



MEETING THE STANDARD

THE FACE OVERVIEW TOOLS

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Appendix: The FACE Overview Assessment and the Domains of Single Assessment

INTRODUCTION

This document is FACE's response to the Department of Health's invitation to submit the FACE Overview tools for Accreditation. Minor modifications have been made to the main text and the Appendix has been re-worked in order to accurately reflect the changes in the tools made for V.5. However, for the most part the main body of the document has been left unchanged. The aim of the document is still primarily to set out the FACE approach to Overview Assessment and the document is set out in such a manner as to facilitate easy review of the FACE Overview tools.

The structure of the document is as follows:

Section 1 describes the general FACE approach to assessment and introduces the Core Assessment & Outcomes Package for Single Assessment and Older People, including a brief description of the full set of FACE tools, of which the Contact & Overview Toolset forms a part.

Section 2 provides a tool-by-tool and page-by-page 'walk through' of the Overview tools, explaining the rationale underlying the contents of each section and the approach to completion.

Section 3 summarises the approach to training, how the tool is currently being used, the results to date of field trials and developments under way.

Section 4 provides the developers' response to the Department of Health accreditation criteria. This includes an Appendix detailing the manner in which the Overview Toolset addresses each of the Single Assessment domains.

1 THE FACE APPROACH

This section briefly describes the background to the FACE approach and how it has been applied to the development of assessment tools for single assessment. ¹ FACE (standard for Functional Analysis of Care Environments) is an approach to assessment designed to be applicable in any context in which information about people is recorded. The approach is intended to be as applicable to young people as to older people; indeed, to be applicable to everyone, regardless of whether they are in need of health and social care services. The FACE approach to assessment has 2 main characteristics:

- It follows the naturally-occurring process.
- It integrates recording and measurement functions through use of a standardised framework for assessment, known as the FACE Framework.

These two elements of the FACE approach are summarised below.

1.1 FOLLOWING THE NATURALLY-OCCURRING PROCESS

In order for assessment tools to be easy to use routinely they need to sit comfortably with the naturally-occurring process of interaction between practitioner and service user. So what is the 'naturally-occurring process'? A summary of key steps in this process is shown in Table 1 below. This analysis brings out a number of points. First, the process relies on the practitioner creating a facilitative atmosphere in order for the service user to feel comfortable both with describing their concerns and the broader exploration of these which may follow, responding flexibly and sensitively to each individual. This in turn implies the need for open-endedness in the conduct of the assessment process.

Secondly, professional judgment plays a pivotal role. The assessment process is guided by judgment deriving from professional training, the evidence base and the expertise of the practitioner. Assessment tools need to reflect and facilitate this.

Thirdly, the assessment process is a complex one in which many factors have to be explored and balanced in reaching judgments and in arriving at a shared understanding and approach with the service user. Assessment tools need to reflect this complexity.

Finally, it is important to distinguish between the assessment process and the recording of that process. Whilst the assessment process may be complex, perhaps lengthy, this does not mean that the record of that process should be complex and lengthy. Rather, the record of the assessment needs to be succinct and easy to understand – as well as accurately reflecting the process.

Taking into account such considerations, FACE assessments are designed to permit flexibility of interaction between practitioner and service user. They provide a succinct and structured format for the recording of the assessment process, a format which also serves as a reminder to the practitioner to cover the relevant areas and a useful method of structuring information gathering. The completed assessment thereby records the results of the naturally-occurring process, summarising the key judgments made throughout the process and the data supporting those judgments.

¹ This section is lifted with minor changes from the Training Materials.

Table 1: Steps in the naturally-occurring assessment process

Step	Process
1	The person arrives with a problem or concern.
2	They explain it to the practitioner in their own words.
3	The practitioner attempts to understand the problem or concern using their professional expertise, placing it in a broader context. For example, someone may complain of low mood, tearfulness, lack of interest in anything. The practitioner may attempt to elucidate whether something has happened in the person's life to trigger such a reaction e.g. a bereavement or other change in circumstance; how frequently the person feels like this; how long they have been in this state etc. The result of this initial clarification process should be an agreed description of the problem or concern.
4	<p>If necessary, broader assessment is undertaken. If the problem is complex the practitioner will undertake a broad-based 'overview' assessment, exploring the broader context of the person's situation. This has three main purposes:</p> <ul style="list-style-type: none"> (i) To better appreciate the nature of the problem e.g. by exploring relevant details of the person's personal and social history, the history of the presenting problem and its impact on the person's life – how they are coping with everyday activities, their domestic situation etc., personal safety issues etc. (ii) To place the problem in the context of a broader understanding of the person's abilities, wishes and circumstances in order that a balanced view may be taken as to what appropriate action or care is required. (iii) To 'screen' for other issues, perhaps not initially identified, that may need to be taken into account in deciding upon appropriate action. For example, routine screening may identify unreported difficulties in undertaking daily activities or health issues which need to be considered or further investigated.
5	If this broad overview assessment identifies areas of concern that require more in-depth assessment then these will be identified during the assessment. Such assessment may be undertaken directly or 'flagged' as being required at a later stage.
6	The views of a family member or informal carer associated with the person may also be sought, if appropriate, in order to better understand both their perception of the issues and the impact upon their life.
7	As the assessment proceeds the links and relationships between different aspects of the person's life and needs (e.g. the interaction between health and social needs) become clear. The practitioner arrives at an integrated view of the person whereby the impact of the person's needs, the interactions between needs and circumstances and the person's response to and understanding of these becomes clear.
8	Based upon Steps 3-7, the practitioner and service user arrive at a shared understanding of the key problems, difficulties or concerns; any associated risks to the person's or others' safety; how needs and risks are balanced by positive aspects of the person's circumstances (e.g. support, personal resilience) and what the person would like to occur to address them.
9	Based upon Step 8 the practitioner will suggest and discuss possible courses of action, including referral elsewhere, further assessment or the provision of care within the setting in which the person has been assessed. If the latter is indicated then the goals of care will be agreed and a care plan developed. ²
10	Finally, it is the practitioner's task to ensure that the results of the assessment are summarised in a format that permits easy communication to others e.g. the service user, their carer, the referrer, other team members/agencies who may be involved in care delivery.

² Goal-setting and care planning are NOT, however, functions covered by the Overview Toolset (see section 2.1 below). These functions are covered by the FACE Care Planning tools and are supplied separately within V.5.

1.2 THE FACE FRAMEWORK

All FACE assessments use a holistic person-based assessment framework. The framework has been designed to meet the following requirements:

- The framework should permit a holistic multi-dimensional representation of a person, encompassing health, social and functional domains.
- The framework must have a dual aspect: it must be capable of being used for both assessment purposes on a day-to-day level and for measurement purposes.
- The framework should be capable of use by service users as well as practitioners in thinking about their lives and condition.
- The framework should be capable of use across health and social care.

Based upon the above principles a framework has been developed that organises all FACE Assessments into the following high-level domains:

- The Psychological domain covers all aspects of psychological functioning and well-being, including signs and symptoms of mental ill-health, cognitive function, behaviour, personality, beliefs, values and attitudes.
- The Physical domain covers all aspects of physical health and well-being, illness, disease prevention, sensory and physical impairment and disability.
- The Activities of Daily Living domain ranges from basic aspects of personal functioning e.g. self-care, eating and drinking to more complex activities such as educational skills and work performance.
- The Social domain includes all aspects of social relationships, interpersonal functioning, social circumstances, such as financial, housing or legal circumstances and social vulnerability. It also includes the needs and circumstances of Family & Informal Carers.

Additional domains also include, for example, Personal and Social History, Response to Care (e.g. compliance, satisfaction) and Risk.

The FACE Framework has a dual aspect. First, it provides a simple, broad and neutral multi-dimensional framework for organising assessment information on a day-to-day level. The framework has proven to be acceptable to practitioners of many backgrounds working within both health and social care, thus making it a viable organising schema for multi-professional, multi-agency work. In addition, the FACE Framework has robust psychometric properties that make it acceptable as a framework for measurement. Thus, for example, it makes sense to talk about a 'Physical well-being' score that gets better or worse over time; or an 'Activities of daily living' score that improves or deteriorates.

Considerable technical work has been undertaken over a ten-year period to demonstrate these two features. However, the essential point is that this dual aspect facilitates the integration of recording and measurement functions: recording is facilitated by the broad acceptability of the framework at ground level and measurement is facilitated by use of the framework for scoring purposes. Thus the FACE framework 'faces' in two directions: towards simplifying information gathering at ground level and towards the use of that information for measurement purposes, for example in population profiling, measurement of dependency or of outcome.

The analysis of the naturally-occurring process and the FACE Framework have been used as the starting point for the development of a variety of FACE Toolsets for different care groups. These include:

- Older people
- Young people
- Mental health
- Learning disability
- Podiatry

Each toolset uses the same holistic approach and covers all FACE domains. However, different toolsets have different emphases or slightly different content according to the range of needs of the particular care group.

1.3 FACE FOR OLDER PEOPLE/SINGLE ASSESSMENT

The FACE framework is compatible with the domains of Single Assessment as set out in Department of Health guidance and it has therefore proved possible to develop Assessment tools for Older people/Single Assessment which both meet guidance requirements and which are compatible with FACE Toolsets developed for other care groups.

The Core Assessment & Outcomes Package for Single Assessment and Older People's Services contains two sets of tools:

- The Contact and Overview Tools
- The Second-line Assessment Tools

The Contact and Overview Tools contains the following tools designed to support Overview Assessment. These are:

- Background information & Contact assessment
- The Overview Assessment
- The Carer's Questionnaire
- The Service User's Questionnaire

A detailed account of the design and rationale of these tools is provided in sections 2 and 3 below and is also included in the accompanying user's guide and Training materials.

Second-line tools include:

- Communication Assessment
- Assessment of Lifestyle and Personal Strengths
- Assessment of Psychological Well-being
- Assessment of Activities of daily Living
- Assessment of Physical well-being
- Social Assessment
- Risk Profile
- Carer's Assessment

Collectively, the second-line tools provide a comprehensive assessment of the person. Although 'specialist' in the sense that they go into considerably more detail than the Overview assessment, the tools are designed for multi-professional use and use language that should be intelligible to all members of the multidisciplinary team. This contrasts with 'specialist' tools that are designed for uni-professional use and which would not be readily intelligible by practitioners from a range of disciplines. Whilst the present submission is for accreditation of the Overview Toolset, the Second-line tools are included within the submission, partly for general information purposes and partly to illustrate the relationship between the level of assessment undertaken within the Overview Toolset and the more detailed tools.

As described in Section 2 below, the more in-depth assessments can be triggered by different parts of the Overview Assessment. There is a fine line between the use of an Overview assessment tool to screen for issues that require in-depth assessment and the use of the Overview tool to assess those issues themselves. The FACE second-line assessments are designed to pick up where the Overview tools leave off, with overlap being kept to a minimum.

2 THE CONTACT AND OVERVIEW TOOLSET

This section describes the Contact and Overview toolset. Much of it is reproduced with minor wording changes only from Section 2 of the Training Materials, which form an essential part of the package.

FACE contains 4 tools designed to support Overview Assessment. These are:

- Background details and Contact assessment
- The Overview Assessment
- The Carer's Questionnaire
- The Service User's Questionnaire

The central tool is the Overview Assessment itself, but the other tools play an important supporting role, which may vary according to the needs of the service user and the context in which assessment is being undertaken. As the idea of a 'toolset' implies, the underlying concept is to provide practitioners, service users and carers with a set of tools that may be used in different combinations to achieve the desired goal of accurate person-centred assessment proportionate to the need of the individual.

2.1 AIMS OF THE TOOLSET

The remainder of this section describes the design, purposes and content of the different tools. As will be seen, the tools are designed to document each step in the naturally occurring process and to respond to the range of contingencies that may arise during this process.

The Overview Assessment is intended to be:

- Succinct but comprehensive.
- Sufficiently structured as to ensure that all relevant areas are covered but not so prescriptive as to impinge upon the natural assessment process or professional judgment.

- Sufficiently precise to be acceptable to skilled, experienced staff; yet couched in sufficiently everyday language to be easily understood and used by less-skilled staff.
 - Proportional to the level of need presented.

In addition to conforming to these broad principles the tool has a number of specific aims:

- To provide a holistic assessment of the service user's and carers' concerns/problems/needs.
- To screen for risk.
- To identify difficulties with independence.
- To identify needs for further screening/specialist assessment.
- To summarise needs, risks and protective factors.
- To record the above succinctly and in an easy-to-communicate format.

The Overview Assessment is NOT a goal-setting and care planning tool but designed to lead naturally into such a process if it is required. The setting of goals and planning of care, including determination of interventions, frequency, whom to be involved, ongoing monitoring and review, and evaluation of goal attainment form part of the Care Planning tools also provided and do not form part of this submission. Whilst it would be straightforward to include elements of this system within the Overview Assessment a conscious decision has been made not to do this at present, for two reasons.

First, assessment information and care planning information are logically distinct. Whilst the experienced practitioner will naturally consider care options when undertaking an assessment there is benefit in a clear distinction being made between the point at which assessment ends and that at which goal-setting and care planning begin. Not least, it prevents practitioners from arriving at premature judgments concerning interventions prior to a full assessment being completed and thus before the links between different needs have been established and priorities agreed.

Secondly, goal-setting and care planning systems are often already established at a local level and SAP implementation may be needlessly complicated by imposition of an alternative approach to that already in existence. This is especially so in relation to electronic implementation since many areas have care management and/or clinical system which already contain an approach to care planning which may or may not be compatible with the FACE Care Planning approach. Implementation of SAP would be greatly complicated if mappings or other complex relationships needed to be established with such systems.

Thus the approach has been to draw a very clear line between Assessment and Care Planning, offering the FACE approach to goal-setting and care planning as an option to local services but not formally including it as part of the Contact and Overview toolset.

2.2 WHO THE TOOL IS FOR

The Overview Assessment is designed for multi-professional use and is being used by the full range of health and social care professionals involved with adult services.

It can be used in wide range of care contexts including home-based assessment/care, general practice settings, acute hospital settings, social care and mental health services.

2.3 FORMAT OF THE TOOLS

All tools may be completed on paper as shown. However, they are supplied on CD-ROM as Word templates. This includes a version with Word 'dropdown' fields for easy completion. Users of the tools who wish to complete them on paper simply print out as many copies as they wish. If completed on PC then the space available for free text will expand as required. If completed on paper additional space may be required and for this purpose a continuation sheet is supplied.

Supply of the tools in Word template form has several benefits. First, if local users of the tools wish to make minor modifications to the documentation to conform with local requirements then they can do so by simply editing the templates. So, for example, inserting a local logo or an additional data item or a variation in wording can be undertaken directly. Secondly, the Word templates are formatted in such a way as to permit them to be completed directly on computer, even in the absence of a fully electronic version. Recording information in this way has many advantages: descriptive notes are far easier to read than hand-written notes; multiple copies of the documents can be printed out (making it easy to e.g. give or send a copy to the service user); and electronic transmission using e-mail to colleagues or other agencies is straightforward, assuming that the necessary encryption protocols etc. are in place. Thus, even in the absence of a fully integrated electronic infrastructure, data collection and communication can still be considerably simplified.

In addition to the Word template format, the tools are also available in full electronic form through a number of software suppliers and on a number of platforms, including Tablet PCs, laptop and desktop PCs. In fully computerised form the tools more easily support a wider range of functionality, including feeding the Single Assessment Summary, the measurement of dependency, tracking of goal attainment and measurement of outcomes. In addition, within electronic versions prompts and considerations may be shown automatically and links between domains explored (see also 2.7 below).

2.4 BACKGROUND INFORMATION & CONTACT ASSESSMENT

The Background information form collects: basic demographic information; details of household, key holder and access; details of key individuals, such as Nominated contact, Next of kin, GP and Dentist; and Referral Details. The latter includes both details of initial referral and onward referral, where appropriate.

Wherever possible national data standards (e.g. regarding ethnicity, items from the RAP dataset) have been used.

The Background information form is an optional element of the package since some localities already have pro formas which collect similar data and there may be little value in adjusting this documentation. Thus in some areas the FACE form is being used as standard; in others a pre-existing local document is being used. This is in accordance with the design principle of permitting flexibility in use of the toolset as long as the integrity of the central assessment tool is not compromised.

The Contact Assessment on the final page is designed to meet Department of Health guidance concerning the '7 questions' for contact assessment. The initial section in page 1 is headed 'Presenting problems and needs' and provides space for documentation of the service user's view of their problem/concern/difficulty as they initially formulate it in their own words. If the Service user questionnaire has been completed this may be used as the basis for what is recorded in conjunction with whatever further details are offered by the service user once conversation begins. This corresponds to Step 1 of the 'naturally-occurring process' referred to in Section 2 above.

Once there is a shared understanding of the problem/need the practitioner should be in a position to determine whether a full Overview Assessment is required. As indicated, it may be evident from the outset that specialist rather than overview assessment is required, in which case this can be indicated in the relevant box pertaining to further actions.

In attempting to understand the service user's description of their problem or concern the practitioner will become aware of any difficulties they are experiencing in understanding and therefore should be able at this stage to take a view as to whether the service user has communication difficulties that may prevent or impede the assessment. If such difficulties are apparent then the fact should be recorded and the more detailed FACE Communication assessment undertaken. Note that communication difficulties arising from differences in preferred language and/or the need for an interpreter will have been identified and recorded in the Background information.

2.5 THE SERVICE USER'S QUESTIONNAIRE

One of the criticisms of the early versions of FACE for Older People was inadequate explicit documentation of the service user's perspective. This criticism has been addressed in several ways in V.5 of the toolset, both within the Overview Assessment itself and through inclusion of the 'How Are You?' Service User's questionnaire. The design of the latter tool took into account the following considerations:

- Some service users will consider it helpful to complete a questionnaire but others will not.
- In completing a questionnaire most service users will want to focus on their areas of concern and will not want to spend time documenting what may appear as irrelevant detail of other aspects of their life.
- The focus should therefore be on providing the service user with the opportunity to explain their concerns in their own words, without the distraction of either standardised wording or scaled questions.

The aim has therefore been to produce a brief questionnaire in an attractive, simple format. The four main questions focus on the person's concerns or difficulties, relevant background, their impact and what help the person would like:

Please describe the main problems, concerns or difficulties that you would like to discuss

When did they first start? Please describe any relevant background: (for example, any changes in your life that may have occurred recently)

How is your daily life affected at present? (for example, do you have problems with everyday activities such as dressing or shopping?)

What help would you like? (for example, medical help, practical help, someone to talk to)

In addition, a final question asks about consent for information-sharing:

Are you happy for your answers to be sent to others who may be involved with your care?

The questionnaire can be used in a number of ways: it can be sent to service users to complete prior to attending an appointment; it can be completed whilst waiting to be seen; or it can be used as a format for the practitioner to record the service user's view. The questionnaire provides a good starting point for the practitioner's conversation with the service user, leading in a natural way to exploration of the person's concerns or difficulties and what might be done to help. However, if the service user chooses not to complete it, the Contact and Overview Assessments also provide space for documenting the service user's perspective (see 2.7 below).

2.6 THE CARER'S QUESTIONNAIRE

The How Are You? Carer's questionnaire is similar in philosophy to the Service user's questionnaire. It is designed to provide the carer with the opportunity to express concerns or needs in a brief, simple and unthreatening format. The front of the questionnaire explains its purpose and requests basic information about the carer, whether they live with the person and, if not, how long a journey time it is for them to reach them. Inside, the questionnaire contains 7 questions were derived from discussion with local carers' groups and examination of the literature that carer's groups use to advertise their existence to other carers. They are designed to express in simple language the key concerns that carer's have:

Do you worry about leaving him/her alone?

Do you have time for yourself?

Would you like more information on his/her problems or care?

Do you think care giving is affecting your health or sense of well-being?

Is care giving affecting your relationships with other people? (e.g. friends or family)

Do you feel like you need a break from looking after him/her?

Do you have the opportunity to pursue your own interests e.g. work, hobbies, leisure activity?

Each question has three responses: 'Yes, a lot', 'A little' and 'No'. These can be scored 2, 1 and 0 respectively (with the exception of the question *Do you have time for yourself?* where the scoring is reversed).

These questions are followed by a statement that the carer may request a carer's assessment if they wish; and then by free text for them to describe in their own words any concerns or issues they wish to raise. Finally, the back page provides the opportunity for the carer to describe any specific help they would like and asks them to indicate whether they are happy for the information to be shared.

The question is often asked whether a score above a particular threshold on the questions should 'trigger' a formal carer's assessment. The answer to this is twofold. On the one hand, we do not believe it appropriate for an absolute score to determine whether a carer's assessment is required. For example, the answer 'Yes, a lot' to the question: '*Do you think care giving is affecting your health or sense of well-being?*' probably indicates the need for a carer's assessment, even in the absence of a positive answer to any of the other questions. So common sense and practitioner discretion must be allowed to play their part. On the other hand, once

sufficient data has been collated from use of the Carer's questionnaire it will be feasible to examine the relationship between scores and subsequent undertaking of carer's assessments and provision of support. This will enable the generation of advice to practitioners to support their judgment, along the lines of x% of carer's who had a score above y were judged to require z level of support. Such advice will be able to usefully inform practitioners (and carers) in making their judgments of need, without prescribing in a mechanistic manner. The approach here thus follows the principle of not supplanting but supporting practitioner judgment.

2.7 THE OVERVIEW ASSESSMENT

This section provides a description of and commentary to the content of the Overview Assessment. First, however, there are a number of important general points to be made about the design of the tool:

The layout of the tool is designed to facilitate flexible movement between free-flowing conversation, structured assessment and recording of needs, and recording of more personal descriptive detail relevant to the individual in free text format. Guidance on completing the assessment, in the form of both prompts and considerations is provided on the left-hand page³. This guidance is itself an abbreviated form of the more comprehensive guidance available in the User's Guide.

The tool has **ten** pages. For convenience each page is described separately.

Page 1

In V.5 all reference to the term 'older people' has been removed. This is for two reasons; first, some service users do not like being described as an 'older person' and secondly because the V.5 tool is designed to be used as a generic tool, rather than just with older people.

The Personal details section records name, date of birth, NHS and Social Services ID.

The Assessment details section records details of who undertook the assessment.

The first paragraph summarises the person's presenting **problems, difficulties or concerns**, as they are understood following the initial process of exploration (step 2 of the naturally-occurring process). In general, this will be a shared/agreed understanding but in some cases differences between the service user and practitioner may have become apparent even at this early stage, in which case these should be explicitly recorded.

Throughout the assessment practitioners need to be aware of the possible impact of cultural or spiritual issues on the assessment. This includes: ensuring that as a practitioner the problem or concern is understood in the correct cultural context; appreciating how that context may affect the service user's perception and understanding of their difficulties; and appreciating how the context may facilitate or constrain possible approaches to addressing the person's problems or needs. It is therefore essential that the practitioner is alert to cultural and spiritual issues from the beginning of the dialogue. For this reason, space for documenting such points is

³ Except for page 1, where guidance is included on the back page of the assessment.

provided at this early stage, even though such issues require consideration throughout the assessment. In addition, cultural understanding may be as relevant to addressing a simple issue requiring only contact assessment as one that requires a full overview assessment, so it is essential that space for recording such issues is permitted early on in the document.

At this early stage it is also important for the practitioner to appreciate what other services the service user may have been in contact with or is already receiving. The checklist of formal care/support currently received and the associated space for free text permits this to be documented.

General note on pages 2-7

Pages 2-7 form the heart of the Overview assessment. The headings used to organise the assessment are those of the FACE framework (see above). If conducted in the order on the form the assessment would move from review of the person's physical well-being to consideration of their psychological well-being and then any medications currently being taken. From there the impact of such difficulties on their independence would be assessed, followed by **exploration of social support** and circumstances and the involvement of informal carers.

However, the assessment does not, however, necessarily have to be completed in this order. If the initial presentation is more clearly a social problem the 'social' sections can be completed initially and the 'health' sections returned to at a later stage. Thus the documentation process can follow the natural flow of interaction between the service user and practitioner rather than dictating it. The assessor should therefore choose in which order to undertake the assessment, so that from the service user's point of view the focus is on those issues which concern them and broadening out from there rather than an apparently arbitrary order imposed by the practitioner. The succinct format of the tool makes this reasonably easy to achieve in practice and of course is made even easier in electronic format.

Page 2

Page 2 documents the results of the assessment of **Communication and Physical well-being**, including **medical history and health screening**. The primary objectives are:

- To document problems reported directly by the service user.
- To record the practitioner's view of the person's well-being.
- To screen for problems that may not have been initially reported by the service user but which may be relevant to their presenting problem/need or of importance in their own right.

The use of the tool is fairly self-explanatory: in the left-hand boxes the practitioner records whether or not an issue was identified in each area and enters details of problems/needs as reported by the service user and formulated by the practitioner in the free text space provided. The items are ordered so that the service user is provided with the opportunity to report initially in general terms whether they feel well or unwell and then this leads into a more specific review of how they are eating and drinking, whether there are known illnesses, whether the person has been having problems with their bowels etc. Sample prompt questions are provided in the

User's Guide to help inexperienced or less skilled practitioners complete the assessment.

Space is provided for the recording of ICD-10 Diagnosis if known. If not, the assessor is asked to provide a description of known conditions.⁴

It is important to identify positive aspects of Physical well-being as well as needs or problems. This is stressed by the guidance notes within the tool for each section.

A key requirement of the Physical assessment is to ensure that health screening is up to date so this area is highlighted separately and the practitioner asked to document findings of the most recent screening separately.

Specific questions pertaining to current alcohol consumption and smoking are also included, with a text box for recording previous history.

As with all domains, the guidance notes within the tool direct the assessor to record both their view and the service user's view of any problems identified or reported.

By the time the Physical assessment has been completed the practitioner should be in a position to judge whether further Physical assessment or referral is needed, as per the 'trigger' provided on the form. In addition, the Physical assessment provides a natural 'lead-in' to the assessment of psychological well-being since mental health problems are typically associated with such symptoms as lack of energy, poor sleep, reduced appetite etc. which may also be touched upon in a physical context.

Page 3

The first panel on Page 3 documents the results of the assessment of Psychological well-being. The primary objectives are:

- To document problems reported directly by the service user.
- To record the practitioner's view of the person's well-being.
- To screen for problems that may not have been initially reported by the service user but which may be relevant to their presenting problem/need or of importance in their own right.

The 'checklist' of mental health issues comprises 'key indicators' of mental health difficulties: problems with low, irritable or changeable mood; somatic symptoms such as lowering of energy, sleep problems; poor or reduced memory; anxiety; risk behaviours such as wandering, suicide attempts; and indicators of severe mental illness (e.g. hallucinations, odd or inappropriate behaviour). Space is provided to detail ICD-10 diagnosis using an abbreviated set of ICD-10 Mental and behavioural disorders based upon the main Chapter 5 sub-headings of ICD-10⁵. Again, sample

⁴ Consideration has been given to provision of an abbreviated checklist of ICD-10 chapter headings for this purpose to aid assessors, as for the Mental Health diagnoses in the following section. Unfortunately, ICD-10 is not terribly well-suited to this purpose since the chapter headings do not provide a clear guide to the non-expert assessor as to what is classified below. For example, whilst many infectious diseases are classified under codes A-B in Chapter 1 'Certain infectious and parasitic diseases', many common infections are classified elsewhere (e.g. upper respiratory tract infections) occur in Chapter 10, Diseases of the respiratory system.

⁵ The list was developed by the National Casemix Office for national use for groupings in mental health.

prompt questions are provided in the User's Guide to help inexperienced or less skilled practitioners complete the assessment.

If a mental health problem is identified then typically the person will be referred for specialist mental health assessment elsewhere, using the more in-depth FACE Psychological well-being assessment designed for this purpose or other locally-used tool.

The bottom section of page 3 records both the use of medication and any associated difficulties in administration or access. From a conversational perspective it is natural to move from discussion of physical and/or mental health problems to consideration of medication being provided to address them.

Medication is a complex area and so detailed guidelines are given within the guidance regarding the areas that need to be covered. These include: prescribed medication; other medication; use of other supplements; side-effects; difficulties/help required in taking or accessing medication; and the need for medication review. If the service user does not report taking any medication then this is entered at the top of the section and the assessor is instructed to move directly to the next section.

Page 4

This section is headed 'Activities of daily living'. Following consideration of physical and/or mental health problems it is natural to move on to discussion of the impact of these on the person's independence and daily life.

The Activities of daily living section is the only section of the assessment that uses a formal scale. Activities are divided into three areas: self-care, everyday tasks and mobility. The person's level of independence in activities in these areas is rated using a scale ranging from 'performs independently' to 'unable to perform activity/activity performed by other person'. Within the mobility section, separate sections record mobility within and outside the home. **A summary rating of 'maximum level of assistance required' is also made.** [changed from 'overall level of dependency']

Finally, this section ends with two important questions: the first concerning whether there has been a decline in skills, including whether the person themselves has observed this; the second concerning the person's ability to respond to emergencies **and whether the person themselves perceives this to be a problem.** [not sure this is covered in guidance on form]

As with all other sections the assessor is asked to describe both the person's and the assessor's view, noting any differences of view. In this area there can be differences, especially if the assessor is especially aware of the risks associated with the person carrying out activities unaided whilst the person is more focused on the benefits of maintaining independence. The guidance notes therefore point the assessor to paying special attention to this issue.

If a problem/need is identified in the area of activities of daily living the assessor is advised to consider undertaking the specialist ADLs assessment or making an appropriate referral. However, the activities of daily living section is the most detailed within the overview assessment and in many contexts more detailed assessment may not be required, even if a need has been identified.

Page 5

[section on weekly activities removed, shading removed]

This consists of sections considering the person's interpersonal relationships and social circumstances including their housing situation, home environment, access to activities and employment, and finances. The assessor is guided to record both the service user's and their own view. The assessor is also specifically guided to consider the extent to which availability of social support and social circumstances, such as housing, finances etc. might have an impact on needs identified earlier within the assessment. A final item asks whether the person has been a victim of crime. Prompts help the assessor explore concerns in this area and whether they restrict activity.

In the event that a social problem/need is identified the assessor is guided to consider appropriate further assessments or make the necessary referral for such assessment to be undertaken.

Page 6

The top half of Page 6 focuses on Family and carers. In the first panel the presence of otherwise of an informal carer is noted along with the carer's personal details and frequency of contact. The assessor is asked to detail the relationship and type of support provided, as well as the presence of any other carers. In the next panel space is provided to record the carer's perspective on the person's problems/needs, including their hoped for outcome of the assessment.

The next section details the nature of the caring role. This is followed by questions about moving and handling risk, and what would happen if the carer was ill or unavailable.

The next section is used to record the carer's view of the help or support the service user requires. This is followed by a question about whether the carer provides regular and substantial care, and a question detailing the carer's assessment preference.

Page 7

The first section of this page outlines the carer's needs and concerns. This is followed by questions about risks to the carer's ability to care for the service user, and a section to record the carer's view of help or support they would like.

The final questions on this page detail whether a carer's support plan is required, and details of consent and information sharing. There is also a space for the carer/family member's signature.

Page 8

This page of the assessment is designed as a summary sheet that brings together the findings of the previous assessment, whether it be a contact assessment or an overview assessment.

The first panel asks the assessor to identify protective factors, that as positive aspects of the person's situation, whether these relate to levels of social support from outside, availability of resources or personal qualities of the person

themselves, such as resilience, personal abilities etc. Thus the assessor and the person are encouraged to take a balanced view of the situation: identifying the risks but also identifying those factors mitigating against risk which support the person's independent functioning and control of their own life.

From a process perspective the consideration of risk and protective factors is designed to lead to a balanced consideration and collaborative agreement on the nature of the person's key problems, concerns or difficulties. Whilst these may have been discussed in some detail both at the beginning of the assessment and during the more detailed discussion pertaining to each section, at this point in the process it is important to step back from the detail and to attempt to focus on a succinct and clear formulation of the main needs to be addressed. In doing this the assessor is guided to ensure that the wording used is agreed with the service user so that what results from the assessment, whether it be a care plan, referral or further assessment is clearly based upon a collaborative process in which it is transparent to all involved what the needs are and how they are to be responded to.

In the second section the assessor is asked to summarise risks to the person that may have been identified through completion of earlier sections, including documenting the person's and their carer's perception of such risks and any differences in perception. Each risk is rated 0 (no apparent risk); 1 (some apparent risk, no previous history confirming risk) or 2 (some apparent risk, with previous history). This is designed not as a formal scale⁶ but rather as a convenient shorthand method of summarising the presence of risk and the level of evidence supporting the judgment. The precise wording, using, for example, the phrase 'apparent risk' has evolved over a period of years. We have found that practitioners are more comfortable with this wording than standard ratings of risk which often make practitioners feel they are being forced into a prediction of the future rather than simply describing in a precise way what appears to them at present. The guidance notes encourage the assessor to link perceived risks to factors identified earlier in the assessment.

This is followed by spaces to record the service user's and carer's views and priorities.

Finally, the assessor's summary panel documents the impact of the person's current needs on their independence and quality of life, and the impact on the carer. The aim is at this stage to be integrating the findings from the previous areas of assessment (Step 9). This has several aspects:

- The extent to which current needs limit or restrict the person's daily activities.
- The extent to which current needs present a risk to the person or those around them.
- The extent to which different areas of need or areas of the person's life interact with or affect each other (e.g. a health need may limit activity but equally a lack of activity may increase dependency or present a greater risk of social isolation or mental health problems).
- The impact of those needs on the perception of the person. They may regard their needs as less serious or more pressing than the practitioner or their family/informal carers.

⁶ In fact, however, it does have strong psychometric properties.

-
- The predictability and stability of needs

Page 9

This page summarises the person's health and social care needs and overall level of need/risk. There are also three questions about whether the person would benefit from support to manage their condition, whether Direct Payments have been requested, and whether the need for continuing care is indicated.

The bottom section details action to be taken, including further assessments required. One action that may be indicated is the development of a care plan. In this case the assessor and service user may complete the FACE Care Planning documentation included within the package or complete a care and goals plan using local documentation.

Page 10

The top section of this page records whether consent issues have been discussed and whether consent was given. A free text box permits the recording of details of limitations in information-sharing and there is also a space for the signature of the service user. The approach to recording is deliberately non-prescriptive and non-legalistic, it being assumed that local services will be using either locally-agreed or nationally-accepted protocols to request and document consent. Thus the aim here is simply to document in an easy-to-transmit form agreements concerning information-sharing, so that receivers of the assessment will be informed of the situation.

This page also contains a 'record of completion' section, and provides space to indicate to whom copies of the assessment have been provided.

3 USING THE TOOLS

This section describes various aspects of the use of the Overview tools, including the documentary and practical support provided to users of the tools; results of field trials; current users and planned developments.

3.1 PROMPTS AND CONSIDERATIONS

Prompts and considerations are provided within the tool itself. These prompts and considerations are an abbreviated form of the more comprehensive guidance and prompts provided within the User's Guide (see below). As part of the training process practitioners are encouraged to become fully familiar with the User's Guide. This means that by the time they use the tool in the field the abbreviated prompts provide sufficient support in a form that is easy to refer to whilst conducting the assessment.

3.2 THE USER'S GUIDE

The User's guide forms an essential part of the Overview toolset. It has a number of functions:

- To introduce practitioners to the approach to assessment.
- To provide guidance on how to use the tool.
- To indicate detailed prompts/considerations that may be used in conducting the assessment.
- The User's Guide is the source of the prompts/considerations included as guidance within the paper-based tool. Practitioners are familiarised with the User's guide in training and encouraged to refer to it when beginning to use the tool. The comprehensive prompts and guidance in the User's guide can play a useful tool in training, especially with less experienced staff. The prompts can be used in role-play to ensure that less experienced staff learn the skill of ensuring that relevant areas are covered, whilst maintaining a conversational and open-ended style of interaction.

A useful training exercise is for practitioners to briefly run through the User's guide after having completed an assessment, checking the extent to which their use of prompts and following of guidance was satisfactory and noting areas that they may have explored insufficiently. A self-report format is being developed for this purpose. The concept is that this should operate as a form of self-training and ongoing learning that helps ensure that the standards and principles of assessment are maintained.

In computerised forms of the tools the full guidance, prompts and considerations from the User's guide can be pulled up automatically as the assessor arrives at each section, thus providing a seamless method of ensuring that the assessor has access to the relevant guidance whilst completing the assessment.

3.3 TRAINING MATERIALS AND APPROACH TO TRAINING

FACE provides both training to staff who plan to use the tool and 'training the trainers' training sessions for trainers appointed to lead the use of the tools. Training sessions have a strong interactive component and rely on the use of 'vignettes' designed to help practitioners learn to use the tools (see the FACE Training Materials document). These provide an entertaining and instructive focus for learning about the tools and are also designed to result in high levels of consistency in use of the instrument.

3.4 RELIABILITY AND VALIDITY

Considerable development work has been undertaken to demonstrate the robustness of the FACE framework. These include demonstration that the domains are internally consistent, independent and reliably used by practitioners from a range of professional backgrounds.

Only one section of the Contact and Overview Assessment, that covering activities of daily living, is intended to provide a measure of functioning. The other sections are designed to collect contextually relevant information to support judgments of need and/or to screen for the presence of problems or difficulties that require further assessment using tools that do have strong measurement properties.

To date reliability and validity has studies have focused on those items which use a formal a scale. First, two small inter-rater reliability studies were undertaken with district nurses on an early version of the tool to ensure that high levels of agreement were achievable on these items (see Table 2 below).

Table 2: Inter-rater reliability of key FACE measurement items			
Study 1 (n=20)			
Items	Weighted kappa for continuous ordinal scores	Weighted kappa for dichotomous ordinal scores	Intra-class correlation co-efficient
Self-care	0.60	0.64	0.86
Everyday tasks	0.65	0.69	0.78
Mobility	0.90	0.91	0.89
Overall dependency	n/a	n/a	n/a
Study 2 (n=25)			
Item	Weighted kappa for continuous ordinal scores	Weighted kappa for dichotomous ordinal scores	Intra-class correlation co-efficient
Self-care	0.83	0.82	0.93
Everyday tasks	0.81	0.81	0.94
Mobility	0.91	0.91	0.93
Overall dependency	0.76	0.77	0.87

The table shows that satisfactory levels of reliability were achieved, especially on the later (study 2) version of the items.

In addition, assessments completed by practitioners during training sessions have been collated to assess the level of agreement shown by different practitioners based on the training vignettes. Review of the data to date has shown high levels of agreement and similar studies on other FACE Assessments have consistently produced kappas of around 0.9. Such data is now being collated routinely at FACE training sessions. This will provide the raw material for analysis of more substantial quantities of data (e.g. comparing levels of agreement across professions) and is intended to result in the ability to feed back routinely to practitioners on the level of consistency achieved.

Concurrent validity studies have also been undertaken comparing scores on the Overview Assessment with scores on other established tools, the Cape and the Barthel (n=35). The total FACE score had a correlation of 0.73 with the Barthel total score, with individual items correlating 0.5-0.7. The correlation with the CAPE total score was similar at 0.72, with correlations on individual items again being generally in the range 0.5-0.7.

The Contact and Overview Assessment has been shaped by a combination of the overall FACE approach, national guidance and extensive consultation over a long period with representatives of all professions, service users, carers and independent organisations. This, coupled to the fact that many areas have moved towards adoption following pilots is suggestive of adequate content validity. Over the past year the tool has begun to be used on a wider basis and this has provided the opportunity to set up a more extensive research programme. Studies are currently being planned which will examine the reliability of identification of need using the tool on a domain by domain basis. There are now several FACE 'beacon sites' who are committed to undertaking a minimum of one reliability or validity study per year and have agreed to supply anonymised data for statistical and research purposes. These arrangements are designed to ensure that the evidence base continues to grow and is maintained over time.

3.5 USERS OF THE TOOLS

There are now about 150 health and social care organisations using the Overview toolset. Many of these are listed on the FACE website (www.facecode.com).

All services are planning full roll-out of the tools in their organisation/locality.

The Overview tools are being used in a wide range of settings including:

- District nursing teams
- Intermediate care teams
- Social work teams
- Discharge co-ordination teams
- Specialist falls nurses
- Rehabilitation wards
- Accident and Emergency services
- Community Mental Health Teams

- Mental health in-patient wards

Whilst most practitioners are using the Overview Assessment as their central assessment tool, in some contexts the Overview Assessment is being used in conjunction with one or more of the second-line. For example, some older people's mental health services are using the Overview Assessment as a broad-based holistic tool in conjunction with (as a minimum) the Psychological well-being Assessment, which provides a more in-depth assessment of mental health issues as would always be required in secondary services.

3.6 COMPLETION TIME

The time taken to complete the Overview Assessment is reported to range from 45 minutes to an hour and a half with the average being about one hour. As would be expected, completion time is reported to reduce significantly as practitioners become accustomed to the tool.

3.7 FEEDBACK FROM USERS OF THE TOOLS

The instrument has been developed over a 5 year period in close collaboration with practitioners working in a wide range of settings, including primary care, social services, intermediate care and mental health services. As well as testing of acceptability and usability to practitioners, feedback from users and carers has been sought to confirm relevance, ease of use and acceptability of language.

Many areas using the tools have conducted their own field trials, some of which have been independently evaluated. Such trials have involved all stakeholders and typically involve feedback from both health and social care practitioners.

Initial use of the tools (in 2001) received mixed feedback. Some practitioners found it too long – perhaps because they were unused to conducting holistic assessments – whilst others felt it did not cover some areas in sufficient depth. It was sometimes hard to evaluate this feedback as many practitioners were only beginning to come to terms with the concept of single assessment and this combined with the many local process issues often meant that perceptions of the tool were affected by broader issues.

However, in the past year, since the release of Version 3 in early 2004, positive feedback has improved dramatically and there has been much wider take-up of the tools. Overall, current feedback suggests that the format provides an attractive balance between structured recording and the ability to record in free text. Many practitioners have commented on the clarity and practicality of layout and general ease of completion. As one project lead reported:

“People seem to appreciate the balance of prompts, opportunities to seek user input and the facility for concise summaries of issues arising, such that one can get an at a glance picture.”

Many practitioners have also commented that the tool leads *“to a very person-centred assessment.”*

The response from service users has also been favourable. One project lead reported that:

“users like the form and feel that it covers the areas that they feel are important to them.”

The fact that it is possible to complete the online in Word format has also attracted a lot of positive comment, especially in areas where full electronic implementation of SAP is not an immediate goal.

The developers are continuously receiving feedback and requests for changes and new inclusions are considered for each new version and agreed with existing users of the tools.

3.8 FUTURE DEVELOPMENTS

The developers are committed to continued development of the tools. This will be done, as it has been to date, through a combination of interaction with users of the tools and more formal research and development. Developments under way include:

- Use of the tool for outcome measurement.
- The development of tool for self-assessment and for use with long-term conditions.
- The development of databases for research and statistical purposes. These will enable the establishment of norms which can be used to inform decision-making and the exploration of issues such as the relationship between different scores and combinations of needs on referral, level of provision and outcome.

4 DEVELOPER'S RESPONSE TO CRITERIA FOR EVALUATING OFF-THE-SHELF ASSESSMENT TOOLS

See table below and following Appendix.

Developer's Response to Criteria for Evaluating Off-the-Shelf Assessment Tools				
Criteria	Evaluation			
	Yes	To a great extent	To some extent	Hardly at all / No
1. Does the wording and structure of the tool facilitate a person-centred conversation suitable for older people and professionals alike?	YES			
	<p>The tool is designed to follow and support the naturally-occurring flow of interaction between practitioner and service user (see Table 1). Throughout, opportunities for a natural flow of information are maximised. The assessment is worded so that on the one hand it has the necessary precision to support professional assessment but on the other is intelligible and non-technical so that it can easily be understood by service users.</p> <p>The structure permits the order of assessment to follow the concerns of the service user and thus maintain a natural process of holistic exploration.</p> <p>The layout is conducive to maintaining an appropriate balance between ensuring that key areas are covered and documenting personal descriptive detail relevant to the individual service user. This balance is vital to maintaining the conversational aspect of the assessment.</p> <p>Guidance makes clear at all stages both what information is required and the necessity of focusing sensitively on the service user's perspective. In addition, the emphasis on recording positive as well as problematic aspects of well-being and circumstances ensures that the service user does not experience the assessment as being inquisitorial or focusing unduly on negative aspects of their lives.</p> <p>The provision of optional prompts, both on the form, in the User's Guide and in training materials enables less experienced practitioners to draw out assessment information in a respectful and non-intrusive manner. Experienced practitioners can also use these as flexible guidance.</p>			

<p>2. Does the tool make the contribution of older people to their assessment explicit?</p>	<p>YES</p>			
<p>3. Does the tool keep older people's views, wishes, strengths & abilities to the fore?</p>	<p>YES</p>			

The tool makes the older person's contribution explicit throughout the assessment:

- The Service user's questionnaire provides an initial opportunity for the service user to document their concerns, when they started, their impact and the help they would like.
- The Contact and Overview document presenting problems and needs and in the user's own words.
- Page 1 'Cultural/spiritual issues relevant to assessment' – guidance indicates to record person's own words if possible.
- Page 1 'Summary of person's presenting problems or needs' guidance notes require recording of service user perspective.
- Pages 2-5 guidance notes for these pages each major section require recording of person's and assessor's view. User's guide prompts for each area enable user to describe in own words throughout assessment.
- Page 7 – guidance notes for these pages require recording of service user's perceptions of risk.
- Page 7 – guidance notes for these pages require recording of service user's perception of protective factors.
- Page 8 – Summary of key problems, concerns or difficulties, wording to be agreed with service user.
- The tool guides the assessor towards a dialogue with the person being assessed after which a jointly owned description of need is recorded and goals jointly agreed. The tool also guides people toward an explicit recording of differences in perspective if this occurs.

The older person's views are kept to the fore throughout (see response to Criterion 2 above.)

The older person's expectations/hoped for outcomes are recorded as part of the Contact assessment.

Throughout the Overview assessment, assessors are then explicitly guided towards highlighting those individual preferences, strengths, and personal qualities which act as protection against challenges, this emphasis being reinforced in the User's guide. For example positive aspects of well-being are recorded in the Physical and Psychological sections; and the assessor is guided to emphasise positive aspects of independence as well as dependency needs.

The explicit recording of protective factors on the last page ensures that needs are assessed in the light of positive strengths and abilities, a requirement reinforced by the User's guide.

<p>4. Does the tool make the impact of older people's environments, relationships and other factors on their needs explicit?</p>	<p>YES</p>			
<p>5. Is the tool presented and designed to support professional judgement?</p>	<p>YES</p>			

The guidance and content of the Social circumstances section and Family and informal carers sections (page 6) ensure that these factors are taken into account in an explicit manner. The assessor is also prompted to highlight the need for more in-depth assessment if required.

The section on 'Overall impact of current needs' (page 8) explicitly documents the current and future impact of the person's needs on their day-to-day life and the interaction between different needs.

The User's guide guides assessor to take these factors into account in considering key problems/needs and possible intervention.

More broadly, the underlying holistic assessment model is open as regards direction of causality in relation to either health or social needs and thus encourages broad consideration of these issues.

A key principle underlying the FACE approach is to support rather than supplant professional judgement and considerable research has been undertaken to ensure that the approach to assessment captures the underlying consistency and expertise of professional judgment in a structured manner that is experienced as acknowledging rather than overriding professional skills and autonomy.

This approach is made very clear in both the layout and guidance within the tool, the User's guide and Training materials.

Tool development has taken place (and continues to take place) through a process of continual dialogue with 'grass roots' practitioners from all professions and has found wide acceptability.

<p>6. Does the tool help professionals to link different parts of the assessment, evaluate risks, and refer on to other agencies?</p>	<p>YES</p>			
<p>7. Does the tool take fair account of age, gender, race, disability and other factors that may have a bearing on needs and care plans?</p>	<p>YES</p>			
<p>8. Does the tool adequately cover the domains/sub-domains of the Single Assessment Process? (See Annexes F and H, HSC 2002/001; LAC (2002)1)</p>	<p>YES</p>			
<p>9. Is the tool suitable for use by a range of health and social care professionals?</p>	<p>YES</p>			

<p>10. Do manuals or guidance give clear instructions on how the tool should be used, by whom and when?</p>	YES		
<p>11. Is the tool contractually bound to the provider of a single software solution?</p>	NO		
<p>12. Does the tool provide information for the Single Assessment Summary?</p>	YES		
<p>There are 3 levels of guidance associated with how the tool should be used:</p> <ol style="list-style-type: none"> 1. The structure of the tool itself, which guides the assessor through the assessment process, including prompts and triggers that are incorporated within the Overview Assessment itself. 2. The User's Guide provides extensive guidance on how to use the tool, by whom and when. It also includes sample 'prompt' questions for practitioners to consider using when conducting the assessment. 3. Training Materials provide comprehensive supporting documentation including: <ul style="list-style-type: none"> - introductory material for trainers on the principles and design underlying the tools - detailed explanation of how the tools should be used - standardised training vignettes which trainees can use to complete the assessment when training. Associated with each vignette is a table setting out the appropriate answer to each item within the tool and explanatory notes. 	<p>Our policy is to support as wide a range of software suppliers as possible in providing FACE Assessments in electronic form. We have no special arrangements with a provider of a single software solution.</p>	<p>As described below, the tool provides information required for the Single Assessment Summary. In addition, the developers are committed to ensuring the tool maximises support for the Single Assessment Summary once the Summary is finalised.</p> <p>The Basic Personal Information collects data required by the Assessment Summary.</p> <p>Throughout the Overview Assessment a standard key/method of annotation is used for indicating the presence of a need, whether it is being currently addressed or whether it has been previously addressed, thus permitting generation of the Needs and Circumstances codes required for the Assessment Summary (see page 2 onwards).</p> <p>The section on 'Overall impact of current needs' page 8 generates information pertaining to the 'Impact of current needs' section of the Single Assessment Summary.</p> <p>Risks to independence are captured in the 'Summary of risks arising' section page 8.</p> <p>Within the broader FACE package, the Lifestyle and Personal Strengths assessment records the Additional Personal Information required by the Assessment Summary.</p>	

<p>13. Does the tool use national standard data-sets where appropriate (or is the tool capable of using such data-sets as they become available)?</p>	<p>YES</p>			
	<p>Every effort has been made to follow national standard datasets. Our general policy is to follow national standard data items and classifications. In the present version of the tool we have, for example used standard items from the RAP dataset and the ONS ethnic origin census classification in the abbreviated form recommended by NHSIA. Our commitment to users of the tools is that we will incorporate such data-sets and their associated items and classifications as they become required.</p>			
<p>14. Does the tool satisfy statutory requirements with respect to consent and confidentiality, including the Human Rights Act 1998?</p>	<p>YES</p>			
	<p>The recording of consent to the sharing of information is explicit. The levels of possible information-sharing are made clear and exceptions to this documented in the User's guide, with guidance on managing this issue sensitively.</p>			

Appendix: The FACE Overview Assessment V. 5 and The Domains of Single Assessment	
USER'S PERSPECTIVE	How addressed
Needs and issues in the user's own words	<ul style="list-style-type: none"> • The Service user's questionnaire provides an initial opportunity for the service user to document their concerns, when they started, their impact and the help they would like. • The Contact and page 1 of the Overview document presenting problems and needs and in the user's own words. • Page 1 'Cultural/spiritual issues relevant to assessment' – guidance indicates to record person's own words if possible. • Page 1 'Summary of person's presenting problems or needs' guidance notes require recording of service user perspective. • Pages next to 2-5 guidance notes for each major section require recording of person's and assessor's view. User's guide prompts for each area enable user to describe in own words throughout assessment. • Page 8 – guidance notes require recording of service user's perceptions of risk. • Page 8 – guidance notes require recording of service user's perception of protective factors. • Page 8 – Summary of key problems, concerns or difficulties, wording to be agreed with service user.
User's expectations, strengths, abilities and motivation	<ul style="list-style-type: none"> • The Service user's questionnaire provides an initial opportunity for the service user to describe their expectations. • The Contact and p.9 of Overview – guidance requires recording of expectations/hoped for outcomes. • Pages 2-9 – guidance for these pages requires recording of positive aspects of physical and psychological well-being, independence and social support and circumstances. • User's guide to pages 2-9 checks whether assessor has recorded strengths/abilities in each FACE domain and points to recording of both positive aspects of well-being and positive aspects of adaptation/coping with difficulties. • Page 8 – protective factors – requires recording of user's and assessor's perceptions, including summarizing of user's personal abilities/resilience/motivation.
CLINICAL BACKGROUND	How addressed
History of medical conditions and diagnoses	<ul style="list-style-type: none"> • Guidance to 'Summary of person's presenting problems or needs' indicates need to record relevant background, including illnesses. • Physical well-being guidance indicates need to record allergies, personal or family medical history, diagnoses and recent admissions. • Physical well-being items on 'Life threatening or chronic illnesses', Seizures/epilepsy, Recent procedure. • User's guide includes prompt questions on personal and family medical history.

History of falls	<ul style="list-style-type: none"> Item within Mobility section page 4.
Medication use and ability to self-medicate	<ul style="list-style-type: none"> Medication section, page 6. Guidance notes pertaining to this section on page 6. Prompt questions relating to these areas in user's guide.
DISEASE PREVENTION	How addressed
History of blood pressure monitoring	<ul style="list-style-type: none"> Health screening section, page 2, guidance on vital signs. Item indicating if health screening is up to date/required. Guidance note to arrange if required. Prompt questions relating to blood pressure in user's guide.
Nutrition, diet and fluids	<ul style="list-style-type: none"> Items within Health screening section, page 2. Comprehensive prompt questions on these areas in user's guide.
Vaccination history	<ul style="list-style-type: none"> Health screening section, page 2, vaccinations included in guidance. Prompt questions relating to vaccination in user's guide.
Drinking and smoking history	<ul style="list-style-type: none"> Items on drinking and smoking in Health screening section, page 2. Prompt questions relating to current use and history of previous use in user's guide.
Exercise pattern	<ul style="list-style-type: none"> Health screening section, page 2, exercise taken included in guidance. Prompt questions relating to exercise in user's guide. Assessor guided to consider exercise taken as positive aspect of physical well-being in user's guide.
History of cervical and breast screening	<ul style="list-style-type: none"> Health screening section, page 2, guidance reference to cervical/breast screening. Prompt questions relating to cervical and breast screening in user's guide. Item indicating if health screening is up to date/required. Guidance note to arrange if required.
PERSONAL CARE & PHYSICAL WELL-BEING	How addressed
Personal hygiene, including washing, bathing, toileting and grooming	<ul style="list-style-type: none"> Items within activities of daily living section, page 4. Items on transferring to/from toilet; to/from commode in Mobility section, page 4. Item on continence within Physical section page 2 also provides opportunity to identify needs in this area. Prompt questions relating to these areas in user's guide.
Dressing	<ul style="list-style-type: none"> Items within activities of daily living section, under heading 'self-care', page 4. Prompt questions relating to these areas in user's guide.
Pain	<ul style="list-style-type: none"> Item within Physical well-being section, page 2. Prompt questions relating to this area in user's guide.
Oral health	<ul style="list-style-type: none"> Item within Physical well-being section, page 2. Prompt questions relating to this area in user's guide.
Foot-care	<ul style="list-style-type: none"> Item within Physical well-being section, page 2. Prompt questions relating to this area in user's guide.
Mobility	<ul style="list-style-type: none"> Extensive items on mobility within Activities of daily living section, page 4.

	<ul style="list-style-type: none"> • Prompt questions relating to this area in user's guide.
Continence and other aspects of elimination	<ul style="list-style-type: none"> • Item within Physical well-being section, page 2. • Prompt questions relating to this area in user's guide. • Item on personal hygiene within activities of daily section page 5 also provides opportunity to explore needs in this area.
Sleeping patterns	<ul style="list-style-type: none"> • Item on sleep within Psychological well-being section. • Prompt questions relating to this area in user's guide.
SENSES	How addressed
Sight	<ul style="list-style-type: none"> • Item within Physical well-being section, page 2. • Prompt questions relating to this area in user's guide.
Hearing	<ul style="list-style-type: none"> • Item within Physical well-being section, page 2. • Prompt questions relating to this area in user's guide.
Communication	<ul style="list-style-type: none"> • Need for interpreter, preferred language and other assistance required to support communication recorded on page 1 of Background information. • Is there a problem/difficulty with communication item in Contact, including prompt to complete Communication assessment if required. • Guidance notes within Psychological well-being section point assessor to focus on difficulties in expression/understanding. • Detailed prompts and guidance re communication within user's guide.
MENTAL HEALTH	How addressed
Cognition and dementia, including orientation and memory	<ul style="list-style-type: none"> • Item within Psychological well-being section on memory/forgetfulness and orientation. • Prompt to complete Psychological well-being assessment (containing detailed assessment of orientation/memory) if problem identified. • Question on recent decline in skills on page 4 also provides opportunity to explore this area. • Items on 'Risk related to wandering' and 'Domestic risk' within Risk section also provide opportunity to explore this area. • Guidance notes within Psychological well-being assessment point assessor to focus on difficulties in attention/concentration and/or expression/understanding. • Prompt questions regarding e.g. carer observing or reporting recent forgetfulness included within user's guide.
Mental health including depression, reactions to loss, and emotional difficulties	<ul style="list-style-type: none"> • Guidance on page 3 to consider impact of life events e.g. bereavements on presenting problems and needs. • Detailed checklist of items within Psychological well-being section page 3. • Prompts to complete Psychological well-being assessment (containing detailed assessment of orientation/memory) if problem identified. • Prompt questions in users guide pertaining to Psychological well-being section. • Prompt questions in user's guide relating to Presenting problems and needs and Physical well-being also point assessor to considering Psychological well-being when physical problems are reported.

RELATIONSHIPS	How addressed
Social contacts, relationships, and involvement in leisure, hobbies, work, and learning	<ul style="list-style-type: none"> • Weekly activities timetable records such involvement. • Prompt questions in user's guide support such recording. • Protective factors section on page 8 includes guidance to assessor to consider social support/relationships/activities.
Carer support and strength of caring arrangements, including the carer's perspective	<ul style="list-style-type: none"> • Social support and circumstances section page 8 records level of carer/social support and associated difficulties. • Formal care/support currently received section page 1 records current formal caring arrangements. • Carer's questionnaire records carer's perspective. • Family and informal carer section records carer's input and perspective. • Assessor guided to include Carer's perception included in documentation of risks arising page 8.
SAFETY	How addressed
Abuse and neglect	<ul style="list-style-type: none"> • Adult protection issues item within Social support and circumstances section, page 5. • Prompts concerning this area in user's guide. • Item on Risk of abuse by others in Risk factors section page 8. • Assessor alerted to possibility of adult protection issues in user's guide pertaining to Information-sharing page 10, if carer and service user appear in conflict regarding consent and information-sharing. • Assessor alerted to vulnerability issue re financial management in User's guide pertaining to this item.
Other aspects of personal safety	<ul style="list-style-type: none"> • Item on ability to cope with emergencies page 4. • Items on 'victim of crime' and prompt regarding need for Community safety assessment page 5. • Prompts on this area in user's guide. • Aspects of personal safety addressed extensively in Risk factors section page 8. • Protective factors section page 8 addresses aspects that support personal safety.
Public safety	<ul style="list-style-type: none"> • Items on risk to others and domestic risk in Risk factors section, page 8. • Guidance on this area in user's guide.
IMMEDIATE ENVIRONMENT AND RESOURCES	How addressed
Care of the home and managing daily tasks such as food preparation, cleaning and shopping	<ul style="list-style-type: none"> • Items on cooking/food preparation, housework, shopping under Everyday tasks heading page 4. • Prompts/guidance on these areas in user's guide. • Item on 'domestic risk' in Risk factors section page 8.
Housing – location, access, amenities and heating	<ul style="list-style-type: none"> • Items on these areas within Social support and circumstances section page 8. • Prompts/guidance on these areas in user's guide. • Prompt to complete more comprehensive Social assessment (containing detailed assessment of these areas) on page 9, if apparent problem identified.

Level and management of finances	<ul style="list-style-type: none">• Items on problems receiving benefits, whether benefits have been reviewed in the past 2 years, finance management, whether income is reported as less than government-guaranteed minimum within Social support and circumstances section page 8.
Access to local facilities and services	<ul style="list-style-type: none">• Item on Access to services/amenities within Social support and circumstances section page 8.• Prompts/guidance concerning these items in user's guide.