

PART I

WHERE IT ALL BEGAN

1

THE UK POLICY CONTEXT

INTRODUCTION

The UK policy context has changed considerably over the years since the inception of the National Health Service and Social Services. In the last ten years devolution has influenced health and social care policy through devolved governments' need to provide tailor-made services that satisfy the needs of their citizens or customers. For example, in Wales the focus is on inequalities in health and the understanding that health is not just health service business but also the responsibility of individual lifestyle and economics. The Welsh Assembly Government (WAG) solutions to these problems are increasingly influenced by European welfare policy. Policy diversity across the UK is therefore inevitable and it's important that practitioners and students are aware of these differences in practice.

This chapter outlines the UK policy development and context for Sharing Assessment information within and across agencies throughout the UK. It also includes reference to the devolved health and social care policies of the Scottish Government and the National Assembly for Wales. These tailored policies – in addition to those published by the Department of Health (DoH) – serve to meet the needs of differing populations and cultures within the UK today.

Chapter Aims

The aims of this chapter are:

- To introduce the reader to the idea of sharing assessment information and its principles, for example person-centred care.
- To introduce the reader to the concept of assessment.
- To introduce the reader to the role of the carer within these standardised frameworks for assessment.
- To introduce the reader to drivers such as demography, legislation and evidenced policy. Diversity is acknowledged through reference to some of the many policy documents that are found within the devolved public services in Wales and Scotland.

WHAT IS ASSESSMENT?

Before we can discuss sharing assessment information we need to clarify what we understand by assessment itself. Assessment is a set of complex tasks that requires us as either individual health or social care professionals to acquire, develop and maintain our needs for specific knowledge and skills throughout our professional careers. The knowledge and skills required are those which are both profession specific (e.g., models, theory, physical examination, measurement) and generic (e.g., communication skills, listening and observing). These are essential parts of the assessment experience, which are dictated by the service user's context and needs (Armstrong and Mitchell, 2008).

What is assessment? Think about the many times that you've been assessed in a health or social care context, when were they?

You may have thought of ... The time when you've visited the GP, the midwife when you were born or having your own children, the health visitor when you were a baby or young child, the school nurse when having a vaccination, the occupational health team when you gained employment, etc. The truth is that we experience assessment many times throughout our lives and each one of those professional groups, in addition to others, such as the social worker, the physiotherapist and occupational therapist. They assess in different ways, gathering and using both subjective and objective information and guided by theories and models taught specifically within their undergraduate and postgraduate professional curricula and the speciality within which they practice.

Activity

Adams (2007: 283) states that the

aim of assessment is to make a judgement about a person's situation and needs.

Coulshed and Orme (1998: 21) some time ago defined assessment as

an ongoing process, in which the client participates, who's purpose is to understand people in relation to their environment; it is a basis for planning what needs to be done to maintain, improve or bring about change in the person, the environment, or both.

Grossman and Lange (2006: 77) more recently saw that

a decision for nursing care evolves from the nursing assessment, which includes not only what the nurse observes but also the nurse's ability to perceive what might be actually 'going on' in a person's life. If the nurse had more knowledge regarding the person's circumstances and potential challenges, he or she would be able to ask questions that would be most valuable in performing a holistic assessment.

For many of us assessment is a condition of our registration but what's the purpose of assessment? Think about those times that you were engaged in an assessment either as a service user or the assessor. Why did you participate in the act of assessment?

You may have thought of ... To solve a problem (e.g., difficulty breathing or inability to prepare a meal), to meet a need (e.g., to breathe with ease or to ensure adequate nutritional intake), to ensure that a person received a service to meet a need or a number of needs, to avoid a risk(s) to independence, to manage risk(s), to gain a nursing or medical diagnosis, to gain a whole picture of an individual's behaviour.

Activity

The quality of the judgement made by the professional is dependent on the quality of the assessment and whether or not the information gained within it is reliable. Likewise the quality of the subsequent care plan and the ability of the care plan to meet the agreed service user outcomes are dependent upon the quality of the knowledge gained and whether the right questions are asked within the assessment. Hence the assessment, the 'How', 'Why', 'What' and 'When' type of questions professionals ask within it, are important aspects in ensuring that the right information is gained to build an accurate picture of need, an appropriate care plan, treatment or care package with achievable outcomes.

What sources of information do we use to build an accurate and reliable assessment?

You may have thought of ... The service user, the carer, other key people in the service user's life, current and previous records, assessments from other professionals past or present and, depending on where you work, information from other agencies such as the police, ambulance personnel and of course witnesses, e.g., of an accident or a fall.

Activity

Assessment involves key people such as a service user and/or a professional in the process of gathering reliable information in order to make judgements as to a person's needs, in respect of their health and wellbeing, situation or environment. These judgements then facilitate action that may make change possible or maintain the desired status quo.

SHARING ASSESSMENT INFORMATION

Sharing assessment information is a fundamental part of the UK modernisation strategy and will enable public services to deliver individual assessment in the twenty-first century.

Why do we need to share assessment information? Think about the times when you've participated in an assessment with a person.

You may have thought of ... The service user has a lot of problems and a lot of needs, which require the skills from different professionals and at times different agencies. Therefore, working closer together may mean that we can solve more problems through utilising each other's knowledge and skills. This could mean shorter hospital stays, more timely treatment and care, and increased satisfaction for the service user and staff.

There are many good reasons for professionals to share assessment information but the most fundamental is the need for service users to feel that they are not repeatedly asked the same questions. The act of dovetailing the assessments to avoid repetition and duplication will in time lead to a seamless, effective, efficiently delivered, accurate and timely assessment. This should then lead to the planned treatment and care, which meet identified and agreed outcomes for an increasing number of people who have complex needs.

What do we mean by an increasing number of people who have complex needs? Think about your practice, whether in hospital or in the community. What is significant about the population of patients or service users you encounter on a day to day basis?

You may have thought of ... The population is getting older, there are an increasing number of people who, dealing with one long term condition may as they get older, have several. In addition to that a person may experience frailty. This may lead to an individual requiring more than one need to be met at the same time – which can't be satisfied by the skills of one professional – and so it demands a different approach to care. For definitions of 'need' see Chapter 2.

DRIVERS FOR SHARING INFORMATION

The UK population is growing quickly at an annual growth of 0.7 per cent. It is projected to reach 71 million by 2031 due to more births than deaths and an inflow of immigrants. In addition, our population is growing older with those over the age of 65 years increasing to 22 per cent of the population by 2031 (Office of National Statistics (ONS), 2007). Children born in the UK in 2006 would expect (on average) to live to 76.9 years (boys) and 81.9 (girls) years. As a result, the chances of a child born in the UK in 2006 reaching 65 years is projected at 91 per cent for boys and 94 per cent for girls compared with 74 per cent for boys and 84 per cent for girls born in 1980–82.

However, while women live longer they can also expect to spend more years in poor health and with a disability. Chronic diseases such as diabetes, heart disease,

stroke and back problems are common in older age but arthritis and rheumatism are the most common. As we get older, we experience increasing numbers of chronic diseases which then impact on our ability to live our lives as we would wish (ONS, 2006).

So it's inevitable that in the future, individuals will need to access primary, acute and community care services (in proportion to need) in order to be as independent as possible. In accordance with the UK Census in 2001, the proportion of the population reporting a long term illness or disability increased with age, especially those over 90 years of age (ONS, 2001). Many (85 per cent), who reported their health as not so good also reported having a limiting long term illness or disability. Of those people consulting their GP in 2001–02, 40 per cent were over the age of 65 years (ONS, 2004).

Therefore, staff will need to engage with one another within and across agencies to fulfil the needs of those most vulnerable people. Unfortunately, staff working across health and social care services often feel confused about the policy, law and guidance available that should enable them to comfortably share information with colleagues when working in the service user's best interests.

Can you think of the policies, law and guidance which influence your everyday practice when sharing assessment information?

You may have thought of ... The National Service Frameworks, NHS and Social Service strategy documents, the Data Protection Act 1998. At this stage you may also wish to consider your own professional code of practice or conduct. What does it say in relation to sharing assessment information? See 'Further Reading' at the end of this chapter.

Activity

PERSON-CENTRED CARE

In 2001, the Department of Health (DoH) published the *National Service Framework for Older People*. It is a ten year strategy which was linked to the *NHS Plan* (DoH, 2000) and *Modernising Social Services* (DoH, 1998). Their principles of universal care based on individual need are delivered within the National Service Framework for Older People (DoH, 2001a). Its eight standards within chapter two form an expectation that we as practitioners will link assessed individual need to services which promote health and independence, fairness, dignity and respect. It is acknowledged that as we age we may have more complex needs and require the assessment and intervention of more than one professional and agency. Therefore, in order to avoid duplication and wasted effort we need to work together to provide 'seamless care' for service users. Standard Two 'Person-Centred Care' (DoH, 2001a: 23) requires that the

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the Single Assessment Process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

The principles of person-centred care are individuality, choice and equity of access. The standard clearly makes the link between the act of individual assessment (the professional judgement about the knowledge gained from the service user) and the contracted provision of individually chosen services. Therefore the accuracy of individual assessment, the service user participation within the assessment process, and how we collect and use the information can have a direct impact on why and how we develop services now and in the future. This in return affects an individual's choice of services.

However, person-centred care requires both health and social care services to work in such a way that the exchange of information, the act of joint assessment and the provision of services are such that the service user with complex needs (and carer) feel that they are the centre of the act of care and treatment. The service user is an active participant within the assessment process that will improve a person's quality of life (Adams, 2007). Standard Two is directly linked to the original document 'Essence of Care' and its revised guidance and benchmarking tool (DoH, 2001c; 2003a). This takes a person-centred approach to promoting best practice across health and social care services.

Informing Practice

What does the NSF (DoH, 2001a) Standard Two say about the Single Assessment Process?

It says that the SAP is a standardised assessment process which crosses both health and social care agencies. It should raise standards of professional assessment practice through the identification of shared principles. It should also promote a more rounded assessment for older people which may occur at differing levels depending on individual need. The storing and sharing of information across agencies should be in a logical and systematic fashion while complying with the Data Protection Act 1998 and confidentiality.

Informing Practice

What if I work in another part of the UK, do I use the NSF (DoH, 2001a) to guide my practice?

The 'National Service Framework for Older People in Wales' was published by the Welsh Assembly in 2006. It followed and is driven by the publications of *Strategy for Older People in Wales* in 2003, *Designed for Life* (WAG, 2005) and *Fulfilled Lives, Supportive Communities* (WAG, 2007b). The ten standards within the *National Service Framework for Older People in Wales* also has a Standard Two called Person-Centred Care which requires that

Health and social care services treat people as individuals and enable them to make choices about their own care. This is achieved through the unified assessment process, integrated commissioning arrangements, the integrated provision of services and appropriate personal and professional behaviour of staff.

You would probably agree that it is very similar to the DoH Standard Two. However, the difference can be seen in the WAG Standard Two placing further emphasis on relationships between service user and professional in the context of a whole system of service delivery. This standard is also directly linked to the 12 'Fundamentals of Care' (WAG, 2003), which strengthens the significance of communication, information, dignity, respect, choice and promoting independence.

In Scotland, the Better Outcomes for Older People: Framework for Joint Services (The Scottish Government, 2005a) Part 1 Action 5 states that local partnerships should develop joint services that:

- support the person-centred approach;
- focus on improving outcomes for older people; and
- are based on the whole system approach.

These are seen as the key principles which underpin the design of joint services that deliver Single Shared Assessments in Scotland.

Informing Practice

Those policy documents were published a long time ago. Is there any evidence that this approach works and it's what people want?

Hardy et al. (1999) found in their study of 'Dimensions of Choice in the Assessment and Care Management System' that there was a big gap in the service user and carer desire for involvement and the reality of practice. They interviewed 28 service users, 20 informal carers and 72 care managers in four local authorities in England. More recently, in 2006 the Commission for Healthcare Audit and Inspection undertook a whole systems review of services for older people in England (40 NHS Trusts and 10 local authorities) with research of older people's views on the local services through methods such as focus groups and surveys. Two key aspects which need continued and further attention are:

- 'The full implementation of SAP and the need for older people to have a copy of their assessment and care plan' and
- 'A change in culture is required', moving away from services being service-led to being person centred, enabling older people to have a central role in designing their own individual care and in planning the range of services that are available to all older people. (p. 9)

Also, in 2006 Age Concern undertook nine focus groups to ask what did older people want from community health and social services. They discovered that older people have wanted 'a joined up health and social care service', to identify and meet the needs of carers, to make services personal and holistic. The policies and their standardised frameworks (discussed within this book) aim to promote the sharing of information in order to help meet what people with complex needs (whether young or old) want from their health and social care services. Nevertheless, there are key aspects of the law which we must consider before we explore and apply this information to practice.

THE LAW

The Data Protection Act (1998) and the Human Rights Act (1998) provide the legal and ethical parameters within which we can share information across agencies and develop information-sharing protocols within which we can safely and comfortably work. An information-sharing protocol is a formal agreement between organisations that share personal information. It sets out the rules and standards for the safe and timely sharing of the information. It states what information can be shared and explains how it can be collected and shared between the organisations involved (Department for Constitutional Affairs, 2003; WAG, 2006d). In Wales, there are two parts to the Wales Accord on the Sharing of Personal Information (WASPI), the Accord (a regional document) and the Personal Information Sharing Protocol (PISP) (a local agreement). The Accord is the common set of principles and standards that organisations agree to operate within and the PISP is the agreement on the detail of the information to be shared, the 'who, why, where, what, when and how of information sharing'.

Informing Practice

What has the Human Rights Act (1998) got to do with information sharing?

Article 8 of the Human Rights Act is the right to respect for private and family life, home and correspondence.

This automatically creates a right to respect for privacy. This means that any interference must be in accordance with the law, national democracy or a 'legitimate' reason, e.g., while acting for the protection of an individual's health.

Therefore an individual has a right to have his or her personal information respected as private.

Informing Practice

So where does the Data Protection Act (1998) fit in?

The Data Protection Act (1998) provides the legal framework within which professionals can handle a service user's personal information. It has eight principles which state that all data must be:

- 1 Processed fairly and lawfully.
 - 2 Obtained and used for a specified and lawful purpose.
 - 3 Adequate, relevant and not excessive.
 - 4 Accurate and kept up to date.
 - 5 Kept for no longer than is necessary.
 - 6 Kept secure.
 - 7 Only transferred to other countries which have adequate data protection.
 - 8 Processed in accordance with individual rights.
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So, in order to share information from primary to acute services (for example in the form of a consultant referral) or referral from acute health care to social care services (for example when planning patient discharge), practitioners need to gain consent from the service user. This provides an opportunity to reduce duplication through not having to ask the service user repeated questions in relation to his or her needs and care.

Take a look at Appendix 5 and the example of the 'Consent to Share' in Booklet 1, which demonstrates the lawful practice within this context. This, in addition to the organisational arrangements for sharing information (DCA, 2003; WAG, 2006d), ensures that staff working within the organisations are doing so lawfully in the confines of the Human Rights Act (1998), the Data Protection Act (1998) and the common duty of confidence. Practitioners should ensure that they obtain consent after they have informed the service user of the reasons for obtaining the consent and sharing the information with other agencies. The law of Tort gives a service user an opportunity to seek damages should he or she have experienced a breach of confidentiality. Should the service user be unable or refuse to give consent then this should be honoured and documented with the service user's reasons for refusal (Data Protection Act, 1998). The Consent to Share Information document in Appendix 5 also asks the service user for consent to share information about the assessment, condition or treatment with relatives. This further demonstrates a service user approach to consent which reflects what's required by law and helps professionals gain clarity about the service user's relationships in practice.

CARERS AND STANDARDISED ASSESSMENT FRAMEWORKS

The law has changed considerably in recent years in respect of Carer's legal rights. This isn't surprising since illness has a considerable impact on individuals and their families or friends who care for them. The Census in 2001 stated that 11.7 per cent of the people of Wales and 9.9 per cent of people in England provided some unpaid care. Some 90,000 people in Wales (3.1 per cent of the population of Wales) said that they provided more than 50 hours per week of care to an individual. In Scotland the Scottish Household Survey (2006) demonstrated that between 12–14 per cent of all households in Scotland contains an adult who provides some form of unpaid care and over 1/3 of those carers are over 60 years of age.

Carers often balance work life, family life and caring. They require flexible working. For employees who have been working for their employer for 26 weeks or more, the Work and Families Act 2006 gives parents of children under six years and disabled children under 18 years the opportunity to change their terms and conditions.

What do we mean by a carer? Think about your own role within your family, do you undertake a caring role? What type of role is it? What tasks do you undertake? How would you describe yourself in that context?

Activity

You may be ... a mother, daughter, father, son, brother, sister, next door neighbour and not consider yourself as a carer.

Ask yourself if any of your family members consider themselves as carers or do you consider them as fulfilling the role of a carer?

The Carers (Recognition and Services) Act 1995, covering England, Scotland and Wales, defined a 'carer' as someone providing 'a substantial amount of care on a regular basis'.

The Princess Royal Trust for Carers' describes a carer as

someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. The term carer should not be confused with a care worker, or care assistant, who receives payment for looking after someone.

While The Work and Families Act 2006 defines a carer as

someone who cares for, or expects to care for, a husband, wife or partner, a relative such as a child, uncle, sister, parent-in-law, son-in-law or grandparent, or someone who falls into neither category but lives at the same address as the carer.

Unfortunately, this doesn't acknowledge the role of the carer who works but looks after a relative who lives independently in his or her own home but needs daily or more attendance for medication prompting, washing/bathing, meal preparation or cooking, cleaning and emotional support due to illness and frailty.

In 1999, the Department of Health carer's strategy *Caring about Carers* acknowledged the enormous and selfless part that unpaid carers play in helping people to stay in their own homes. It recognised that carers wanted to have confidence that services would promote the wellbeing of those they cared for, while also having their own needs heard in order to maintain their own health. The interim report on the review of the strategy, *New Deal for Carers*, has since found that our care for carers has much scope for improvement. Predominantly, carers 'live in a knowledge vacuum' without 'digestible' knowledge and that there is a lack of service coordination centred on carers' needs (DoH, 2007a). More recently, the DoH (2008a) has published its new carers ten year strategy, which tries to address these issues by respecting the carer as the 'expert care partner' and attempting to protect the life balance of working, living and caring. It is going to achieve this through the provision of breaks from caring, annual health checks for carers, providing emotional support and training to strengthen the caring role and to increase skills and confidence to return to the workplace when required. The DoH (2008a) has committed itself to agreeing a standard definition of caring across government and to also provide training to ensure that staff within the public sectors have the knowledge to provide better services for carers.

Informing Practice

What about carers in Wales and Scotland?

The Carers Action Plan (WAG, 2007c) ties in with the Welsh health and social care strategies 'Designed for Life' (WAG, 2005) and 'Fulfilled Lives, Supportive Communities' (WAG, 2007b) and provides services with milestones to achieve for health and social care communities. These include a carer's minimum dataset to provide local management information, which will help to identify what services carers need, e.g., respite and training.

The Scottish Government has many publications in respect of health, wellbeing and their care of carers. From the 1999 *Caring for Carers* strategy onwards to published research findings and guidance, they all acknowledge the important role of the carer and the need for assessment. In Scotland, the Community Care and Health (Scotland) Act 2002 recognised unpaid carers as key partners in the provision of care, and entitled them to an assessment in their own right.

The standardised assessment frameworks such as the Single Assessment Process (SAP) (DoH, 2002), the Single Shared Assessment (SSA) (Scottish Executive, 2001a) and Unified Assessment (UA) (WAG, 2002) give carers an opportunity to be heard and have their needs considered through a carers assessment. This is increasingly important as increases in healthy life expectancy fail to keep pace with total life expectancy and the pool of carers is expected to diminish in the forthcoming years (King's Fund, 2006; WAG, 2007c). Chapter 3 in this book will give you further insight into an individual's need for a carer's assessment.

Informing Practice

What about the law in respect of a carers assessment and how is it linked to the standardised assessment frameworks?

The Carers (Recognition and Services) Act 1995 gave carers the right to request a local authority assessment of their own circumstances and needs arising from their role as a carer. However, they weren't entitled to specific services in their own right. The entitlement depended on the service user receiving care having had an assessment of his or her own needs. Following this, The Carers and Disabled Children Act 2000 allowed carers to receive services in their own right. However, The Carers (Equal Opportunities) Act 2004 in England and Wales required councils to inform carers of their rights to an assessment, and also to promote better joint working with other public bodies (such as education, housing or health bodies) to ensure support for carers was delivered in a logical way.

THE POLICY RATIONALE

As governments in the Western world predict what and how the effects of chronic disease and an ageing population will have on our health and social care services,

integrated care policy has been identified as an important part of managing these challenges that will present themselves in the future (Billings and Leichsenring, 2005). In 2008 the DoH launched its Integrated Care Pilot Programme to explore the development, provision and outcomes of integrated care models in the future (DoH, 2008c).

Informing Practice

What do you mean by integrated care?

There have been several definitions of integrated care but Lloyd and Wait (2005) offer a definition that puts the individual patient perspective at the centre of care and suggests an organisational and cultural change in service delivery.

Integrated care seeks to close the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless. (p. 7)

Leutz (1999; 2005) continues to differentiate the 3 levels of integration as 'linkages', 'coordination' and 'full integration'. 'Linkages' suggests that the service user's transition from one service to another occurs through referral and follow up. However, it is dependent upon individual professionals within that system recognising different needs and knowing which other professionals and services (within different systems) to refer to in order to meet the service users needs. Linkages are used for individuals and populations that have mild to moderate needs.

Coordination of services recognises that processes, systems and relationships are required to be in place when an individual faces a crisis and doesn't have the ability to self manage or the family support to do so on the individual's behalf. 'Coordination' is appropriate for those people who have moderate or severe stable conditions and who receive routine short term or long term services.

'Full integration' suggests that close collaboration is required for usually a small amount of people. This is used for service users with moderate to severe conditions which are unstable.

In order to manage the assessment of increasing numbers of older people and people with long term illnesses and disability, professionals have started to modernise their approach to assessment and the way in which they ensure proportionality of assessment and to share their assessment information across professional groups and agencies. This approach utilises the three levels of integration (Leutz, 1999; 2005) and the concepts of identifying individual and population need and outcomes. These are also concepts which transcend many of the policy initiatives within the UK today, for example managing long term conditions (WAG, 2007d; DoH, 2008b)

Identifying individual needs and outcomes through assessment integration has formed a particularly important part of the UK integrated health and social care policy agenda during the beginning of the twenty-first century. These standardised assessment frameworks, such as the Single Assessment Process (DoH, 2002), Single Shared

Assessment (2001) and Unified Assessment (2002) promote an opportunity for the integrated commissioning arrangements and integrated provision of services between health and social care agencies when meeting the needs of people who have unstable moderate to severe conditions (DoH, 2007b). To a certain extent, whole system's theory (Bertalanffy, 1968) and Leutz's (1999; 2005) six laws of integration have formed the basis of the policies which support this new way of organising and sharing assessment information throughout the UK. Check out Chapter 2 for further information on Leutz's levels of integration and what they mean in practice.

Informing Practice

I hear a lot of people mentioning whole systems theory – what does this mean?

'The whole is greater than the sum of its parts' is a well known quote which derives originally from Bertalanffy's 1968 whole system's theory. The idea is that a system (such as a health or social care system) is a whole living entity which adapts and survives by exchanging with its environment (Edgren, 2008). This 'complex whole entity' or 'Complex Adaptive System' is made up of parts which, when linked together, have not only a greater value or worth, but competence to perform a task which is reliant on all the parts cooperating with one another. To help us with this idea, think of a hospital as a system and the many parts which make it work efficiently. If you've been in hospital yourself you'll know that accident and emergency and the medical assessment units act as parts of the filter system to ensure that those people who require acute care receive it promptly. Departments like x-ray, haematology and biochemistry are integral to the system and without them a firm diagnosis would be difficult, if not impossible, in some cases. Likewise the role of physiotherapy, occupational therapy and nursing etc, each has a role which contributes to the efficient delivery of the whole system of care. So, whole systems thinking can help us to conceptualise the social processes which connect the different parts that make up an organisational whole. (Checkland, 1999)

In 2006, the Audit Commission (p. 4) described this as 'a concept that describes how services are organised around the person who uses them and the interdependence of one service upon another'. This can be very useful when thinking about information sharing and how information flows within and across organisations.

But what does this mean in practice?

Think about a service user at the centre of his or her care system. We need to consider the organisations that provide the care (these may be formal or informal), the organisational processes that engage with the service user and his or her advocate in providing the care and the outcomes that the service user has agreed are achievable. Have a look at Diagram 1.1 which illustrates this idea. The service user (with his or her assessment and care co-ordinator) is located at the centre of the diagram. The organisations with their professionals surround the service user. The two way lines depict the communication between the service user (an assessment and care co-ordinator) in the assessment process and care plan delivery. The service user advocate may also be in this central position with the service user. The important point here is that when you put the service user at the centre and services are organised with them and around them, then social processes transcend the 'normal' organisational barriers within which we work.

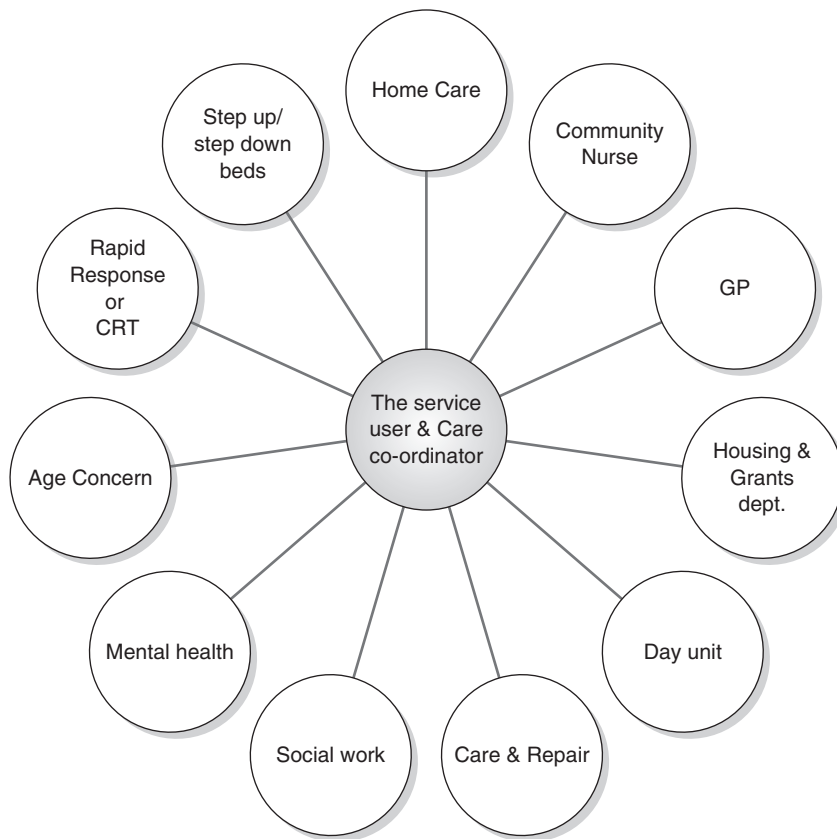


Diagram 1.1

Activity

Now consider a service user or patient you have cared for or are caring for at this moment. Can you draw a similar picture to demonstrate how the different organisations and professionals were involved in the assessment, care planning and delivery process? How many times have you had to share information with a person who doesn't work in the same organisation as you to ensure that you achieve your service user's needs, meet an outcome or simply solve a problem?

STANDARDISED ASSESSMENT FRAMEWORKS

The UK and some other European countries promote values which support and encourage independence and autonomy through its assessment for both clients and carers. This is achieved through key principles such as identifying a person's

needs and outcomes, promoting independence, identifying eligibility and level of formal carer support and acknowledgement of individuality.

As a result of devolution in the UK, the standardisation of assessment frameworks and their guidance (across health and social care agencies), which advocate these principles have been published in different ways. Although these principles remain the same and are embraced by professionals throughout, there are notable differences in the assessment guidance which should be considered and have an impact on the type and level of services received by the patient (Scottish Executive, 2001a; DoH, 2002; WAG, 2002). In England, the standardised assessment framework is called the Single Assessment Process and is for older adults only, although it should be noted that the Common Assessment Framework proposed in the Department of Health (2007c) document *Our Health, Our Care, Our Say* is proposed for all adults. The equivalent standardised framework in Scotland is called the Single Shared Assessment and in Wales it's called the Unified Assessment. In Scotland and Wales the assessment frameworks are for all adults and have Fair Access to Care Services (FACS) integrated within them. This ensures that eligibility for local authority services are considered following individual service user assessment. These frameworks will be discussed in detail in Chapter 2.

Informing Practice

What has this got to do with using assessment frameworks in practice?

Well, it's important that staff and students working and studying in their respective countries understand the origins and context of a policy activity (such as information sharing and standardised assessment frameworks), in order to achieve the social well-being that the public and governments require.

In 2000/2001 these standardised assessment frameworks were first advocated in the three UK NHS plans. The Department of Health's (2000) *NHS Plan*, the Scottish Executive's (2000) *National Plan* and the National Assembly for Wales's (2001) *NHS Plan for Wales* all promoted working in partnership, person-centred services and promoting independence, health and wellbeing for all people. However, all of these plans had differences with regard to the standardised assessment frameworks. The Department of Health's (2000) *NHS Plan*'s intentions were for a Single Assessment Process for health and social care – initially for older people – using protocols agreed across the agencies. The plan also talked about a 'one-stop package of care', joint assessment of a person's needs, professional co-location, person held notes and care coordination of care arrangements. The Scottish Executive's (2000) *National Plan* proposed 'services and communities' planning together and working in partnership across traditional boundaries and across a range of different organisations. The *NHS Plan in Wales* (National Assembly for Wales, 2001) further proposed integrated packages of care for people with chronic illness.

Key policy documents in the UK have further developed the concepts of SAP, SSA and UA, especially the National Service Frameworks, strategic planning

documents, guidance for discharge planning, Continuing NHS Healthcare and NHS Funded Nursing Care. These all promote the principles of SAP, SSA and UAP, which are to undertake a holistic approach to assessing health and social care needs, promote independence and autonomy, minimise individual risk to independence and ensure assessment and services are person centred. It's important to ensure that a student or practitioner is encouraged to read the relevant policy documents that have been published within their practising county (see Resources).

For example in Wales, the vision set out in policy documents such as *Fulfilled Lives, Supportive Communities: A Strategy for Social Services in Wales over the Next Decade* (WAG, 2007b) is clear with its principal intentions to place people at the centre of assessment and care management. So to ensure person-centred care and promote independence, professional partnerships are core to the success of this process. Developing on the implementation of the Unified Assessment Process (UAP) in Wales, a driver for change in the strategy is a common assessment framework. This would draw on the successful components of the UAP, which reflects person-centred care proportionate to need (WAG, 2002).

Informing Practice

What's the point of doing all of this if the services are not there in practice for the service user and carer?

We have an ageing population in the UK, the potential numbers of people who will need health and social care is going to be higher than it is now. Health and social care services use information to predict and plan for the services it thinks its population needs in the future. Commissioners generally want to understand how much health and social care is needed and what types of services will meet those needs. Through identifying the trends of current individual need, services can then predict what services will be required in the future.

When assessment is gathered electronically by practitioners it generally fits into a framework of an agreed minimum amount of information, e.g., name, date of birth, GP. Have a look at Appendix 5, Booklet 1 Hospital Enquiry and the Social Services Booklet (Unified Assessment and Care Management Summary Record) and see the common set of information across both of the documents. This forms part of a minimum standard of information which has been defined within your country of practice (see Useful Websites). Imagine that you had a group of patients with this information: if you analysed the information collectively, you could probably group it into some common themes that would tell you something about their collective needs and where they lived. This would then help you predict the type and where services should be organised to meet their needs.

CHAPTER SUMMARY

This chapter has introduced the idea and principles of assessment and sharing information as a major player in the modernisation of services in the UK today. It introduces the practitioner to these ideas through discussing the demographic drivers, such as the growing elderly population, which have increasing disabilities with a diminishing pool of unpaid carers. The diversity of the policy context is represented by its devolved health and social care in Scotland and Wales, within which the practitioner must engage if s/he is to practice as government and public expect. The Acts of law enable the practitioner to share information safely while protecting the individual's privacy and rights. This chapter has given the reader a foundation of tools from which to understand why there is a need to share information effectively and safely.

REVIEW ACTIVITY

- 1 What are the key issues that are driving the policies to promote sharing assessment information today?
- 2 From which key policy document(s) did the concept of the standardised frameworks for sharing assessment information originate?
- 3 What are the principles of person-centred care?
- 4 Where are you now within the Knowledge Barometer?

Further Reading

- Adams., R. (2007) 'Assessment', in Adams., R. (ed.) *Foundations of Health and Social Care*. Basingstoke: Palgrave Macmillan, p. 282–92.
- Care Council for Wales (2002) Codes of Practice. www.ccwales.org.uk/DesktopDefault.aspx?tabid=429
- General Social Care Council (2002) Codes of Practice. www.gsc.org.uk/codes/Get+copies+of+our+codes/
- House of Commons (2008) Valuing and Supporting Carers. Work and Pensions Committee. Session 2007–2008. www.publications.parliament.uk/pa/cm200708/cmselect/cmworpen/485/48502.htm#evidence
- Nursing and Midwifery Council (2008) The Code. www.nmc-uk.org/aSection.aspx?SectionID=45
- Scottish Social Services Council (2005) Codes of Practice. www.sssc.uk.com/NR/rdonlyres/761AD208-BF96-4C71-8EFF-CD61092FB626/0/CodesofPractice21405.pdf

Useful websites

Long Term Conditions [www.dh.gov.uk/en/Healthcare/Longterm conditions/index.htm](http://www.dh.gov.uk/en/Healthcare/Longterm+conditions/index.htm)
The Princess Royal Trust for Carers www.carers.org/who-is-a-carer,118,GP.html Wales
Accord on the Sharing of Personal Information www.wales.nhs.uk/sites3/home.cfm?orgid=702

National Minimum Standards for All Adults in Scotland www.scotland.gov.uk/Topics/Health/care/JointFuture/NMISScotland/Q/EditMode/on/ForceUpdate/on

National Primary and Care Trust Development Programme www.natpact.nhs.uk/cms/2.php