DOAS SAP Exploratory Paper:

THE SINGLE ASSESSMENT PROCESS AND THE COMPLEX ENVIRONMENT
EXPLORING THE REQUIREMENT FOR HOLISTIC ASSESSMENT
WHERE TWO PEOPLE WITH NEEDS LIVE TOGETHER

Background
The principles of the Single Assessment Process (SAP) have now been established for some time, and in recent weeks reinforced by the new White Paper, "Our health, our care, our say". One of the key fundamentals has always been that the focus must be 'person centred'. Whilst this has been evolving as an underlying principle for most localities, it is fair to say that the White Paper has demonstrated that there is still some way to go. One area that as yet has not been formally acknowledged or addressed within the process, is that where more than one person with needs live together. For the purposes of this paper, this is referred to as a 'complex environment', which is not to be confused with 'complex needs' which refers solely to the needs of one individual. It is of course the case that complex environments may, or may not, also concern people who have complex needs.

What is a 'complex environment'?
In this context, a complex environment is one where the needs of more than one person have to be taken into consideration. Typically this will be in circumstances where two people live together and have separate individual needs that both require care plans.

Under these circumstances, decisions need to be made regarding what processes can be implemented, to ensure that neither person is disadvantaged and that appropriate support is given that ensures both individual and holistic needs are recognised and supported.

The extension of the process outlined in the White Paper, to other care groups (e.g. Long Term Conditions or Learning Disabilities); will inevitably increase the frequency of complex environments being encountered. It is therefore important that this area is explored and accommodated within the current SAP processes.

There are various options for including complex environments within SAP, and it is to be recognised that none of these will exclusively be the right approach. Each stage of the process will need to be flexible enough to cater for the variations that these circumstances will create.

Entry/Referral Options
- Initial entry or referral may well be as a result of just one of the individuals becoming known to one of the agencies. As a result of an initial assessment it may become clear that there is a need and a desire for another person within the home environment to also be assessed.

- Both people may choose to refer themselves together or be referred as having 'joint' needs. Mostly it is likely to be when a couple reach a stage whereby they collectively feel that they can no longer cope with their own needs. They may for some time have been each other's principal carer, until the stage when this no is longer sufficient to enable them to sustain independence.

- There may have been a significant event within the home environment that has caused a breakdown in the current dynamic, such as a breakdown in relationships, bereavement, or a trauma or sudden deterioration in the health of one or both people.

Assessment Options
- Both individuals may choose to be assessed jointly, stating that their interdependence makes it impossible to separate their needs. This would be a complicated process to respond to, as clearly there would potentially be a need for many professionals and agencies to work closely together in ways that they are not accustomed. A good example of this would be where a mother and child both have significant but very different needs that will change over time, but nevertheless see their interdependence as a significant feature of their environment.

- Both individuals choose to be assessed separately, with the result that separate care plans are developed. In this instance, synchronisation is of paramount importance in the delivery of care, in order to ensure that, where requested, there is an optimisation of the resources being provided. This will avoid the inconvenience and disruption caused by service delivery being staggered through the day at separate times to each other.

- The assessment of each individual needs to be carefully and sensitively appraised in order to attempt to balance the individual's perception of their needs against those of their 'co-service user'.

- Care co-ordination needs to be able to recognise a multiplicity of scenarios to include joint co-ordination by the two service users, co-ordination by just one jointly agreed service user, and of course professional care co-ordination of each individual either separately or jointly.

Review options
- Whether assessment has been carried out jointly or separately, there needs to be the ability to both singly and jointly review at any stage.

- Equally, part of the review process might determine the requirement to separate a joint assessment into two separate ones, or conversely to amalgamate two separate assessments into one joint assessment with associated care plan.

Exit options
- One or other person may improve sufficiently to no longer require services, pass away or require residential care for their needs. What happens at this stage within SAP will be determined by decisions regarding discharge or dormancy at the end of a SAP 'episode'.

- A more general option to be considered is that whereby all care delivery is procured from 3rd party suppliers. It needs to be confirmed how this is to be regarded, monitored and maintained as a record by the SAP process that is administered by the core agencies.

Consent
- Fundamental to all of this is the thorny issue of consent. In the instance of 'joint assessment' then clearly consent is significantly more complicated to determine appropriately.

- Can the consent of one service user ever be taken as consent by both (power of attorney etc)?

- Safeguards need to be introduced to ensure that then needs/requirements of one service user do not override and impair those of the other.

- Processes need to be devised to cater for the scenario where one service user withdraws consent.

Recommendations
The whole issue of the delivery of care holistically is one that, to my knowledge, has never been addressed by SAP in the context of more than one person with needs. As previously mentioned, it is a situation that will occur with increasing frequency as SAP extends into the domains of the other care groups.

It is important to ensure that the process maps allow for 'joint care delivery' in complex environments. However it is to be recognised that the IT requirements that would result are inevitably going to be significant and complex.

When material is filed on an electronic system, joint material needs to file under both individuals, and Legitimate Relationships need to be to both individuals, where they have agreed joint assessment and care planning. During periods where individuals wish to be worked with jointly, an indicator to this effect needs to appear on both records.

The carer aspects within these environments must also be recognised. Assessment must deal with any care-giving needs that the individual has, and should not ignore the possibility of carer support (e.g. respite) as well as ordinary support for needs and risks. The complexities of how to identify, acknowledge and support the care-giving role of people who themselves also have needs, is one that needs further exploration. It will need to be sensitive to the potential necessity for keeping these elements separate from any jointly held assessments, as well as incorporating them into jointly held documentation if required.

It is recommended that an appendix to the process diagrams is produced that caters specifically for this situation, by a small working group set up for this purpose. Once completed, it will need to be agreed collectively as to how this will then be appropriately incorporated into the evolving core process map.

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