • Agree access to community care services. • Agree application of Resource Use Measure (RUM) 	<ul style="list-style-type: none"> • Agree information requirements. • Agree the protocol for sharing (consent, collection, transmission, storage, access). • Agree systems and technologies.

12. These steps are described more fully in Part 2 of the Annex. In addition, in Part 1 (which describes Single, Shared Assessment) action expected of agencies is highlighted in **bold**.

13. Agencies may wish to develop a project management approach to implementation, to give stakeholders the lead they need from management, and the opportunity to develop corporate ownership of the new arrangements from the outset.

14. Agencies should therefore implement from 1 April 2002 the new arrangements for Single, Shared Assessment set out in this circular. The key points for them are:

- To develop a new culture for assessment under Single, Shared Assessment which ensures that the needs of the user are paramount.
- To provide a more holistic and efficient approach to assessment.
- To broaden the range of assessors to include professionals from health and housing and, where relevant, other agencies and disciplines.
- To concentrate on systems providing the benefits and desired results set out in this guidance. To assess their existing or newly developed assessment tool and processes against the minimum standards developed from the validation criteria set out in Part 3, with the option of developing a local system or introducing Carenap D or E as appropriate.³
- To develop a more systematic approach to the allocation of resources, based on the Resource Use Measure (see Part 1, paras 40-42 and Part 4.1 of the Annex).
- To secure collective ownership of the new arrangements.

Resources

14. These arrangements are designed to improve results for people being assessed, partly through more focused inputs from professionals and by reducing the need for multiple assessments. Over time, therefore, they should be cost effective. Agencies may, however, incur short-term costs in training staff and developing new approaches. In the GAE settlement for 2001-04, local authorities received a significant uplift for spending on social work generally; and health boards' unified budgets provide significant headroom for the development and improvement of systems and services.

Action

15. Local authorities and their partners should now develop new arrangements for Single, Shared Assessment as set out in this guidance. We will provide further information in support of these arrangements on the JFU's website <http://www.scotland.gov.uk/health/jointfutureunit>. And in the course of 2002-03 we will provide further information and advice to enable Single, Shared Assessment to be applied comprehensively to all care groups.

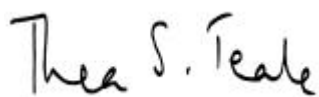
Enquiries

16. Enquiries relating to this circular should be addressed in the first instance to Brenda Kerr, Joint Future Unit, Scottish Executive, Health Department, Community Care Division, 3rd Floor, East

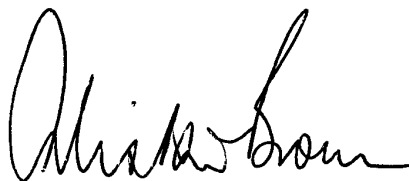
³ Assessment tools developed for use with older people Carenap E and people with dementia Carenap D (see Part 4.3).

Rear, St Andrew's House, Regent Road, Edinburgh EH1 3DG (telephone: 0131 244 3744). Professional issues should be referred to Liz Taylor elizabeth.taylor@scotland.gsi.gov.uk (or telephone 0131 244 3652). This circular is also available on Scottish Health on the Web: www.show.scot.nhs.uk/sehd/publications/ccd.htm. Further copies are available by telephoning 0131 244 3523 or e-mail richard.park@scotland.gsi.gov.uk. It will also be available on the Joint Future Unit website <http://www.scotland.gov.uk/health/jointfutureunit> where further practical advice and updates on promising practice can be found in due course.

Yours sincerely



THEA TEALE



ALISTAIR BROWN



GEOFF HUGGINS

**GUIDANCE ON
SINGLE, SHARED ASSESSMENT
IN COMMUNITY CARE**

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Aim of Guidance

This guidance:

- Explains what is meant by Single, Shared Assessment
- Suggests the necessary steps to implement Single, Shared Assessment.

PART 1: WHAT IS SINGLE, SHARED ASSESSMENT?

1. This section explains what we mean by Single, Shared Assessment, how it sits within the wider assessment and care management framework, and who is involved.

Background

2. The Joint Future Group (JFG) identified the need to improve assessment systems and results as part of its wider remit of improving joint working between social work, health and housing. It concluded that assessment systems, far from being the cornerstone of community care, were neither consistently effective nor efficient. They were bureaucratic, engaged with the individual on too many separate occasions, and were often repeated because of professionals' reluctance to accept the views of others. Moreover, their content and results were inconsistent.

3. The Joint Future Group recommended the concept of a Single, Shared Assessment which would be person-centred, more streamlined, led by a single professional, with other specialist involvement **as appropriate**, and the results would be acceptable to all professionals in social work, health and housing. It complements joint resourcing and joint service management.

Legislative Framework

4. Under section 12A of the Social Work (Scotland) Act 1968, local authorities have a duty to assess any adult (i.e. person over 18) who they believe may need community care services. In doing that assessment, local authorities must consult a medical practitioner if the individual appears to require nursing care, and consult the NHS or housing authority if the person may need support with either health or housing related issues as a consequence of the assessment. That legal framework does not need to change to accommodate Single, Shared Assessment, but cultures and practice do need to change. Local authorities can delegate their

duty to assess to others, and widening the range of professionals who can assess is part of the new direction.

Principles

Key Principles in Single Shared Assessment

- People who use services and their carers should be actively involved and enabled to participate.
- The type(s) of assessment should be appropriate to the person's indicated needs:
 - ? Simple assessment
 - ? Comprehensive assessment
 - ? Specialist assessment
 - ? Self-assessment.
- Assessment should be undertaken by the most appropriate lead professional.
- The assessor should be appropriately skilled and qualified to deal with the type and level of assessment.
- Appropriate information should be shared by informed consent of the person or the person's representative.
- Single, Shared Assessment must facilitate access to all community care services.
- Other professionals and agencies must accept the results.

Expected results

5. Single, Shared Assessment should achieve better results for people who use services and their carers by improving the efficiency of the assessment process, and linking the service user with the most appropriate professional to take the lead in co-ordinating assessment and care planning. There will be benefits for people who use services and for agencies.

Benefits for people who use services

- focuses on their needs and those of their carers;
- offers an appropriate level and range of assessment;
- avoids duplication of information-giving, and number of assessments;
- provides a key contact person (i.e. the lead assessor);
- achieves speedier and integrated care planning; and
- provides access to a range of co-ordinated services.

Benefits for agencies

- minimises duplication of work;
- reduces bureaucracy;
- integrates systems and procedures;
- achieves better use of staff skills and expertise;
- makes more effective use of resources;
- supports and builds on good practice; and
- results accepted by fellow professionals.

What is Single, Shared Assessment?

6. Breaking the term down into its constituent parts makes that clear, as follows:

<p>Single, Shared Assessment</p> <ul style="list-style-type: none">• is person-centred and needs-led;• relates to level of need; and• is a process, and not an event. <p>Single, Shared Assessment</p> <ul style="list-style-type: none">• seeks information once;• has a lead professional who co-ordinates documents and shares appropriate information;• co-ordinates all contributions; and• produces a single summary assessment of need. <p>Single, Shared Assessment</p> <ul style="list-style-type: none">• actively involves people who use services and their carers;• is a shared process that supports joint working; and• provides results acceptable to all agencies.

7. While the concept raises assessment to a new level, it is nevertheless linked to existing systems (eg referral/accessing care), categories of assessment (simple through to specialist), and players (users/carers/professionals). The rest of this section elaborates on these links and introduces complementary concepts such as the Resource Use Measure (RUM).

Accessing Single, Shared Assessment

8. Single, Shared Assessment is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency. To ensure the most appropriate assessment response, whichever agency or professional is the initial contact, **agencies will need an integrated system for receiving and acting on referrals**, free from bureaucratic screening procedures. **They also need to be clear on applying the Single, Shared Assessment principles where only one agency or professional/specialist is involved.**

9. To achieve these results, **agencies need to:**

- publish information explaining the purpose of Single, Shared Assessment, the routes to it, and the range of needs that may be addressed;
- review their systems for acting on referrals, and ensure that they fit the integrated system in Single, Shared Assessment;
- ensure that staff understand the concept and the local process of Single, Shared Assessment and their role in it.

Involving people who use services and their carers

10. People who use services and their carers are at the centre of the Single, Shared Assessment process. The person whose needs are being assessed should be encouraged to make as full a contribution as possible. The assessor should actively seek the carer's views as a partner in this process. Where the person being assessed and their carer's views differ, the assessor should consider involving advocacy services.

11. **Agencies should review and, where necessary, develop jointly their arrangements for ensuring that people with special communication needs and people from minority ethnic groups can participate fully in the assessment of their needs.** Specialist and other staff in the statutory and independent sectors working with these groups will need training in Single, Shared Assessment, and how they can maximise individuals involvement in it.

12. As at present, agencies should obtain at the outset the informed consent of the person to the assessment. The Adults with Incapacity (Scotland) Act 2000 states that where an individual is apparently unable to give proper consent, for whatever reason, every attempt should be made to establish the person's views on their past and present circumstances and on any proposed action arising from the assessment. The user's interests should be safeguarded through the involvement of a legal representative, specialist worker, a carer or advocate, as appropriate.

The needs of carers

13. All agencies should recognise carers as partners in the provision of care, and their contribution should not be assumed or taken for granted. All carers should be able to access flexible, quality services to support them in their caring role and meet their own needs. The Carers Recognition and Services Act 1995 has enabled carers to request a separate assessment of their needs when the cared-for person is being assessed. Subsequent measures in the Community Care and Health (Scotland) Bill, which is currently under consideration by the Scottish Parliament, will provide for an independent assessment of carers' needs in their own right. **The Single, Shared Assessment process therefore should be designed to ensure that carers' needs can be identified either in conjunction with or separately from the person being cared for.**

Sharing information with the consent of service users

14. The expected results for service users and carers and for agencies of Single, Shared Assessment can be achieved only if information relating to the assessment of individuals' needs and the planning of their care is shared between professionals and agencies involved in their care. A great deal of productive information sharing happens already. The implementation of Single, Shared Assessment is an opportunity to consolidate good practice and develop information sharing as part of an integrated approach to service provision.

15. **Sharing information should be on the basis of informed consent** by the person being assessed, with written authorisation where possible, **gathered as an integral part of the assessment process**. Staff undertaking Single, Shared Assessment will have responsibility for seeking consent. They must understand and be able to explain the purpose and implications of sharing information, what this may entail, and the safeguards of confidentiality that apply. Clear information should be available for people who use services and for staff.

16. Where assessors judge that obtaining informed consent to information sharing is not possible, the same safeguards for the individual should be applied as in consent to participation in the assessment (see para 12). Single, Shared Assessment does not alter people's rights or agencies' responses to those who are not able to give informed consent.

17. Evidence suggests that a minority of people will not be willing to consent to sharing information. They need to understand the consequences of that. Agencies should also have agreed systems in place for referral between professionals and agencies when these circumstances present.

Single, Shared Assessment: the process

18. Single, Shared Assessment is the central part of the assessment and care management framework. **Its implementation calls for social work, health and housing to review jointly their existing assessment systems and practices and consider how they can build on the best of these and integrate them to achieve a single, shared system**. The following elements are necessary to the **process**.

Type and level of assessment

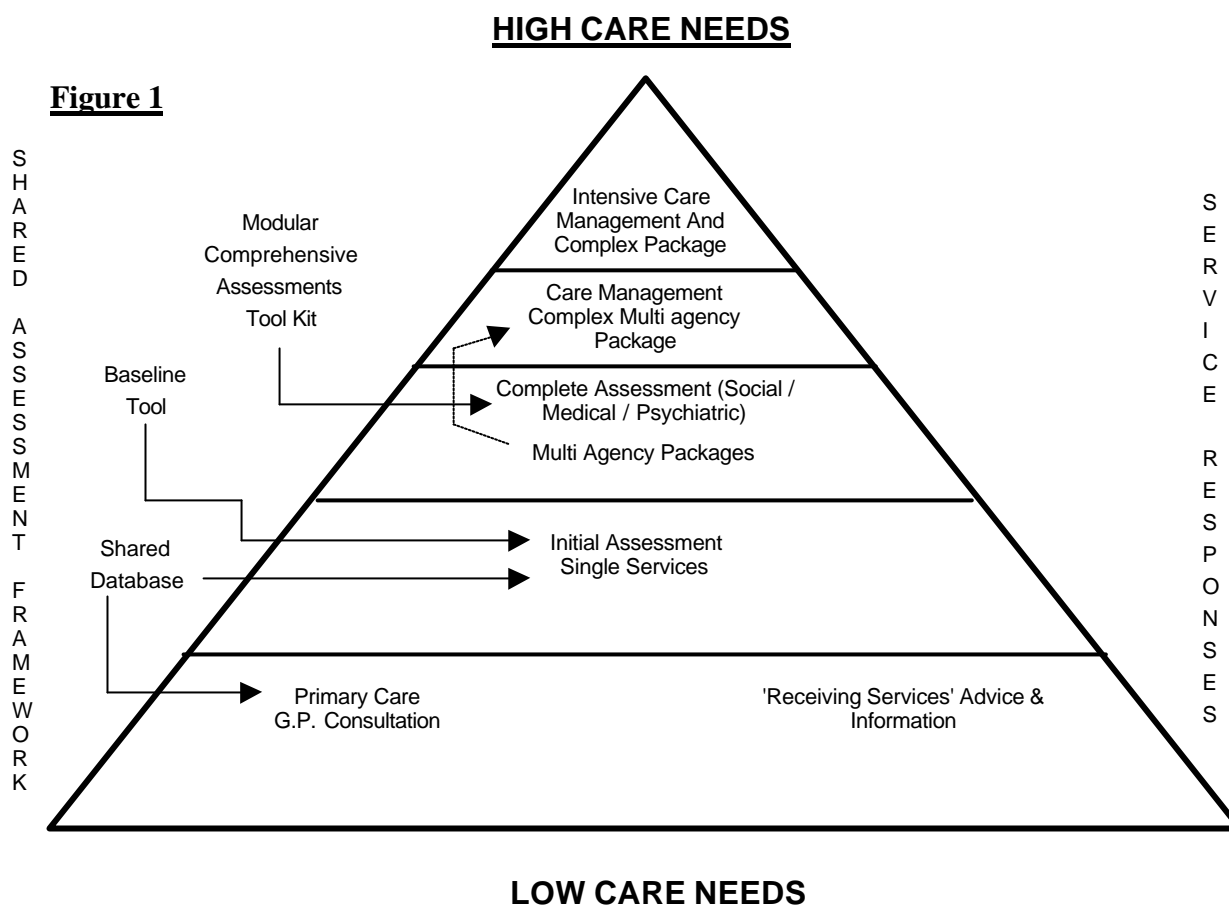
19. Single, Shared Assessment includes the same types and levels of assessment already used by agencies. For the sake of simplicity four types, including self-assessment, are described below. **The starting point should be the type of assessment that seems most appropriate to the perceived level of need of the person requiring help:**

- **Simple assessment** applies where indicated needs or requests for services are straightforward and can be dealt with by low level response. As it may involve one or more than one agency, some co-ordination of contributions to the assessment may be needed.
- **Comprehensive assessment** applies where a wider range and complexity of needs are indicated. It is likely to involve more than one agency in contributing to a holistic assessment of needs. Specialist input may be necessary to specific areas of need. In comprehensive assessment effort needs to focus on co-ordination of contributions to the assessment. People who are at risk of admission to residential care or nursing homes should receive a comprehensive assessment with specialist input, if necessary, and intensive care management to explore fully the options for rehabilitation and care at home.
- **Specialist assessment** may apply to simple needs of a particular nature or particularly complex needs requiring more in-depth investigation by a professional with recognised expertise.
- **Self-assessment** is where people identify their own needs and propose solutions to meet them, as the sole assessment or in conjunction with other assessments. They may receive professional advice or the support of an advocate. Self-assessment is already a feature in some areas for simple needs and a range of straightforward services. **Agencies should consider afresh its potential to improve results and efficiency, and how best to promote its use.**

Example of a Single, Shared Assessment Framework – “Care Pathways” in Glasgow

The partners in Glasgow have developed an approach based around “Care Pathways”. Care Pathways is a comprehensive and complementary route map to guide the pathway of care, ensuring an individual gets the right service response at the right time. It should assist the process of identifying where health, social care and housing staff come together to provide a more integrated service for older people, thus ensuring an effective safety net across agencies.

Fundamental to a Care Pathways approach is the concept of tiers (or levels) of need and a response framework. This defines a continuum of care from low to high level needs with proportionate assessment, management and care responses. It offers a number of advantages in identifying eligibility for services, triggers for movement along the care continuum, and strategic planning where estimated need and resources are built in to each level. Taken together, the Care Pathways and tiers of service approach provides the cornerstone of a whole systems approach to assessment and care management for older people and people with dementia. This model is illustrated in Figure 1 below. The complementary assessment tool is Carenap E.



Links to specialist assessments and intensive care management

20. **To address the needs of people with specialist and complex needs, agencies will need to agree which specialist inputs may be accessed through Single, Shared Assessment, and systems for referral by and for reporting to the lead assessor.** A set of trigger questions could direct lead assessors to a suitable specialist.

21. Some user groups have their own systems of assessment (eg Care Programme Approach in mental health, and Area Co-ordination in learning disability). **The relationship between these and Single, Shared Assessment needs to be clear. The Single, Shared Assessment should be the co-ordinated, multi-agency assessment in all these cases.**

22. Medical practitioners also need to be familiar with the Single, Shared Assessment process and how they contribute to it. The link between certain medical conditions (such as dementia, stroke and some fractures) and other health and social care problems highlights the importance to the planning of a person's care of sharing information on medical diagnosis and assessment.

23. People aged 75 years and over expect an annual health check by GPs. This will be an important gateway to Single, Shared Assessment, and GPs should consider how the areas of need in the local Single, Shared Assessment tool might inform their approach to the over 75s health check.

24. People with more complex or rapidly changing needs, including those who may be considered as requiring institutional care, may require Intensive Care Management by a suitably trained professional. This is part of the Single, Shared Assessment framework. Care managers will therefore carry out comprehensive assessments and co-ordinate care arrangements much as they do at present. Where a comprehensive Single, Shared Assessment has been carried out already this should be accepted by the care manager and supplemented by further assessment only if needs are likely to change.

25. **Agencies should ensure that access to care management is as direct as possible.** Potential referrers and staff will need guidance on who will be involved in assessments and on the indicators for referral to Intensive Care Management so that they may direct people to that service. The Executive will issue guidance on Intensive Care Management in 2002.

Who can be an Assessor?

26. **Single, Shared Assessment may involve staff in social work, health and housing services.** The new arrangements encourage not only a wide range of professional assessors but also recognise the specialist assessments by agencies such as Blind Societies. The potential range of staff is wide in terms of their job, qualifications, skills and expertise. The role they play in Single, Shared Assessment should be commensurate with their level of knowledge, skills and expertise in needs assessment or in their professional field. All staff will require training – preferably jointly - to prepare them for Single, Shared Assessment. Some may need additional training in needs-led assessment. It is likely that the relationship between the type (or level) of assessment and assessor will be:

<ul style="list-style-type: none"> • Simple assessment - 	<p>professionally qualified staff in health, housing and social work who are the first contact;</p> <p>vocationally qualified staff; and</p> <p>unqualified staff with training in assessment.</p>
<ul style="list-style-type: none"> • Comprehensive assessment - 	<p>professionally qualified staff in social work or health;</p>
<ul style="list-style-type: none"> • Specialist assessment - 	<p>professionally qualified staff in social work, health and housing, who may have recognised expertise;</p> <p>vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed; and</p> <p>professionally qualified or trained staff in specialist independent agencies.</p>

27. **Screening procedures should ensure that Single, Shared Assessment is undertaken by the most appropriate person**, i.e. the “lead professional” who will have responsibility for co-ordinating the assessment. This may not always be the professional in first contact with the service user. Normally, comprehensive assessments will be undertaken by community based staff, but hospital staff can support all types of assessment.

28. The contribution that housing agencies can make to the assessment process was clearly stated in the guidance issued by the Scottish Executive in July 1999- ‘Modernising Community Care- The Housing Contribution’. There will be a further opportunity for housing staff to be more involved through the introduction of Supporting People in 2003.

Assessment Tools

29. Single, Shared Assessment requires that individual assessments be underpinned by the use of an effective assessment tool. The tool:

- | |
|---|
| <ul style="list-style-type: none"> • aids the process of assessment by providing a record of individuals’ circumstances and needs that is consistent in content and format, and facilitates information sharing between agencies and services; and • guides the person undertaking the assessment in gathering information about the individual’s circumstances and needs, resulting in a record of need that will inform and assist care planning. |
|---|

30. Assessment tools support but do not replace the essential dialogue between assessors and service users about the person's needs and their views on how these might be met. The assessors' role should continue to be proactive, but more systematic.

31. While having an effective assessment tool is an integral part of Single, Shared Assessment, there is some flexibility in the choice of the tool itself. Two tools have been developed and tested that with refinement that is underway would support the assessment of older people and people with dementia. They are the Care Needs Assessment Package for Dementia (Carenap D) and for the Elderly (Carenap E). **Agencies have the choice of adopting these or other appropriate tools⁴, or developing or refining jointly their own Single, Shared Assessment tool.** Their choice should be determined in the light of self-assessment against the minimum standards set out in Part 3 of this Annex.

Validating assessment processes and tools

32. We have developed 2 separate checklists of minimum standards to provide:

- a framework for agencies to develop, adapt and assess local tools and processes; and
- a mechanism for the Scottish Executive to review jointly with agencies progress towards implementing Single, Shared Assessment.

33. The Chief Nursing Officer's Group on Free Nursing Care drew up validation criteria to bring greater consistency to the development of assessment tools and processes for older people's services. These criteria have been extended to meet the Joint Future Group's expectation of Single, Shared Assessment. The minimum standards against which local processes and the components of the assessment tool should be tested are set out in Part 3 of this Annex.

34. These minimum standards emphasise that while different localities may opt for different tools or approaches to assessment, **their systems should be able to generate sets of standardised core data.** We have also drawn up a minimum core data set for older people's services (also to be found in Part 3). It can also be used as a framework for developing core data sets for other care groups, but we expect to offer further advice on that in due course.

35. **Agencies therefore need to review as soon as possible their existing systems and tools against the checklists provided.**

Care planning and resource allocation

36. Care planning links the assessment of need to the provision of appropriate services. Just as there should be one Single, Shared Assessment summary, care planning should result in a single care plan. **Agencies should agree the relationships between assessment and**

⁴ Partnerships seeking information on the range of tools available publicly will find a useful resource at <<http://www.doh.gov.uk/scg/sap/toolsandscales>>

care planning, between care planning and the allocation of resources or provision of services, and who is responsible for undertaking each stage.

37. Single Shared Assessment should lead to a more holistic approach to service delivery and resource use. It complements joint resourcing and joint service management for older people, which is also due to start in April 2002. It will provide a more holistic approach to resource use generally, and access to integrated, devolved resources in localities. Until all these arrangements are fully in place assessors/care planners may have to approach service managers, within and across agencies, on the basis in place at present. **But if users are to get the value of Single Shared Assessment, agencies need to ensure that the relationship between holistic assessment and holistic resourcing is quickly established.**

38. Care planning should actively include people who use services and their carers in identifying ways of meeting needs. It should take account of the person's views and available resources. The person using services should agree the care plan and any financial contribution before it is implemented, and should receive a copy. The process should be clear and transparent.

39. There may be circumstances where the person does not have the capacity to consent to key aspects of the care plan, eg property, finances, medical treatment or personal care and welfare. If this results in dispute between family members or if the person is thought unlikely to comply with key elements of the care plan, consideration should be given to using appropriate powers in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Scotland) Act 1984.

Single, Shared Assessment and the Resource Use Measure

40. As part of the holistic approach to Single, Shared Assessment, we are developing a Resource Use Measure (RUM) to provide a standardised means of translating the outcome of an assessment into an indication of the resources to meet the person's needs. Thus, it will determine individuals' eligibility for free nursing and free personal care. More generally, at present people with the same needs may get very different levels of service depending on where they live. A key purpose of the RUM is, therefore, to bring about greater equity of provision for a given level of need.

41. The RUM will be designed to allow the categorisation of individuals into bands of need on the basis of information from the Single, Shared Assessment. Application of the RUM will allow comparison of the service inputs between levels of need, and between areas. Overall, it will be an indicator of how resources have been used. In aggregate form, it may also be useful for resource allocation. But it does **not** replace professional judgement of the most appropriate package of care to suit individually assessed needs.

42. The development of the RUM is described more fully in Part 4. We have considered carefully the time needed to transfer the information in the assessment to the RUM. It should take no more than a few minutes. The RUM represents a positive addition to the tools available to professionals and managers at all levels, and is an integral part of the Single, Shared Assessment framework.

Terminology

43. To avoid confusion and misunderstanding, agencies should review the terminology used locally and agree a common language to describe the assessment process and associated activities in community care .

**PART 2: IMPLEMENTATION OF SINGLE, SHARED ASSESSMENT
KEY STEPS**

PART 2: IMPLEMENTATION – KEY STEPS

1. Part 2 moves from what is ‘Single, Shared Assessment’ to the key steps that agencies together need to put in place to implement it. **The key message is that local authorities, health boards, NHS trusts and other stakeholders in community care need to move together to establish a local framework for Single, Shared Assessment.** Local authorities should provide a positive lead, but the emphasis is on joint ownership and delivery of the new arrangements. This will require commitment and leadership at all levels, and particularly from Directors and Chief Executives, to break down barriers to effective partnership working and to change cultures, roles and practices for the better.

2. The local framework should take account of the work already in hand on developing a Local Partnership Agreement for joint resourcing and joint management. To avoid duplication of effort the framework should build on existing arrangements for assessment and care planning where they reflect the key principles for Single, Shared Assessment. Good and promising practice is the basis for taking forward this guidance.

3. The local framework for Single Shared Assessment should set out:

- **joint working** arrangements based on a shared understanding and approach;
- **procedures** based on the key principles outlined at the start of Part 1, that ensure good standards of assessment for all service users and across agencies, leading to better results; and
- systems for **sharing information** between professionals and agencies in support of the Single, Shared Assessment process.

Agencies will need to put in place key steps in these three areas of activity to establish a local framework that will ensure effective implementation of Single, Shared Assessment, as set out in the rest of Part 2.

Joint working

4. The key steps under the broad heading of **joint working** are:

4.1 **Involve stakeholders:** Developing arrangements for Single, Shared Assessment should take account of the diversity of interests, including staff in health, housing and social work who will undertake or contribute to the assessment process; staff whose work will be affected by Single, Shared Assessment; and statutory and independent providers who will deliver the resultant care. Most importantly, people who use services, their carers and potential service users have a key role to play and should help shape the framework. That should include people with special needs and those from minority ethnic communities.

4.2 **Agree purpose and results:** The purpose and expected results of Single, Shared Assessment are set out in Part 1, but agencies may wish to clarify or develop these for local use. Stakeholders need to understand its aims and benefits if they are to be committed to it.

Setting milestones is essential: the expected results after 3 years should be a particular milestone.

4.3 **Agree underpinning values:** Agencies should draw up jointly a common set of values that are person-centred and include:

- listening to the views of people about their needs and wishes for care;
- empowering service users to make decisions about their care and the level of acceptable risk, and providing choice about how their needs should be met;
- ensuring that people being assessed have every opportunity to consent to the assessment process, its outcome and the plan for providing care, or that their interests are represented when informed consent is not possible;
- promoting individual health and well-being;
- promoting independence and care at home as far as is feasible and desired;
- recognising and supporting the contribution of family and other carers and ensuring their contribution and needs are considered either as part of the assessment of the cared for person, or as a separate carers' assessment using the Single, Shared Assessment approach; and
- valuing the contribution of different professionals and supporting them to meet the needs of people who use services and their carers.

4.4 **Agree roles, responsibilities and accountabilities:** The framework should set out the range of needs for which each agency is responsible under Single, Shared Assessment. It is also important to determine roles, responsibilities and accountabilities at an individual or team level so that staff are clear about what is expected of them. The framework should identify which staff will be involved in Single, Shared Assessment, their level of expertise and the type of assessment they may undertake. Some aspects to consider are:

- Who will be 'lead professional'?
- Who is likely to contribute to an assessment or to undertake specialist assessment?
- What role will staff in acute and other hospital settings play?
- Who are the key staff who will take forward the implementation?
- Are any new line management or reporting arrangements needed?

4.5 **Agree a plan for joint staff training and development:** The task of agreeing roles and responsibilities should identify staff who will require training in Single, Shared Assessment. There will be three main groups, each with different training needs:

- those involved as assessors and who will have varying levels of skill in assessment;
- those supporting assessors or the assessment process; and
- those referring people for assessment or providing services as a result of assessment (some being in independent agencies, and who need to know about the process).

4.6 We must emphasise the value of training being joint across agencies and disciplines, and plans should cover both staff development as Single, Shared Assessment evolves and training for new staff.

4.7 **Agree common terminology:** This small but important step is described in Part 1, para 43.

4.8 **Identify change leaders:** Advice earlier in this guidance suggests that agencies adopt a project management approach to implementation, and that positive leadership is essential to achieving the goals. Identifying change managers and leaders, and empowering and supporting them will be an important part of successful implementation.

Key Steps – Single share assessment process and procedures

5. The key steps for agencies in determining the **process** are set out below:

5.1 **Map and agree the process:** Agencies should map the pathways through the various assessment routes to indicate where systems and practices can be integrated. The joint map will be an aid to both people being assessed and staff in understanding the Single, Shared Assessment process. Most importantly, processes should start from the perspective of people who use services and focus on eliminating duplication of effort. The local framework should contain agreement on:

- **Publishing information** as part of a strategy to engage with people being assessed, their carers and staff. It can also contribute to case finding.
- **Referral and screening systems** that offer ease of access and transparent decision-making.
- **Levels and types of assessment**, their relationship to level and type of need, and the skills and qualifications of assessors appropriate to each level.
- **The use of the assessment tool** as an aid to information sharing and achieving good standards of assessment.
- **The application of the RUM** to ensure greater consistency between needs and services.
- **Care planning and co-ordination** that reflects the complexity of assessed needs and views of the service user but also takes account of available resources.
- **Reviewing needs** and the impact of services on needs, for everyone in receipt of a continuing service, to ensure that changing needs are met.

Beyond the process itself, agencies need to develop a number of complementary activities, as set out in the following paragraphs.

5.2 Agree the Single, Shared Assessment tool: Agencies have the choice of adopting the Carenap assessment tools, another appropriate published tool, or developing their own tool which they will validate against national standards, as described in Part 3. In making their decision they should weigh the practical effects of importing a ready-made tool against the likely timescale for the joint development of an acceptable local tool, in the context of an imperative to improve systems quickly.

5.3 Agree the use of the assessment tool: Agencies will need to agree the circumstances in which the tool is to be used and whether it may be used in part or as a whole, reflecting the different levels of assessment. **They will wish to identify the core information that should be recorded in the assessment tool in all Single, Shared Assessments, including the minimum core data set (Part 3).**

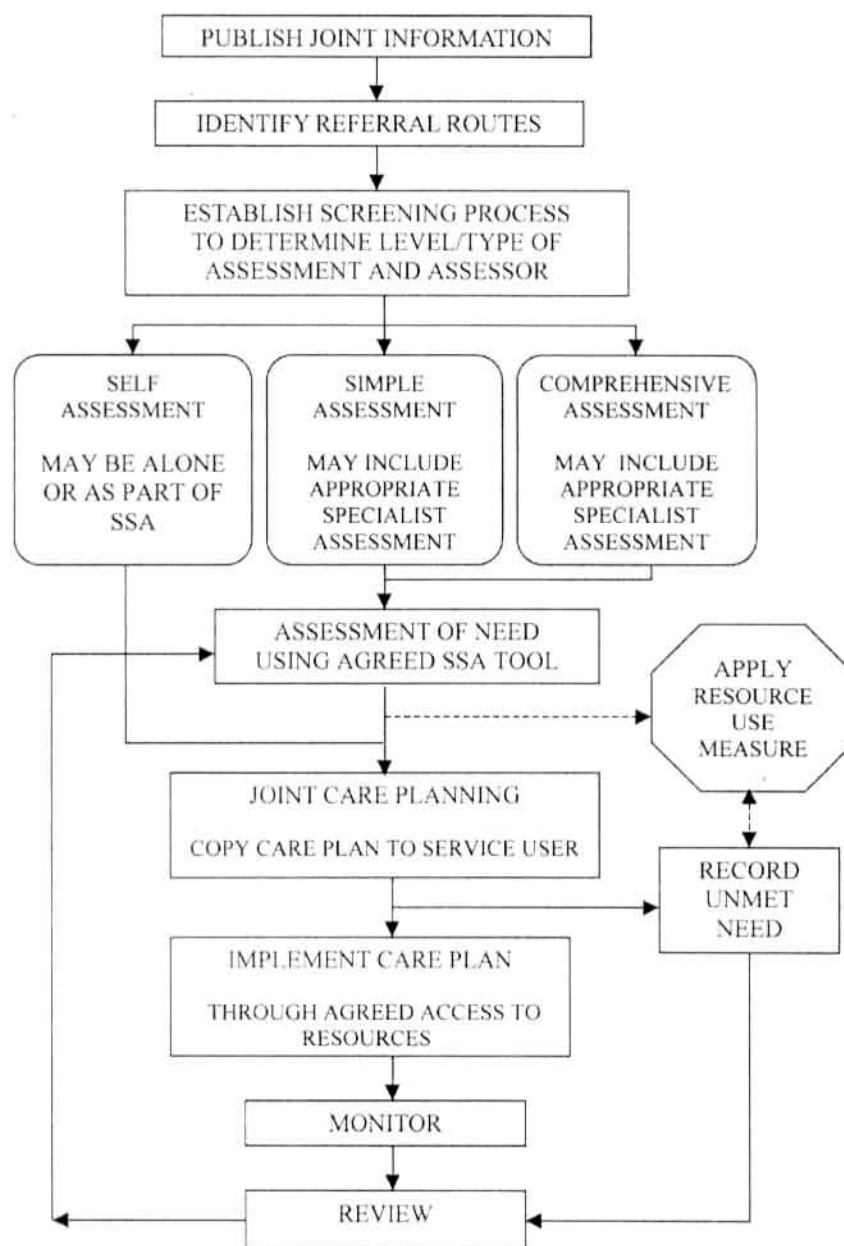
5.4 Agree the links to other specialist inputs and intensive care management: Agencies should agree the indicators or triggers to specialist inputs in health, social work and housing, and to 'Intensive Care Management'. The assessment tool should prompt assessors to consider the need for specialist input. Access to specialist assessment should be simple and direct, to minimise delays.

5.5 **Agree access to community care services:** Agencies should map the full range of services available through Single, Shared Assessment. They need to develop eligibility criteria for these services and the priorities for provision, and advise service users and staff accordingly. They should also agree procedures to access resources and services following assessment and developing a care plan, with appropriate staff training to that end. It should not be necessary for service providers to carry out further assessment; other than perhaps to seek information that will help them match resources to the person's needs.

5.6 **The key steps to implementing the Single, Shared Assessment process have been summarised in the process map – see Figure 2 below.**

Figure 2

SINGLE SHARED ASSESSMENT PROCESS MAP



6. The key steps to implementing **information sharing** are:

6.1 **Agree information requirements:** local agencies need an agreed common information set on people who are referred and assessed, whether or not they go on to receive services. Part 3 sets out a Minimum Standardised Assessment Data Set for Older People which agencies should use to underpin their local agreements. While some assessments may not require to cover all components of need, this Core Data Set should nevertheless form the basis of the assessment tool. Four core data sets are provided:

- personal information;
- assessed need (components of need);
- important medical conditions; and
- care plan.

6.2 To ensure that local agreements are soundly based, agencies will need to agree:

- what data items are available and what tools are in use locally that map to the Core Data Set in Part 3; and.
- a common format, meanings and definitions for common concepts and data items (e.g. through development of data standards, etc).

6.3 **Agree the protocol for sharing information collection, transmission, storage, access:** The Health Department will provide a national lead on information sharing and security. The Confidentiality and Security Advisory Group for Scotland (CSAGS) is committed to providing a general protocol on information sharing for local adaptation, by the end of 2001. Locally, developing an effective protocol is not just an editorial task, especially for practitioners. The discussions on what and how information is shared, processed and stored are crucial to developing the understanding and trust necessary to underpin Single, Shared Assessment. The national template will include material intended to support local dialogue. Meanwhile, good examples are already available⁵ for local agencies wishing to get ahead with scoping the task locally and building possible approaches for the future.

6.4 Joint working will lead increasingly to the need for joint approaches to information handling. CSAGS will consider possible shared approaches to ensuring comparable standards of information management and security between agencies. This may include the introduction of the Caldicott framework⁶, and/or the adapted version of the widely available NHS risk assessment framework, to social care.

⁵ See for example the reports on progress with work undertaken by Leeds CSSR/NHS IA at <<http://www.doh.gov.uk/confiden/protocols>>

⁶ For an outline of the possible initiative, see the English consultation paper and programme update at <<http://www.doh.gov.uk/nhsexipu/confiden/social/>>

6.5 **Agree systems and technologies:** Single, Shared Assessment needs to be underpinned by effective use of information and communications technologies, if the transmission, storage, and access to shared information is to be fit for purpose. Agencies should agree how to ensure rapid assessment and referral, 24 hours a day, 7 days a week. This agreement will translate into a joint action plan with agreed timescales.

6.6. For a number of reasons, agencies may find it advisable to take an evolutionary approach (on the basis of experience) to developing full Information and Communication Technologies (ICT) support. This includes:

- Recognising that the new tools for communication will involve a period of learning and experimentation as practitioners become familiar with them and the opportunities they provide. ‘Information-sharing’ as a necessary activity will develop and evolve over the foreseeable future.
- Making early, incremental progress, rather than waiting for a ‘Big Bang’ solution.
- Some pilot schemes are taking shape already under the eCare project.

An outline of the working assumptions, key principles, and strategic framework that agencies should work towards is set out in Part 4 - *Development of Information Systems*. That approach is already emerging in areas such as North Lanarkshire.

Self Assessment of Progress

7. In order to help agencies plan implementation, we have drawn up a self-assessment pro forma – which follows – showing progress and outstanding action (with timescales) for each of the key steps. As the guidance above recognises, not all of these elements have to be in place to enable Single, Shared Assessment to begin in April 2002. Information development in particular will be phased. The essence is to map out the expected pattern of implementation for local use. The charts will also help the Single, Shared Assessment Team in the Joint Future Unit in its discussions with agencies to support implementation.

8. The information in the pro forma is largely self-explanatory. **For the sake of completeness, it should record how key steps have been achieved, how progress to date has been developed, and how it is planned to address key steps not yet under way.**

PROGRESS ON IMPLEMENTATION: SELF-ASSESSMENT

Key Steps in Implementation: <u>Joint Working</u>	Achieved	Underway	To Begin	Action to be Taken	Timetable
Involve all stakeholders					
Agree shared values					
Agree common terminology					
Identify change leaders					
Agree roles, responsibilities, accountabilities					
Implement joint training plan					
Agree results at 3 years					

PROGRESS ON IMPLEMENTATION: SELF-ASSESSMENT

Key Steps in Implementation Assessment Process	Achieved	Underway	To Begin	Action to be Taken	Timetable
Agree referral and screening systems					
Agree types and levels of assessment					
Agree SSA process					
Agree SSA tool					
Agree use of SSA tool					
Agree links to ICM and other assessments					
Agree access to services					
Agree application of RUM					

PROGRESS ON IMPLEMENTATION: SELF-ASSESSMENT

Key Steps in Implementation <u>Information Sharing</u>	Achieved	Underway	To Begin	Action to be Taken	Timetable
Agree information requirements					
Agree information sharing protocol					
Agree information systems action plan					

PART 3: MINIMUM STANDARDS CHECKLISTS

PART 3: MINIMUM STANDARDS CHECKLISTS

SINGLE, SHARED ASSESSMENT – PROCESS, TOOLS AND CORE DATA SETS

1. To bring greater standardisation to the implementation of Single, Shared Assessment, to provide better results for people in need of community care, and to enable agencies to assess their own progress, we have developed:

- minimum standards checklists for the Single, Shared Assessment process and the assessment tool; and
- core data sets for collecting and sharing information.

2. These will not detract from the need for Single, Shared Assessment to be developed and owned locally, in which agencies will develop their own standards. But these minimum expectations represent a baseline.

3. The checklists on minimum standards for the assessment process and the assessment tool are applicable to all community care groups. But the core data set and guidance apply only to Single, Shared Assessment for older people.

4. Agencies should therefore assess jointly their systems and tools against the minimum standards, and draw up an analysis that identifies:

- What standards are and are not met;
- Steps to achieve standards not met;
- Evidence of how the consensus of all stakeholders is secured.

5. Full compliance is not necessary to implement Single, Shared Assessment from 1 April 2002. But agencies will need to demonstrate the extent to which they meet the criteria. This may, in turn, call for action early in 2002-03 to meet the desired standard.

1. MINIMUM STANDARDS CHECKLIST FOR THE ASSESSMENT PROCESS

The Single Shared Assessment process should meet a number of specific criteria, as set out below. The expected level of performance is shaded: the means of assessing appears against ‘How to measure’. The SSA should:

What is expected	Be applicable across health, social care and housing:
How to measure	<ul style="list-style-type: none"> • Are all parts of the Single, Shared Assessment process (as set out in the Scottish Executive guidance) agreed and in place? • Do local protocols include mechanisms for sharing and accessing relevant information as quickly and fully as possible? • Do local protocols contain clear agreement about accessing services? • Does the Single, Shared Assessment process prevent duplication of assessment across and within agencies? • Does the Single, Shared Assessment process recognise housing/accommodation needs as integral? • Are housing and accommodation needs identified, prioritised and met within the Single, Shared Assessment process?

What is expected	Enable the full range of needs to be assessed, including rehabilitation and specialist involvement:
How to measure	<ul style="list-style-type: none"> • Does local guidance facilitate different levels/types of assessment? • Are arrangements in place to allow for the integration of relevant single agency/professional assessments within the Single, Shared Assessment framework? • Does the Single, Shared Assessment process encompass all areas of need? • Are arrangements in place to measure and monitor progress towards better outcomes for people? • Are joint systems in place that will ensure the quality of the single shared assessment process e.g. standards, joint training and joint review mechanisms? • What triggers are in place to initiate rehabilitation services and specialist assessment? • What arrangements have been made to ensure that accommodation needs will be addressed as an integral part of the process?

What is expected	Be based on evidence that the Single, Shared Assessment process works effectively at the local level:
How to measure	<ul style="list-style-type: none"> • Does the Single, Shared Assessment process enable speedier responses to referrals? • Does the Single, Shared Assessment process enable speedier assessment (without compromising the quality of the assessment)? • Does the Single, Shared Assessment allow speedier access to services? • Have performance standards been set for response times? • Are people using services, including carers, being given the opportunity and enabled to comment on their experience of Single, Shared Assessment?

What is expected	Be applicable to all agency settings:
How to measure	<ul style="list-style-type: none"> • Have the views of assessors in all settings been asked for and taken account of? • Have assessors taken part in relevant joint training? • Are assessors competent and confident with their part in the assessment and are there mechanisms in place locally for assisting them e.g. professional supervision and/or joint peer group reviews? • Do people being assessed and their carers find the process appropriate and acceptable?

What is expected	Be facilitating, in which assessments of need are carried out as sensitively as possible, relevant, recorded in plain language and shared with the person:
How to measure	<ul style="list-style-type: none"> • Is the Single, Shared Assessment process culturally and ethnically responsive? • Is the Single, Shared Assessment process flexible and responsive to the person and their needs? • Does the Single, Shared Assessment process allow for self assessment where appropriate?

What is expected	Be enabling, in which the person's views are clearly expressed, listened to and taken into account in determining the outcome of the assessment:
How to measure	<ul style="list-style-type: none"> • Are the person's views and wishes paramount during assessment and care planning? • Are the people who receive services given a copy of their care plan which how their health, social care and housing needs will be met? • Is a summary of the assessment of their needs, agreed by the person, made available to everyone who undergoes single shared assessment? • Is the assessment either signed by the individual

What is expected	Determine and record (with signatures) the views of the person's carer:
How to measure	<ul style="list-style-type: none"> • Is the carer been offered a separate assessment of their own needs? • Are the views and wishes of the carer taken fully into account during the person's assessment and care planning?

What is expected	Involve an independent advocate where appropriate:
How to measure	<ul style="list-style-type: none"> • Are local advocacy services available, appropriate to the needs of different care groups? • Does the local guidance for assessors describe when it may be appropriate to involve an independent specialist or advocate? • Does the local guidance inform the assessor of the availability and use of advocacy services?

What is expected	Collect and document core data only once, with the assessment tool linking to the Resource Use Measure:
How to measure	<ul style="list-style-type: none"> • Does the process allow for the collection and updating of the personal information core data set (as set out in the Scottish Executive guidance) and ensure that it is shared between agencies with the person's consent? • Does the process allow for the collection of information about components of need (as set out in the Scottish Executive guidance)? • Are the characteristics required for the Resource Use Measure captured in the assessment process?

What is expected	Incorporate review mechanisms which accept and identify changes in need:
How to measure	<ul style="list-style-type: none"> • Does the Single, Shared Assessment process automatically trigger regular review dates identified by the assessor? • Does the local guidance identify who should be responsible for carrying out reviews?

What is expected	Record needs that cannot be met at the time of assessment together with the recording of the likely consequences:
How to measure	<ul style="list-style-type: none"> • What systems have been established to allow individual unmet needs to be prioritised and addressed? • Is information about unmet needs recorded and fed into the joint planning process?

2. MINIMUM STANDARDS FOR THE ASSESSMENT TOOL

The Single Shared Assessment tool should meet a number of specific criteria, as set out below. The expected performance is shaded: the means of assessment appears against 'How to measure'.

What is expected	Be used easily by practitioners across health, social care and housing
How to measure	<ul style="list-style-type: none">• Has the assessment tool been agreed by all agencies and checked against this checklist?

What is expected	Collect personal core data
How to measure	<ul style="list-style-type: none">• Does the assessment tool collect the range of personal core data (for older people) set out in Part 3 section 3?

What is expected	Collect information on the full range of needs
How to measure	<ul style="list-style-type: none">• Does the assessment tool collect the range of information on assessed need as set out in Appendix A3? (For older people)• Are there guidelines on agreed local indicators and access protocols for specialist involvement as part of (or alongside) the tool?

What is expected	Capture the characteristics required for the Resource Use Measure
How to measure	<ul style="list-style-type: none">• At this stage the Resource Use Measure is still under development

What is expected	Incorporate the signature/consent of the person consenting to the assessment
How to measure	<ul style="list-style-type: none">• Does the tool record the person's consent to the assessment?

What is expected	Incorporate the signature/consent of the person consenting to data being shared across agencies.
How to measure	<ul style="list-style-type: none">• Does the tool record that the person's consent to data being shared across agencies?• Is there an alternative system to ensure the person is not disadvantaged in the event of exercising their right not to consent to sharing information?

What is expected	Incorporate the views of the person's carer
How to measure	<ul style="list-style-type: none"> • Does the tool record that a separate carer's assessment has been offered?

What is expected	Prompt the practitioner to consider the involvement of an advocate
How to measure	<ul style="list-style-type: none"> • Does the tool record that the need for an advocate has been considered?

What is expected	Record the dates set for reviews
How to measure	<ul style="list-style-type: none"> • Does the tool provide evidence of recording due review dates?

What is expected	Capable of Recording unmet need
How to measure	<ul style="list-style-type: none"> • Does the tool evidence that unmet need and likely consequences are recorded?

What is expected	Inform a comprehensive care plan as detailed in the core data set
How to measure	<ul style="list-style-type: none"> • Does the tool inform the care plan as set out in Part 3, section 3?

3. MINIMUM STANDARDS CORE DATA SET (OLDER PEOPLE)

1. The minimum standards checklists in sections 3.1 and 3.2 for the Single, Shared Assessment process and development of the assessment tool respectively are for all care groups. The core data set checklists in this section have been developed specifically for use in Single, Shared Assessment of older people. There are 2 levels of application: the Personal Information, the Assessed Need and the Care Plan core data sets should be viewed as the minimum. That on Important Medical Conditions is a guide. (Similar data sets should be developed and agreed for Single, Shared Assessment for all other care groups in the course of 2002-03). It should be recognised that while the data set covers aspects such as ethnicity, individuals may not wish to divulge that information.

Standard Data Sets

2. The following minimum standard assessment core data sets should be the basis for a single summary assessment record. The use of the data sets will provide consistency across all local information systems. (This should in turn provide software developers with information on what they need to incorporate within electronic records and information systems to support the Single, Shared Assessment process.)

3. **The core data set is divided into 4 sub-sets, as follows :**

- **Personal Information Core Data Set**

Contains the personal information about the individual. Local agencies should agree any additional information to be collected, stored and made available to identified professionals in the NHSScotland and local authority services.

- **Assessed Need Core Data Set (Components of Need)**

Comprises all the components of need identified for the Single, Shared Assessment process. For “Clinical background” and “Disease prevention”, brief text should be entered, including a list of current medications.

- **Care Plan Core Data Set**

- Comprises a list of services **with coding** to show if the service is currently provided, the overall care aims, and the name of either the care co-ordinator or key worker. It should show the possibilities for meeting needs in the care plan, without restricting or inhibiting creative solutions to meeting needs.

- **Important Medical Conditions Guide**

Identifies and describes all medical and health conditions likely to require recognition in preparing a care plan. One approach could be a checklist of significant medical conditions and their current status as:

1. **Never experienced.**

2. **Experienced, but currently inactive.**
3. **Experienced and active, and subject to current treatment / intervention.**
4. **Experienced and active, but not subject to current treatment/intervention.**

PERSONAL INFORMATION CORE DATA SET

- | | |
|--|--|
| <input type="checkbox"/> Referral Source | <input type="checkbox"/> Current or previous occupation |
| <input type="checkbox"/> Family name and forenames | <input type="checkbox"/> Household composition |
| <input type="checkbox"/> Preferred Name | <input type="checkbox"/> Name of next of kin |
| <input type="checkbox"/> Present address and postcode | <input type="checkbox"/> Name and address of main carer |
| <input type="checkbox"/> Permanent home address if different | <input type="checkbox"/> Name of GP |
| <input type="checkbox"/> Unique Identifier | <input type="checkbox"/> Hospital in-patient admissions in past 12 months |
| <input type="checkbox"/> Date of birth | <input type="checkbox"/> Permanent or long-standing health conditions or disabilities |
| <input type="checkbox"/> Gender | <input type="checkbox"/> Current care provision, including specialist housing/accommodation. |
| <input type="checkbox"/> Ethnicity | <input type="checkbox"/> Signed permission to share with other agencies |
| <input type="checkbox"/> Religion | |
| <input type="checkbox"/> Preferred first language | |

ASSESSED NEED CORE DATA SET

COMPONENTS OF NEED

Service User's perspective

- Problems and issues perceived and conveyed by the person
- Person's expectations and motivation

Carer's perspective

- Problems and issues perceived and conveyed by the carer
- Carer's expectations and motivation

Relationships

- Family contacts
- Social contacts
- Leisure, hobbies, work, and learning
- Caring arrangements

Spiritual, religious, cultural matters

- Requirements for worship or other religious observation
- Special dietary needs
- Arrangements for provision of care (e.g. gender of carer)
- Ethnic issues

Risk and Safety

- Abuse and neglect
- Other aspects of personal safety
- Public safety

Immediate environment and resources

- Care of the home
- Daily tasks such as food preparation and shopping
- Housing and accommodation
- Housing support
- Heating
- Level and management of finances
- Access to local facilities and services

Personal care and physical well-being

- Personal hygiene, including washing, bathing, using the toilet, grooming
- Dressing
- Pain control
- Oral health
- Foot-care
- Skin care/Tissue viability
- Mobility
- Continence and other aspects of elimination
- Sleeping patterns

COMPONENTS OF NEED (CONTINUED)

Mental health

- Cognition and dementia, including orientation and memory
- Mental health including depression, reactions to loss, and emotional difficulties

Clinical background

- History of medical problems
- History of falls
- Medication use and ability to self-medicate

Disease prevention

- History of blood pressure monitoring
- Nutrition
- Vaccination history
- Drinking and smoking history
- Exercise pattern
- History of cervical and breast screening

Senses

- Sight
- Hearing
- Smell

Communication

- Speech
- Language
- Understanding

CARE PLAN CORE DATA SET

- | | |
|--|---|
| <input type="checkbox"/> Support from family or other carers | <input type="checkbox"/> Dental services |
| <input type="checkbox"/> Home care – domestic help | <input type="checkbox"/> Ophthalmic services |
| <input type="checkbox"/> Home care – personal care | <input type="checkbox"/> Befriending, counselling and support |
| <input type="checkbox"/> Home care – social support | <input type="checkbox"/> Accommodation/Housing |
| <input type="checkbox"/> Housing support | <input type="checkbox"/> Attendance at day centre |
| <input type="checkbox"/> Visiting nurses | <input type="checkbox"/> Attendance at day hospital |
| <input type="checkbox"/> Delivered meals | <input type="checkbox"/> Attendance at out-patients clinic |
| <input type="checkbox"/> Equipment/adaptations | <input type="checkbox"/> Transitional care in hospital or care home |
| <input type="checkbox"/> Respite care at home | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Respite care in a care home or other setting away from home | <input type="checkbox"/> Chiropody |
| <input type="checkbox"/> Other temporary stay in a care home | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Permanent care home admission | <input type="checkbox"/> Speech and language therapy |
| <input type="checkbox"/> Nutrition/dietetics | <input type="checkbox"/> Psychology |

IMPORTANT MEDICAL CONDITIONS CORE DATA SET

Heart / circulation

- CVA (stroke)
- Congestive heart failure
- Coronary heart disease
- Hypertension
- Pulse irregularities
- Peripheral vascular disease

Musculo-skeletal

- Hip fracture
- Arthritis
- Other fractures
- Osteoporosis
- History of falls

Sight

- Cataract
- Glaucoma
- Other sight diagnoses

Mental health

- Depression
- Schizophrenia
- Hallucinations
- Delusions
- Other mental illness

Neurological

- Alzheimer's
- Other forms of dementia
- Head trauma
- Hemiplegia / hemiparesis
- Multiple sclerosis
- Parkinson's disease

Infections

- Pneumonia
- Tuberculosis
- Urinary tract
- MRSA
- Hepatitis
- Other chronic infections

Other diseases

- Cancer
- Diabetes
- Emphysema
- Asthma
- Renal failure
- Thyroid disease
- Other

PART 4: TECHNICAL DEVELOPMENTS

PART 4: TECHNICAL DEVELOPMENTS

4.1 DEVELOPMENT OF THE RESOURCE USE MEASURE

1. The role of the Resource Measure is described in Part 1, paras 40-42. This annex reports progress on its development. The project is in its second development stage (see below). We are currently working with 9 health and local authority areas on potential models, following which we will be piloting one Resource Use Measure across Scotland, from December 2001. The application of the RUM will depend upon information obtained in the Single, Shared Assessment, and it is therefore imperative that these processes are developed alongside one another.

2. Objectives:

- To develop, test and pilot a national Resource Use Measure, which will be cost effective, (adding no more than about 5 minutes to the Single, Shared Assessment process);
- To identify a limited and consistent set of data on needs and dependency characteristics from the Single, Shared Assessment for the RUM;
- To apply **one** RUM across Scotland from April 2002.

3. First Development Stage:

- The first stage (between April and August 2001) consisted of working with practitioners, taking a case study approach, in 4 multi-agency teams to develop and adapt 2 Resource Use Measure approaches derived from the Scottish Care Resource Utilisation Groups and Isaacs and Neville's Intervals of Need. As well as working in their local areas, practitioners have participated in workshops aimed at ensuring the RUM questions are appropriate and meaningful.
- Three workshops have been held. The first to clarify changes to the variables developed from individual teams; the second focused on the variables in relation to mental health; and the third addressed questions on clinical needs. The revised schedules are being tested and refined during the second developmental stage.
- We have developed the analytical framework in consultation with practitioners to identify the key characteristics that will determine the relative resource use for personal and nursing care.

4. Second Development Stage

- This stage applies and further refines the adapted RUMs to a greater number of assessments by increasing the number of health and local authority areas participating from 4 to 9. This will provide the data for the statistical analysis.
- Practitioners have been provided with the revised schedules and care resource proformas, and guidance on their completion (including issues such as confidentiality).

- The format and application of the RUM will be demonstrated to practitioners through sample assessments and care plans. Each team will then work on a further 20 or so cases on their own.
- Practitioners send completed questionnaires and proformas to ISD. ISD will report back. At the end of the second stage, a report analysing all returns will be provided to each practitioner taking part.
- The report will include recommendations for the piloting and continued testing of a single RUM comprising the most relevant variables and elements of the 2 models.
- Consultation workshops will seek to obtain consensus on the variables to be applied in the pilot stage.

Final Modelling

March 2002.

Commencement

April 2002.

4.2 INFORMATION SYSTEMS DEVELOPMENT

1. Single, Shared Assessment will achieve its full potential if supported by integration of information systems and the availability of agreed data sets between the partners.
2. We are developing overarching proposals for the integration of health and social care systems to be agreed by partner agencies during 2002. This work is taking place under the auspices of the Modernising Government Fund in support of the Joint Future Group's recommendations on information sharing.
3. The proposals now being developed provide for Single, Shared Assessment. However, we are taking care to ensure that these proposals will act as a catalyst for community care systems integration generally.
4. Our proposals are based on early learning of the eCare project and Perth and Kinross' 'Care Together' (Health and Social Care Co-operative) initiative. We will consult on them early in 2002.
5. At a technical level our thinking to date involves –
 - The focus being on the step by step deployment of Information Communication Technology (ICT), not the wholesale replacement of existing IT systems.
 - The development of "shared stores" for client information, which provide a safe, half-way house for the exchange of agreed information.
 - The format for the information exchange will be based upon generally available standards known as "XML Schemas"
 - The extension of the latest NHSScotland applications and technologies (such as the Scottish Care Information products) to support, for example, referral and assessment processes.
 - All of this being enabled by an approved mode of connection between partners' electronic networks.
6. Consultation will take place at national and local level during Spring 2002. There are a number of preparatory tasks that can be undertaken locally by the partners now, including the development of information sharing training and protocols. A generic information sharing protocol commissioned by the Joint Future Group and the Confidentiality and Security Advisory Group for Scotland (CSAGS) will be available for adaptation by local partners, by January 2002.

4.3 CARENAP E ASSESSMENT TOOL

A multi-disciplinary needs assessment tool

1. The Care Needs Assessment Package for the Elderly is a comprehensive, multi-disciplinary assessment tool that adopts a needs-led approach to assessment on an individual and a community level. It provides assessors from a range of health or social care backgrounds with a common language, facilitating inter-agency collaboration in the assessment and co-ordination of care for older people. It provides baseline information for practitioners undertaking specialist assessments and leading to comprehensive assessment. Assessors have begun accessing services across professional boundaries using Carenap E as a form of 'service passport'. (A similar tool 'Carenap D applies to people with dementia).

The design

2. Carenap E is an evolution of the Carenap D assessment framework. Carenap E was developed, piloted and evaluated by a multi-disciplinary group in Southwest Glasgow, in conjunction with practitioners in health and social work. The tool has proven to be reliable with an acceptable degree of validity. As part of the implementation of Single Shared Assessment the practitioner group will continue to review Carenap E and further develop the tool.

The package

3. ***The document:*** Carenap E consists of two main parts – a basic information sheet and the person's assessment. The format for recording perceived need and professionally defined need is mainly 'tick box' but with space to create an 'open picture' of the person being assessed. Needs are recorded as 'No need', 'Met Need' or 'Unmet Need' and interventions can be recorded in language that is not specific to services.

The software: A software package allows the storage and manipulation of data regarding individual and corporate need. Work is being undertaken to ensure Carenap E software is compatible with the main social work services and primary care information technology systems. A range of computer generated reports is available.

The training: A complete manual is available to assessors and each Carenap E document includes assessor notes. Training is provided before use.