Appendix 7: Glossary of Terms

Term	Acronym	Definition
Assessment		The overall process for identifying — and recording - the health and social care risks and needs of an individual and evaluating their impact on daily living and quality of life, so that appropriate action can be planned.
Assessment Tools		Scales, questions and checklists brought together to support the assessment process. Following Single Assessment Process guidance, DH accredited, and many local, tools are being used nationally.
Basic Personal Information		See Contact Assessment.
Better Care Higher Standards		"Better Care Higher Standards" is a publication agreed by the local social service department and housing departments and the primary care trust. They inform the public what standards they can expect of community care services and what to do if things go wrong.
Caldicott Guardians		A senior professional working within the NHS and local authorities to ensure that the confidentiality of patient-identifiable information is maintained and that manual and IT systems are secure. Caldicott Guardians oversee issues such as confidentiality and security, information clarity, rights of access and documentation accuracy.
Care Co-ordination		**See Concept Paper Annex 2 - Coordination**
Care Co-ordinator		**See Concept Paper Annex 2 - Coordination**
Care Event		A discrete activity carried out by a health or social care profession for an individual e.g. a GP consultation, or an outpatient appointment.
Care Event Report		Correspondence from one professional to another to highlight the key outcomes of a care event.
Care Home		The Care Standards Act 2000, which came into effect in April 2002, classifies all types of residential homes as ‘care homes’. The Act distinguishes those offering nursing care as ‘Care homes with Nursing’.
Care Homes with Nursing		Under the Care Standards Act 2000, which came into effect in April 2002, all nursing homes are called ‘care homes with nursing’. See also Care Home.
Care Management		For a Social Services Department, these are the processes undertaken when an individual’s care needs are assessed and appropriate services are provided. Care management includes: making available information about possible help; determining the level of assessment to be undertaken once a person has been referred to the social services department; assessing their needs; developing a care plan and a care package to meet their needs; implementing the care plan; and monitoring and reviewing the care plan.
Care Package		Services designed to meet an individual’s assessed needs as part of the care plan arising from their assessment. Consists of one or more services, which may be residential and/or community-based. Also known as a ‘package of care’. A cost is often attached if provided by social care, and hence needs to be approved by the budget holder; may also require contributions from the individual.

Care Pathway		The services an individual receives on a step-by-step basis following their entry into the system.
Care Plan		Under the Single Assessment Process, a personalised care plan details the high level, integrated health and social care requirements after a holistic assessment has taken place. Based on the summary of the risks and needs from the assessment, it should include details of the services to be provided, the assessed individual and their carer(s) participation, the objectives, a review date and consent from the assessed person to share the plan with the care team. The personalised care plan should also identify from the assessment the lifestyle and personal strengths of the person including their abilities, interests and wishes. It finishes with consent from the individual to share the care plan with the care team and a review date. The care plan should be printed in a suitable format for the individual and their carer(s). Lower level care plans, service plans and treatment plans might be a plan of activities associated with one or more needs, and care goals applied to a specific health or care service. As mentioned in the January 2006 White Paper on Community Health and Social Care Services, "An integrated health and social care information system will enable a shared health and social care plan to follow a person as they move through the care system." "We will ensure that, ultimately, everyone who requires and wants one has a personal health and social care plan as part of an integrated health and social care record." "Initially we will focus on offering integrated care plans to those individuals who have complex health and social care needs." "By 2008 we would expect everyone with both long-term health and social care needs to have an integrated care plan if they want one." "By 2010 we would expect everyone with a long-term condition to be offered a care plan." "We will issue good practice guidance early in 2007."
Care Planning		Process based on an assessment of an individual's risks and needs that determines the level and type of support required to meet those needs and the objectives and potential outcomes to be achieved. Care planning leads to a care plan being written for the individual who should have fully participated in the care planning process.
Care Professional		Anybody involved "professionally" in the provision of health/social care and who is an employee of the agents providing care services.
Care Programme Approach	CPA	Formal process of assessing the needs of people with severe mental health problems. Under Single Assessment Process guidance, the Care Programme Approach (CPA) should be applied to older people with severe mental illness due to schizophrenia or other psychoses. The assessment of their needs should be based on SAP when they are older people. SAP, plus critical aspects of CPA, should be applied to other older people with severe functional or organic mental health problems, who were they younger would be provided for under CPA. When individuals subject to CPA reach old

		age, switches to SAP are not inevitable, and should only be made in the best interests of individuals and the continuity of their care.
Care Settings		The type of place where an individual receives care e.g. hospital, care home or in their own home.
Care Team		The health and social care workers involved with the care of the person and their carer(s). This might include staff from the independent, voluntary and private sectors.
Care Trust		A legal entity formed to provide healthcare and social care services.
Carer(s)		Carers can be a parent, spouse, partner, child, relative or friend who provides regular and substantial unpaid care to someone who is disabled, severely ill or frail.
Carers Assessment		A carer's assessment, under the Carers and Disabled Children Act 2000, formally acknowledges the carer's contribution as a partner in the caring process. It determines the carer's own support needs, so that they can continue to contribute if possible, and sets out a contingency plan. This assessment has traditionally been carried out by social services. New legislation, The Carers (Equal Opportunities) Act 2004, states that there is a need to ensure that all carers know that they are entitled to an assessment of their needs for services; place a duty on local authorities to consider a carer's outside interests (work, study or leisure) when carrying out an assessment; and promote better joint working between social services and health, housing and education services to ensure support for carers is delivered in a coherent manner.
Case Management		When an individual has numerous long term conditions and complex needs, their care becomes more difficult for them to manage. Case Management is where a named coordinator, e.g. a Community Matron, actively manages and joins up care by offering, amongst others, continuity of care, coordination and a personalised care plan for vulnerable people most at risk.
Champion		Someone who is appointed to stand up for the interests of a particular user group: e.g. by ensuring that local services are accessible and meet local needs, rooting out discrimination in access to treatment and services, and helping to implement National Service Frameworks. A champion can be a senior staff member in health or social services; a councillor; or a representative of the group concerned, e.g. older people.
Change Agent Team	CAT	Set up to help health and social care communities tackle the problem of individuals staying in hospital longer than necessary (delayed transfers of care). Since then, its remit has grown and now provides advice and support on a wide range of issues that affect the care of older people.
Chronic Disease Management		See Long term Conditions
Clinical Documentation		The capturing and recording of clinical information normally at the point of patient present such as consultation, assessment etc.
Clusters		Regional clusters were created after consultation with Strategic Health Authorities (SHA's) on how best to deliver local Information Technology solutions as part of

		the NHS Care Records Service. It was decided to split England into five geographic areas to work together to take forward the procurement and implementation of the NHS Care Records Service at a local level. These comprise of the: Eastern, North East, North West and West Midlands, London, and Southern clusters.
Common Assessment Framework for Adults		As mentioned in the January 2006 White Paper on Community Health and Social Care Services, "A Common Assessment Framework is in place for children's services. We have already developed a Single Assessment Process for older people's services. Work is underway to build on this to develop a Common Assessment Framework to ensure less duplication across different agencies and allow people to self assess where possible." "An integrated health and social care information system for shared care is planned as part of the NHS Connecting for Health strategy. It is an essential requirement for effective care coordination."
Common Assessment Framework for Children		A standardised approach to assessing children's needs for services. It has been designed for practitioners in all agencies to help them to communicate and work together more effectively. It is particularly suitable for use in universal services (health and education), to identify and tackle problems before they become serious. It is a key component in the Every Child Matters: Change for Children programme, playing an important role in providing early intervention. The CAF for Children consists of: ➢ A simple pre-assessment checklist to help practitioners identify children who would benefit from a common assessment. It can be used on its own or alongside specialist universal assessments; ➢ A process for undertaking a common assessment, to help practitioners gather and understand information about the needs and strengths of the child, based on discussions with the child, their family and other practitioners as appropriate; ➢ A standard form to help practitioners record, and, where appropriate, share with others, the findings from the assessment, helping to complement specialist assessments and reduce duplication. 12 local areas are trialling the CAF and the role of lead professional. During the trial period, the options for the electronic enablement of the CAF will explored. The results of the evaluation will inform any changes to the CAF form and guidance prior to national implementation, and to revised lead professional guidance in 2006. All local areas should work towards implementing the CAF from April 2006, by when a revised version will be produced.
Comprehensive Assessment		Comprehensive assessments replace overview assessments for the most vulnerable and frail people who have many/complex needs and often will involve old age consultants/psychiatrists and their teams on behalf of, or working with, primary care and social care. A Comprehensive Assessment describes a multi-disciplinary and multi-agency process whereby various specialist assessments of all or most of the domains of

		SAP are brought together with the information from any contact and overview assessments that may have triggered them. The idea is to provide a picture of an person's health and social care needs which is both holistic and detailed. Such an assessment is required only where the level of support and/or treatment is likely to be extensive and/or prolonged, such as a permanent admission to nursing care or intensive and/or complex home care packages.
Confidentiality		Respect for the privacy of information - one of the principles that underpin all health and social care practice. Information about a person is generally held under legal and ethical obligations of confidentiality. With certain important exceptions, information provided in confidence should not be used or disclosed in a form that might identify the person concerned without their consent.
Consent to share information		Agreement articulated by an individual with the care professional to share information about them with other care professionals: ➢ Explicit or express consent refers to a clear and voluntary indication of preference or choice, usually oral or in writing and freely given in circumstances where the available options and their consequences have been made clear (informed consent). ➢ Implied consent refers to agreement signalled by the behaviour of an informed individual. It is essential that people with higher support and communication needs are given the time and assistance they need to give their consent on issues that involve them.
Contact Assessment		The first "contact" - or meeting - between the person and health and/or social care agencies. Basic personal information is collected or verified, the nature of the individual's presenting concerns/difficulties established and a brief initial assessment is made of whether the person has potential wider health and social care needs. A referral can be made at this stage or at the other stages of assessment.
Continuing Care		Provision of health and social care over an extended time as the result of disability, accident or illness, in order to meet both physical and mental health needs. Continuing care can be provided in a range of settings, including hospital, care home or hospice and the individual's own home. Continuing care aims to provide the right long-term support, to promote independence, prevent deterioration and maximise a person's health and quality of life. Eligibility for full NHS continuing care is assessed using local eligibility criteria.
Continuity of Care		The importance of continuity of care for the person and their carer(s) throughout the Single Assessment Process cannot be underestimated. Best practice indicates that, ideally, the same health and/or social care worker be involved with the person throughout the process. The aim being to limit the hand offs or handovers between health and social care workers to a minimum.
Coordination		**See Concept Paper Annex 2 - Coordination**
Current Summary	CSR	Part of the Single Assessment Process guidelines, this

Record		draws on information from a range of sources to provide an up-to-date picture of the older person, their health and care needs and any services they receive. The CSR has been defined by the Department of Health as the means by which case information on an assessed person is shared, subject to consent and confidentiality, among health and social care professionals. It draws on information collected during the assessment process but also covers care plan information including support and services that are being provided. It can draw on other sources and should show changes in needs, services and other circumstances between formal assessments.
Decision Support		The potential of areas such as evidence based medicine and information technology to actively support decision-making, both to reduce errors and to increase the effectiveness and cost-effectiveness of healthcare. Decision support systems can be regarded as one way of expressing knowledge.
Delayed Transfers of Care		The Community Care (Delayed Discharges) Act 2003 aims to reduce the time people stay in hospital after treatment while waiting for social care services to be provided. From January 2004 local authorities had to reimburse acute trusts if social care assessments and services are the sole reason that hospital discharge is delayed. Acute trusts are obliged to notify Social Services Departments of inpatients likely to need community care services.
Dignity		Ensuring that a person receives the type of care that makes them feel respected as an individual and helps them develop or maintain self-esteem and take pride in themselves. This should take place in every setting whether in the community or in the acute sector so that there is 'Dignity on the Ward'.
Direct Payments		A way for people who need social services to have more control over the service they receive. People who are eligible for services (day care, personal care, respite care, equipment and adaptations) can opt to receive the money for the service from the local authority and purchase it themselves. In this way they can choose the exact service they want, when they want it and who provides it. They can be made to disabled people aged 16 or over, to people with parental responsibility for disabled children, and to carers aged 16 or over in respect of carer services. Councils have a duty to make a direct payment to people who can consent to have them. This means that direct payments should be discussed as a first option with everyone, at each assessment and each review. The take-up of direct payments is now an indicator in the Commission for Social Care and Inspection's performance assessment regime, and contributes to the overall star rating of a local authority.
Disability		The Disability Discrimination Act 1995 defines disability as 'a physical or mental impairment that has a substantial and long term adverse effect on a person's ability to carry out normal day-to-day activities'. Most people and organisations now accept the 'social model of disability':

		➢ disability arises from society's negative treatment (social or environmental), and is not an inevitable consequence of impairment; ➢ the position of disabled people in society is a human and civil rights issue; and society must be changed to allow full inclusion
Domains/Sub Domains		Categories that make up the holistic assessment of the single assessment process. An example of a domain is 'personal care and physical well-being.' Sub-domains are components of a domain: the sub-domains of 'personal care and physical well-being' include 'personal hygiene, including washing, bathing, toileting and grooming', 'dressing' and 'pain'.
European Computer Driving Licence	ECDL	A training course in basic IT skills available to all NHS staff to help them prepare for new ways of working and increase confidence in their use of IT. ECDL is an internationally recognised qualification that has been adopted as the NHS standard and also by some social care agencies.
Expert Patient Programme		Self-management programme giving people the confidence, skills and knowledge to manage their conditions better and be more in control of their lives.
Fair Access to Care Services		Eligibility criteria, used by Social Services Departments to determine whether a person is eligible for services provided by them. The framework is based on an individual's needs and associated risks to independence, and includes four eligibility bands - critical, substantial, moderate and low. When placing individuals in these bands, councils should not only identify immediate needs but also needs that would deteriorate for lack of timely help.
Hand-off		Term used when a person is passed from one health and social care worker to another.
HealthSpace		A secure place on the internet where people can access and store their personal health information.
		When health and social care professionals assess the domains/sub domains of the Single Assessment Process (including the physical, emotional, mental health, spiritual, environmental, social, sexual, financial, cultural needs of an individual). An awareness of diversity issues including of an individual's history, culture, beliefs and identity is essential; not least when working with Black and Minority Ethnic people. The use of interpreters, speaking to individuals and their carers in their own language with sensitivity and respect, is a key element of Holistic assessment. A holistic assessment should also identify abilities, strengths and preferences. The person's perspective, views and self-assessment should be encouraged. Conclusions on risks and needs then are made for care planning.
Holistic Care Model		Caring for the whole person with many/complex needs whatever their age, illness or disability. People with many/complex needs are classified into levels (e.g. enhanced Care Programme Approach - CPA) and categories (e.g. Common Assessment Framework - CAF, Single Assessment Process - SAP). They are served under a holistic care process consisting of Entry into System, Assessment, Care Plan, Care Delivery and Review/Discharge.

		Central to this process is the holistic assessment, under numerous headings (domains/dimensions), of risks and associated needs (physical, emotional, mental health, spiritual, environmental, social, sexual, financial, cultural needs of an individual.. An awareness of diversity issues including of an individual's history, culture, beliefs and identity is essential; not least when working with Black and Minority Ethnic people. The holistic assessment should also identify abilities, strengths and preferences. The person's perspective, views and self-assessment is encouraged in the joint work with their assessor. The risks and needs are then addressed by joint planning of the care with the person, their carer(s) and relevant professionals to commission the services which are expected to achieve agreed outcomes as documented in the individual's personalised health and social care plan. Throughout this process, the individual is allocated a known contact to provide continuity of care and security to co-ordinate their assessment(s), and, when appropriate, their care planning and services, encouraging supported self care /self management. Regular reviews take place to ensure that the care plan is succeeding, that changes are not missed and that the individual is discharged from care when they no longer need services..
Home Care		Care services provided to an individual in their own home by a care worker paid to provide care as part of their employment.
Hospice Care		Care for a terminally ill person and also for their carers, provided at home, in day care and in the hospice itself. Hospices provide a range of services - pain control, symptom relief, skilled nursing care, counselling, complementary therapies, spiritual care, art, music, physiotherapy, reminiscence, and bereavement support. Multi-professional teams, including volunteers, provide care based on need and personal choice, and strive to offer freedom from pain and to help achieve dignity, peace and calm.
Independent Living		Person-centred approach to social care that offers the individual choice and flexibility to make decisions about the support and care they need so that they can take control of their life.
Individual Budgets		Although direct payments have helped to transform the lives of many people, it can sometimes be difficult for people to make full use of them because of the degree of responsibility involved in managing all aspects of a budget, for example in becoming the employer of a care assistant. Direct payments only cover local authority social care budgets. Individual budgets will bring together separate funds from a variety of agencies including local authority social services, community equipment, Access to Work, independent living funds, disabled facilities grants and the Supporting People Programme. Individuals who are eligible for these funds will then have a single transparent sum allocated to them in their name and held on their behalf, rather like a bank account. They can choose to take this money out either in the form of a direct payment in cash, as provision of

		services, or as a mixture of both cash and services, up to the value of their total budget. This will offer the individual much more flexibility to choose services which are more tailored to their specific needs. There will be 13 Individual Budget pilots for older and disabled people in 2006. These pilots will run for between 18 months and two years and, if successful, will form the spearhead of a national implementation that could begin as early as 2009/10.
Information Sharing Protocol		Documented rules and procedures that govern how far one organisation may disclose information about a person to another. The protocols relate to the security and confidentiality of the information and to data destruction.
Integrated Care		Partnerships in which health and social care staff share information appropriately and work together to ensure that people receive the support and care they need to remain independent in the community.
Integrated Care Pathway	ICP	A tool and a concept that embed guidelines, protocols and locally agreed, evidence-based, person centred, best practice, into everyday use for the individual. In addition, and uniquely to ICP's, they record deviations from planned care in the form of variances.
Integrated Service		Service taking a person-centred approach and seeking to meet a person's social and emotional needs as well as their physical and medical ones.
Intermediate Care		A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable people to return home following hospitalisation; or to prevent admission to a long term Care Home; or intensive care at home to prevent unnecessary hospital admission.
Joint Staff Development/Training		The single assessment process sets out a strategy for joint staff development for localities to follow. It emphasises that professionals should be equipped to carry out person centred care, be skilled at joint working and be knowledgeable about the health and social care concerns of the individuals assessed and cared for.
Joint Working		The working together of staff from organisations, such as local authorities, acute trusts and primary care trusts to identify and solve local problems.
Legitimate Relationship		Concept emphasised by NHS Connecting for Health in terms of only accessing an individual's personal data where there is an appropriate link between a care professional and the individual concerned. Individuals who are uncomfortable with having their information shared with other health and social care professionals will be able to keep information in a 'sealed envelope.
Local Service Provider	LSP	Responsible for making sure the new systems and services delivered through the NHS Connecting for Health, meeting Cluster requirements and are implemented efficiently. Nationally, the LSP's are London - Capital Care Alliance (CCA), South - Fujitsu Alliance (FJA), East - Accenture, North East - Accenture and the North West and North Midlands - Computer Sciences Corporation (CSC).
Long Term Conditions		Illnesses which lasts longer than a year, usually degenerative, causing limitations to one's physical, mental and/or social well-being. Long Term Conditions includes Diabetes, COPD, Asthma, Arthritis, Epilepsy

		and Mental Health. Multiple long term conditions make care particularly complex, and a small number of individuals and conditions account for a disproportionate amount of health care use (especially hospital care). 60% of adults in England report a chronic health problem; 8.8m people have long term illness that severely limits their day to day ability to cope. According to the World Health Organisation, Long Term conditions will be the leading cause of disability by 2020.
Map of Medicine		Aims to make the vast amount of knowledge held within the NHS available to all health care professionals. The Map of Medicine is based on over 250 different patient journeys. These are symptom-based and aspire to map out the steps to be taken by the clinician, starting with the initial presentation of the individual.
Monitoring		Ensuring the continuing quality and effectiveness of the services provided to meet an individual's needs and identifying whether and how the individual's needs have changed.
Multi-disciplinary Assessment		Assessment of an individual's needs that actively involves professionals from different disciplines in collecting and evaluating assessment information.
National Service Frameworks	NSF	Documents setting out national standards for the best ways of providing health and social care services for particular diseases or population groups, e.g. older people.
Needs Assessment		A process by which health and social care professionals assess and then make conclusions on risks and needs. The assessment sets out what is necessary for an individual to maintain their life at a certain standard.
Notification Arrangements to Social Services		Part of the system designed to reduce the number of delayed transfers of care under the Community Care (Delayed Discharges) Act 2003. NHS bodies have to make two notifications to the appropriate social services departments. The first, an Assessment Notification (Section 2), gives notice of the patient's possible need for services on discharge. Following this notification, social services departments have a minimum of three days to carry out an assessment and arrange care. The second, a Discharge Notification (Section 5), gives notice of the day on which it is proposed to discharge the patient. These notifications should be part of existing or good practice information flows and are designed to ensure prompt communication as part of the planning process, not to replace care plans.
Overview Assessment		Holistic heath and social care assessment in which domains/sub-Domains of the single assessment process should be explored in order to identify risks, describe needs and to trigger any additional specialist assessments required. The assessment should be carried out in a conversational style, following the person's concerns rather than methodically working through each domain/sub-domains and its questions in sequence.
Palliative Care		Improving the quality of life of an individual facing life-limiting illness and that of their family. Pain is prevented or relieved by the early identification and holistic assessment and treatment of the pain itself and of other related physical, emotional, social and spiritual needs..

Person Centred Care		Under Person Centred Care, Standard 2 of the NSF for Older People, people should be treated as individuals and receive appropriate and timely care that meets their needs. For people with learning disabilities, Person Centred Planning is a process of life planning for individuals, based around the principles of social and of disability. The importance of a Person Centred approach has also been reinforced with its inclusion in the NSF for Long Term Conditions (2005); with the movement towards dignity in a hospital setting; and an increasing awareness of how important it is when working with people who have dementia, concentrating on what they can do, not on what they are not able to do.
Person Demographics Service	PDS	Application of the national Spine. Demographic information for every individual covered by the NHS in England, e.g. address details, held nationally and accessible through local systems,
Person Held Records		Information held by the assessed individual containing records from health and social care professionals involved in the care team.
Personal Spine Information Service	PSIS	Application of the national Spine. The national repository that holds personal health information for an individual, e.g. drug allergies, details of operations and/or conditions, medication history, pathology, radiology and other results - and a summary of contacts with care providers.
Protocol		A protocol is a rule which guides how an activity should be performed.
Reimbursement		The Community Care (Delayed Discharges) Act 2003 introduced new obligations for health and social care partners in England relating to hospital discharge arrangements. This includes a financial obligation for local authorities to reimburse acute trusts if social care assessments and necessary social care services are the sole reason that hospital discharge is delayed. Acute trusts will be obliged to notify social services departments of inpatients likely to need community care services.
Review		Formal re-evaluation of an individual's assessed risks, needs and personalised care plan at an arranged time. Informal reviews should take place as required.
Risk, Risk Assessment		When the holistic assessment is completed, the assessor and the individual should consider and evaluate conclusions on the risks and needs. This evaluation should take full account of the likely outcome if assistance were not to be provided. The evaluation of risk should focus on the following aspects that are central to an individual's independence: autonomy and freedom to make choices; health and safety including freedom from harm, abuse and neglect, taking wider issues of housing circumstances and community safety into account; the ability to manage personal and other daily routines; and the involvement in family and wider community life, including leisure, hobbies, unpaid and paid work, learning and volunteering. Assessors should also consider risks faced, not only by the person assessed, but by those close to them, such as carers (and to staff and society) They should

		consider which risks cause serious concern and which may be acceptable or can be viewed as a natural and healthy part of independent living.
Role Based Access Control	RBAC	Everyone accessing the NHS Care Record Service will be subject to RBAC. It will include what information can be accessed, how a system user can access it and the system user's role. A single system user will be able to have multiple role profiles (e.g. if doing two different jobs with different access requirements). Staff accessing the system will need a smartcard and pin number which will contain information on their level of access.
Self Assessment		An assessment that is completed by the subject of the assessment without the immediate professional involvement. This may range from structured questionnaires distributed by and returned to professionals for interpretation and further action where required, to systems that define need from the individual's perspective and facilitate care planning by the individual themselves.
Self Care/Self Management		With the appropriate support, many people can learn to be active participants in their own health and social care, living with and managing their conditions/needs. This can help to prevent complications, slow down deterioration and even avoid getting further conditions and increased needs. The majority of people with long term conditions fall into this category - so even small improvements can have a huge impact. The development of direct payments and individual budgets for social care can be seen as important developments in the area of self management.
Single Assessment Process	SAP	Standardised holistic assessment framework across health and social care so duplication is minimised and an individual receives timely and proportionate assistance appropriate to their risks and needs. The Single Assessment Process aims to put individuals at the centre of their own assessment and subsequent personalised care planning. Originally brought in for older people, it is increasingly being used as the framework for other adult groups.
Smartcard		Credit card type issued by a Registration Authority which, together with a PIN, is the only way a system user can log onto the NHS Care Record Service system.
SNOMED CT		SNOMED CT has been adopted as the NHS Standard for clinical terminology. A common computerised language that will be used by NHS Care Records Service to facilitate electronic communications between professionals in clear and unambiguous terms.
Social Care		Care provided to support an individual's social as opposed to health care needs, whether by statutory or non-statutory organisations. Social care is one of the major public service areas. At any one time, up to 1.5 million of the most vulnerable people in society are relying on social workers and support staff for help. Social care services also make a major contribution to tackling social exclusion. Currently, modernising social services is a national priority, and to have the greatest effect this must happen in conjunction with the modernisation of the NHS. Social care comes in many forms. Adults can be

		supported in the community through home care, sitting, meals and day services or through residential or nursing home care. Children and families are supported at home through a wide range of child protection, social work, early years and other services. Sometimes fostering, adoption and residential care services may be an option. Social care services are provided for people who need help to live their lives as independently as possible in the community (either at home or in care settings), people who are vulnerable and people who may need protection . Each Local Authority will tailor its services to meet the needs of local people. It does this within a framework of duties, responsibilities and national standards laid down by central Government.
Social Services		Personal social services is one of the major public services and describe a wide range of support that help people to carry on in their daily lives. It includes: ➢ services for children such as adoption, fostering and protection ➢ help for people with mental health needs ➢ support and care services for older people ➢ support for people with a disability and people with learning disabilities. They are provided by Local Authorities and by the independent sector and voluntary sector. Local Authorities with social services responsibilities have a statutory responsibility to ensure that the social care needs of people are met. The term social care is increasingly now being used instead of social services. This reflects the greater involvement of the independent sector andvoluntary sector in the provision of social care services and the continuing role of of the statutory sector as commisioners as well as providers of support and care. Social services functions in many authorities no longer stand alone, but are increasingly combined with housing, education and the NHS. Local Authorities are expected to provide accessible information about their services. Once an individual has been in contact with their Local Authorities social services they will be able to find out if they, or their carer, are eligible to receive social services help. An assessment may follow to determine the level of need and to identify services that can be provided. Where services are to be provided it is usual for someone from the social services to visit the individual at home (or wherever they are being supported) and to work out with them what is the best way to meet their needs.
Social Services Department	SSD	A statutory agency and department of a local authority, providing needs assessments to determine an individual's eligibility for assistance and ascertain how support can be given to meet eligible needs. Also provides and purchases a range of residential, day and domiciliary care packages to support people in need.
Specialist Assessment		Under the Single Assessment Process, specialist assessment offers a way of exploring specific needs, in detail, and may be triggered by a contact or overview assessment. Specialist assessments, and associated scales, should be carried out by the most appropriate

		health and social care professional. A specialist assessment may not require a formal assessment tool, though some professionals will have access to specific specialist tools. At the end of the assessment, the professional needs to be able to communicate their findings both to the assessed individual and to other professionals, particularly the identified Coordinator. This, in turn, will assist in the development of an overarching care plan for the assessed person.
Spine		The name given to the national database of key information about an individual's health and care and forms the core of the NHS Care Records Service. It will include information like NHS number, date of birth, name and address, and clinical information such as allergies, adverse drug reactions and major treatments.
Transaction and Messaging Spine	TMS	The message handling application element of the national Spine.
Unified Assessment Process	UAP	The equivalent, in Wales, of the Single Assessment Process.
Unscheduled Review		Additional review undertaken when an individual's circumstances have changed.
White Paper on Community Health and Social Care Services		White Paper 'Our Health, our care, our say: a new direction for community services' - the Government's White Paper on improving community health and care services. The White Paper aims to provide people more choice and say over the care they receive in the community, and much closer working and coordination between health and social care. This will include improved access to GPs by increasing the choice of practices for everyone and extending opening hours; a new generation of community hospitals and health centres that provide health and care services in the heart of the community; Direct Payments will be extended and Individualised Budgets will be introduced; and local partnerships between Local Authorities and Primary Care Trusts will be encouraged to produce joint teams More support for people with long term needs will be offered. Work will take place to build on the Single Assessment Process and over time develop a Common Assessment Framework to ensure less duplication across different agencies and allow people to self assess where possible. An integrated health and social care information system for shared care is planned as part of the NHS Connecting for Health strategy. It is an essential requirement for effective care coordination. An integrated health and social care information system will enable a shared health and social care plan to follow an individual as they move through the care system. Ultimately, everyone who requires one has a personal health and social care plan as part of an integrated health and social care record. Initially the focus will be on offering integrated care plans to those individuals who have complex health and social care needs. By 2008 it is expected that everyone with both long-term health and social care needs to have an integrated care plan if they want one. By 2010 it is expected that

		everyone with a long-term condition will be offered a care plan. Good practice guidance will be issued early in 2007.
Whole Systems Approach		Integrated way of working based on the belief that large multi-agency systems of care can be best improved if the process of change involves staff from all levels of all organisations and, crucially, also the individuals and carers involved.