British Journal of Social Work (2011) 1–22
doi:10.1093/bjsw/bcr133

Developing an Integrated Assessment Tool for the Health and Social Care of Older People

Brian J. Taylor

Brian J. Taylor is Senior Lecturer in Social Work in the School of Sociology and Applied Social Studies at the University of Ulster, Northern Ireland. His research and teaching interests include decision making, assessment, care planning, risk and evidence-based practice.

Correspondence to Dr Brian J. Taylor, University of Ulster at Jordanstown, Social Work Room 21C13 Dalriada, Shore Road, Newtownabbey, Northern Ireland, BT37 0QB, UK. E-mail: *bj.taylor@ulster.ac.uk*

Abstract

Assessment is central to identifying needs, making decisions and providing services. Assessment tools have a role in relation to co-ordinating care, communication between professionals and gathering data for monitoring and service improvement. As the health and social care of older people becomes more complex, there is an increased requirement for co-ordinated, effective and efficient assessment. This paper outlines the development of the Northern Ireland Single Assessment Tool (NISAT) for the health and social care of older people. The development involved stakeholders from a wide range of professions, older people and carers. The process included a survey of existing care management assessment tools, various working groups and testing reliability using vignettes and trained actors. Older people were engaged in a music, dance and visual arts project on the theme of assessment to inform the tool development. The components of the tool and their development are reviewed, including considering the role of social work in contributing to specialist assessment as distinct from the role of co-ordinating a holistic assessment process. There are challenges facing co-ordinated assessment processes in health and social care of older people because of the wide variety of care pathways in primary, acute, 'intermediate' and community care settings.

Keywords: Community care, assessment, integrated health and social care, Northern Ireland, person-centred care, multi-professional working, older people, test construction, tool development, social work

Accepted: September 2011

Context

Social workers have always had a role in seeking to co-ordinate the efforts of diverse professions and organisations for the well-being of clients and families. The arrangements introduced in the UK through the community care policy in the early 1990s allowed for a wide variety of arrangements for the commissioning and delivery of community health and social care services (Department of Health and Social Services, 1990; Carr and Challis, 1999; Challis *et al.*, 2001). Initially, the emphasis was on local flexibility within the general policy parameters (Social Services Inspectorate, 1999), although, more recently, the direction has been towards consistency and standardisation (Social Services Inspectorate, 2001; Challis *et al.*, 2001; Department of Health, 2005, 2006; HM Government, 2008; Department of Health, Social Services and Public Safety, 2010).

Assessment is a central component of co-ordinated care and is essential to the identification of needs, decision making and the provision of services (Audit Commission, 1997; Taylor, 2010). Assessment is used to determine eligibility for health and social care services and to manage risk (Taylor, 2006*b*). Assessment informs decisions about intermediate care and long-term care for older people such as whether to enter supported housing or a nursing home or provision of intensive home care services (Department of Health, 2001; Dwyer, 2005; Taylor, 2006*a*; Taylor and Donnelly, 2006*a*). Assessment is intrinsic to decisions about the allocation of public or charitable funds to pay for care or treatment (Royal Commission on Long Term Care, 1999). With socio-demographic changes (such as the age and family profile of society), increasing numbers of older people with increasingly complex health and social care needs require co-ordinated, effective and efficient assessment as part of care decision processes (Kane and Kane, 2000).

Assessment tools have a key function in relation to the above dimensions of assessment and also in communication between professionals and in recording for various purposes including accountability, service monitoring and service improvement (MacKenzie *et al.*, 2005; Simmons, 2007). Assessment tools must be designed not only in relation to the needs of the older person and family, but also in relation to the policy, legislative and funding context (Stewart *et al.*, 1999; McCormack *et al.*, 2007*b*). Assessment tools inform decisions about prioritising services against organisational or government criteria, such as the *Fair Access to Care Services* policy guidance for England (Department of Health, 2003). The dimensions of choice, risk and independence need to be addressed more explicitly than previously in assessment tools (Hardy *et al.*, 1999; Department of Health, 2007*c*; Taylor, 2010).

Various policy initiatives have shaped the development of assessment for health and social care services. In particular, recent UK policy has emphasised *personalisation*, which aims to give the public greater choice and flexibility over services (Beresford, 2008; Department of Health, 2005,

p. 9, 2006, 2008, 2009*a*; HM Government, 2008; Department of Health, 2006) including *direct payments* schemes whereby some clients can manage their own publicly funded care employees (2002 Carers and Direct Payments Act (Northern Ireland); Carr, 2007; 1996 Community Care (Direct Payments) Act; Duffy *et al.*, 2010; Glasby *et al.*, 2009; Glendinning *et al.*, 2008; Needham, 2008, 2010). In England, there has been the development of individual budgets and self-directed care (Leece and Leece, 2006; Ellis, 2007; Carr, 2010). There has been increased attention to an outcomes focus for services and to rehabilitation at the point of hospital discharge where there are now a variety of teams and services in which social workers are involved (Department of Health, 1998) including intermediate care and teams for specific conditions such as falls. There has been continuing attention to seeking effective and efficient multiprofessional working (Department of Health, 2009*a*).

With the introduction of the devolved administrations for Scotland, Wales, Northern Ireland and England, the detailed policy direction and implementation are becoming increasingly diverse across the jurisdictions of the UK. In Northern Ireland, which is our focus, the integrated management structures for health and social care (Taylor, 1998) have some implications that differ from elsewhere in the UK (Department of Health, 2007*a*, 2007*b*; Glasby, 2009; Weiner *et al.*, 2002). For example, the complexity of public health and social care bodies and the pervasive divide between health care organisations and social care organisations in England (Abendstern *et al.*, 2011) is perhaps a less intense problem in Northern Ireland, although integration between professions remains a challenge.

In 2005, the Department of Health, Social Services and Public Safety for Northern Ireland commissioned a project to develop a single assessment tool for the health and social care of older people. The tool would facilitate access to appropriate health and social care interventions ranging from non-complex to complex co-ordinated care and would be used in primary, acute and community health and social care including intermediate care. The tool would be consonant with the general aims of the National Service Framework for Older People in England (Department of Health, 2001; see Scottish Executive, 2001, in relation to Scotland; see Welsh Assembly Government, 2002, 2007, in relation to Wales), although the detailed requirements do not apply.

In Northern Ireland, health and social care services have been delivered through integrated management arrangements since 1973 (Taylor, 1999) for both children's and adults' services. Despite reorganisations of boundaries and organisational functions, the integrated management arrangements have stood the test of time and have become increasingly integrated. Line management for older people's services might be by any health and social care professional. The Health and Social Care Trusts that deliver acute and community health and social care have various arrangements to ensure professional supervision and communication channels

where a professional has an immediate line manager of a different profession from their own.

In Northern Ireland, any health and social care professional, with appropriate training and supervision, can undertake the care management role for people with complex health and social care needs (Department of Health and Social Services, 1990) whereas, in Great Britain, this role is almost exclusively undertaken by social workers (Postle, 2002; Weinberg *et al.*, 2003). Complex cases are defined as those in which there is a significant amount of multi-professional working, in which intensive use of home care services is required or in which a change of domicile is being considered (Department of Health and Social Services, 1990). An informal estimate is that, in practice, this *care* (or *case*) *management* role of co-ordinating the inputs of the various health and social care professionals is undertaken in approximately 75 per cent of cases by social workers and in most of the others by community nurses, typically where nursing needs predominate. This estimate by the author is based on a decade of experience in one Health and Social Care Trust, including responsibility as lead social work training officer for the implementation of the People First community care policy initiative (Department of Health and Social Services, 1990; Taylor, 1998). Increasingly, those who are not social workers are in dedicated care management roles in teams with social workers.

The general aims of integrated (or 'single' or 'unified') assessment are illustrated in Figure 1. In addition to these general aims for the

Aims of an integrated assessment tool:

1. Support the provision of appropriate health and social care services, clarifying need to enable evaluation in the light of eligibility criteria.
2. Promote independent living and identify need at an early stage so as to reduce the need for crisis management (Manthorpe *et al.*, 2004; Taylor and Donnelly, 2006*a*).
3. Capture the older person's views, wishes and perceptions of their own health and social care needs in the context of their past, present and future lives and show that decisions have been made with them based on their individual abilities and strengths (Tanner, 2003; Innes *et al.*, 2006; Moriarty *et al.*, 2007).
4. Embody best evidence to support good assessment (Emilsson, 2005), including research and theories of ageing, the professional role, managing risk (Taylor, 2006*b*), the processes of assessment (Taylor, 2010) and standards of good practice (Social Services Inspectorate, 1999; Stewart *et al.*, 1999).
5. Support staff in effective incorporation of specialist contributions within a holistic assessment (Mackenzie *et al.*, 2005).
6. Embody a degree of proportional assessment (i.e. assessment proportional to needs) and avoid repetition between components.
7. Facilitate effective and efficient co-ordination of professional contributions to the assessment and care planning processes by supporting effective information sharing (Dickinson, 2006) and minimizing duplication (Glasby, 2004; Lubben, 2006) so as to reduce the assessment burden on older people, families and professionals.
8. Provide suitable data for integrated service management and improvement across the range of health and social care services.

Figure 1 Aims of integrated assessment

integrated assessment of health and social care needs of older people, it was important that the tool suited a variety of organisational structures, processes and services. It must not be overly prescriptive regarding job descriptions, team functions, eligibility criteria and services available at a particular place or time. Whilst meeting the current service needs in terms of assessment against eligibility criteria and prioritisation schemes, the tool must not date unduly quickly with environmental changes to retain credibility as a professional tool. The aim was to support professional practice and build confidence in the profession amidst some degree of socio-demographic and policy change (Dickinson *et al.*, 2006: Manthorpe *et al.*, 2007).

Integrated assessment does not mean that professions are regarded as if they could do each other's jobs (Christiansen and Roberts, 2005). Nor is the term used here to mean *arrangements whereby an assessment undertaken by one professional is accepted by others* (Abendstern *et al.*, 2011, p. 468). The acceptance of the assessment by another professional on matters within their competence is not questioned here, although we do recognise that some parts of what each profession assesses is common across professions. The aim is to co-ordinate specialist assessments into a holistic picture. A unified tool must integrate (not merely assemble) specialist assessments and must facilitate access to appropriate services, inter-professional working and a better client experience of assessment. A key issue was to reduce duplication between professions and the burden on older people by identifying core domains of assessment that were common across professions. Whilst ensuring that these were within their defined professional competence, these domains were to be brought into one or more common components of the tool that could be used by any health and social care professional, whilst respecting the fact that there would remain domains, and depths of assessment within domains, that were a specialist area for a particular profession.

The planned tool would replace the existing care management tools where needs are complex. The term *care management* has come to be used in the UK to replace the more international and historic term *case management* that is used more widely in social work. The reason was the response to public consultation at the time of the community care reforms in the early 1990s, where people said that it was their care that was being managed, not them as a 'case' (Department of Health and Social Services, 1990; Taylor, 1998). The term *case management* is now also being used to refer to *management of long-term conditions*. The essentials of the task are, however, not different and the principle remains that the most appropriate professional should undertake *care management* or *case management* (DHSSPS, 2010). In complex cases, there needs to be an agreed mechanism to co-ordinate the contributions of various professionals and to manage expensive care resources.

The development process

One challenge in the project was to create a shared vision for the task, embodying opportunities as well as threats (Dickinson, 2006). Appropriate stakeholders were engaged in the development process so as to identify issues to be addressed, to solve problems that arose and to establish a consensus where possible. This engagement with professionals, voluntary sector providers, older people and family carers provided the project team with vital information and debate, and gave a strong sense of ownership of the developing tool. Consultation took place with over 350 stakeholders during the two-year project, principally through the mechanisms described below. The Project Team reported to a Steering Group at the Department of Health, Social Services and Public Safety, and the various organisations and groups involved in the project are illustrated in Figure 2. The Stakeholder Group was a key element in the ownership and credibility of the developing tool and met approximately every three months during the project.

The User Group was formed to elicit views from older people and family carers (Moriarty *et al.*, 2007). Older people and family carers were engaged through voluntary organisations. Participants were sent consultative materials for comment at appropriate stages, were invited to regular meetings, were informed quarterly of project progress and were able to contribute through the User Group and also through the e-Consultative Group (see below) if they wished.

Creative arts sessions were carried out to engage older people through music, dance and visual art to provide greater insight into older people's lives. A professional artist, dancer and musician experienced in the delivery of arts programmes in health care settings facilitated the sessions assisted by members of day-care staff who were familiar with the older people. A member of the project team was also present. The six workshop sessions were themed to cover issues that had been raised during the project—particularly by the User Group. The fifteen older people who participated were recruited from a large urban day centre and had experienced a range of levels of assessment. Participants had a wide range of health and social care needs, and their needs ranged from moderate to advanced dementia. Topics emerging from the workshops included particularly concern about protection and safety, the importance of family and community support to enable them to look forward positively to older age, concerns over money and the importance of services in overcoming isolation. Participants were asked to share their experiences of assessment and how these experiences differed from their needs and expectations of the process. The outcomes from the workshops emphasised particular areas in the draft tool that were then extended or refined such as personal relationships, security, financial issues, education, leisure activities and the level of support

Department of Health, Social Services and Public Safety (DHSSPS)

One of eleven departments created as part of the Northern Ireland Executive
Responsibility for policy and legislation for hospitals, family practitioner services, community health and personal social services

Health and Social Care Board (HSC Board)

Arranges or 'commissions' a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland
Manages public funding for health and social care

Health and Social Care Trusts (HSC Trusts)

Provide a broad range of health and social care services
Include acute hospitals, psychiatric hospitals, community health, personal social services and services within primary care such as community nursing
Five trusts, organised geographically (and a regional Ambulance Service Trust)

Steering Group

The group to which the Project Team reported
Representatives of social work, medicine, nursing and allied health professions at the DHSSPS
A representative of the HSC Trusts and of the HSC Board

Project Team

Project leads and grant holders: university-based social worker and nurse
Lecturer in rehabilitation sciences
Project Officer (previously a professional in health and social care)
Research Fellow (psychology graduate with Ph.D.

Stakeholder Group—comprised representatives of:

Each of the Health and Social Care Trusts
The Health and Social Care Board
British Association of Social Workers
British Medical Association
British Geriatric Society
Royal College of Nursing
Allied Health Professional Council
Chair of the User Group

User Group—comprised representatives from

Age Concern
Alzheimer's Society
Belfast Carers
Carers Northern Ireland
Centre for Independent Living
Help the Aged
Northern Ireland Dementia Forum

E-Consultative Group—comprised:

Any health and social care staff who wished to join
All General Medical Practitioners in Northern Ireland
Managers and staff in professional education and training
Anyone else who wished to join the mailing list and feedback forum

Figure 2 Key organisations and groups involved in NISAT

individuals require to remain independent. The participants' experiences of assessment appeared to be one of disempowerment with sharing that it was difficult to engage with professionals to the extent that they could share their life experiences and individuality. These comments challenged us to even greater endeavours to ensure that the tool design supported professional assessors to capture the older person's perspectives, life experiences and quality-of-life issues.

An e-Consultative Group was set up to reach as wide an audience as possible and comprised anyone who wished to join (Department of Health, 2009*b*). In order to raise awareness of the project, a quarterly newsletter was produced and distributed via this e-Consultative Group. Two websites were created for the Project: one at the DHSSPS (*www.dhsspsni.gov.uk/ec-single-assessment-tool*) and one at the University of Ulster (*www.science.ulster.ac.uk/sat/*). Quarterly newsletters and project reports were made available on the websites, which also received feedback, questions and comments that were collated and replied to by members of the project team.

Information was gathered from a growing network of practitioners who provided input in relation to specialist areas to be addressed within the tool (McCormack *et al.*, 2008*a*). Based on the issues raised during the process, particularly by the Stakeholder Group and the User Group, meetings and workshops were convened as required to gather information on and discuss the appropriate inclusion of topics such as medicines management, abuse, financial benefit maximisation, palliative care, fuel poverty, dietetics and housing (McCormack *et al.*, 2008*a*, 2008*b*). A Medical Practitioner Group assisted in the development of the component relating to medical needs (Philip, 1997). The Project Team met frequently to discuss issues raised by the groups (including the e-Consultative Group) and to incorporate these into the developing tool.

The NI Single Assessment Tool

Central components of NISAT

Central to the Northern Ireland Single Assessment Tool (NISAT) was the development of three cumulative components so as to give a degree of proportional assessment, and designed to avoid repetition between components. One key challenge was to define who would be regarded as competent to complete each component of the tool. The *Contact Screening* was defined to be suitable to be completed by (at minimum) a trained non-professional such as a skilled receptionist, although it was envisaged that it would also be completed by professionals. The *Core Assessment* was designed to be completed by any health and social care professional in any setting. The *Complex Assessment* was designed to be completed by

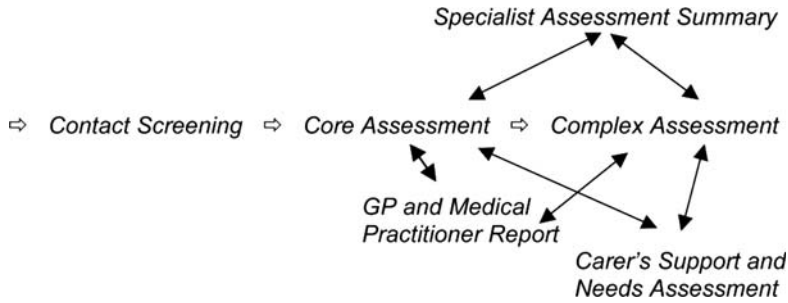

Figure 3 Main elements of the Northern Ireland Single Assessment Tool for the health and social care of older people (from McCormack et al, 2008b, cited in Taylor, 2010)

any health and social care professional trained and supervised in this field of work, such as those professionals currently undertaking care management roles (predominantly social workers). The basic components of the tool are illustrated in Figure 3.

The *Core Assessment* component consists of ten domains. A strong message from our collaborative developmental process was that unnecessary form-filling must be avoided. The aim was a flexible tool to be used in a variety of ways in primary, acute and community care. Although we envisaged that usually the whole of the *Core Assessment* would be completed, the domains were structured so that three domains (Physical Health, Mental Health and Emotional Wellbeing; Awareness and Decision-Making) were regarded as central to every assessment. Difficulties experienced within the three central domains may impact on other aspects of the older person's life, captured in the other seven domains, which are to be completed according to apparent need (see Figure 4). These domain definitions for Northern Ireland are broadly similar to, but not identical to, those envisaged following the National Service Framework for England (Department of Health, 2002, 2004).

The *Complex Assessment* component was designed specifically to address issues of complexity and risk such as the interaction between aspects of care and need, and the risk of change of domicile or need for intensive home care support. The *Complex Assessment* was designed to prompt the integration of specialist assessment (discussed below) into a holistic assessment in complex cases, although specialist assessment could also be requested from Core Assessment (without undertaking the *Complex Assessment*) if the professional thought it appropriate. *Complex Assessment* builds on the *Core Assessment*, provides a framework to incorporate specialist assessments from appropriate professions (including social work if appropriate) and also addresses the issues inherent in complex cases as defined in the community care policy initiative (Department of Health and Social Services, 1990).

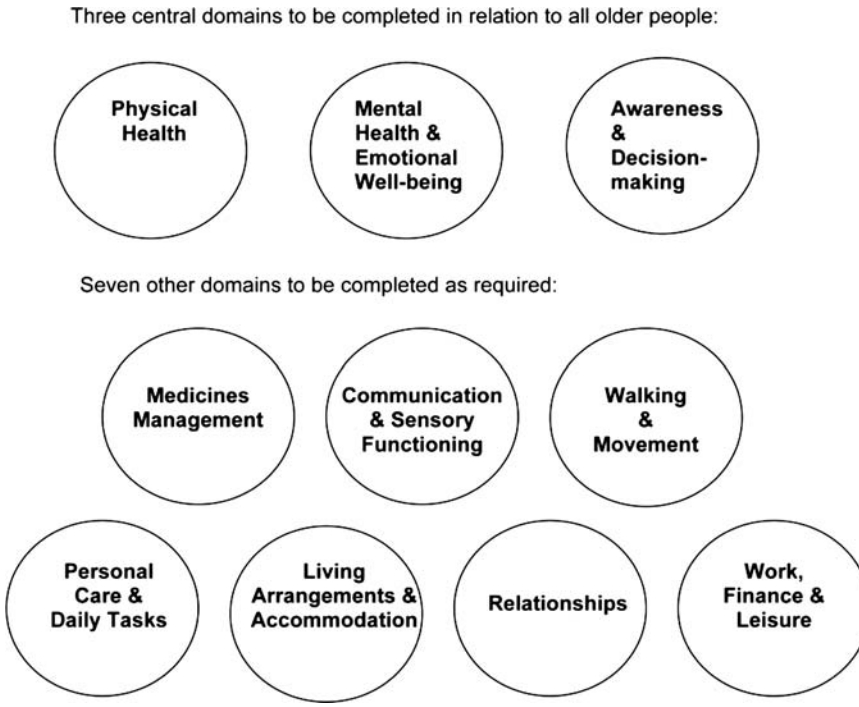

Figure 4 Domains of the Core Assessment Component of the Northern Ireland Single Assessment Tool for the health and social care of older people (from McCormack et al, 2008b)

Additional components of NISAT

Four additional components were developed using broadly the same process and consultation cycle to complement the three components outlined above. These components became the *Specialist Referral Form*, the *Specialist Assessment and Recommendations Form*, a *G.P. and Medical Practitioner's Report* and a *Carer's Support and Needs Assessment* as discussed below.

As an early part of the project, a survey of existing tools used for care management with older people in Northern Ireland was undertaken. This suggested that approximately half of the information gathered by specialist assessment tools was generic across a number of professions whilst approximately half was specific to that profession and the purpose of the tool (McCormack *et al.*, 2007*a*). Such duplication in specialist tools could not be addressed directly in this project. Our focus was the task facing the professional trying to co-ordinate holistic care in making sense of diverse specialist knowledge and levels of detail. This was addressed by creating a *Specialist Referral Form* (by which a specialist

assessment might be requested by a professional completing the Core or the Complex Assessment) and a *Specialist Assessment and Recommendations Form*. This latter was a template for the professional completing a specialist assessment to summarise that assessment in language that any health and social care professional could understand. This was designed to summarise the needs and proposed treatment or care with a view to the implications for other health and social care needs and the provision of holistic care. As an example, one issue is where medication for physical or psychiatric symptoms has an effect on unrelated aspects of functioning at home mediated through such as mood, balance or drowsiness (Bahri, 2010).

A *GP and Medical Practitioner's Report* was created to facilitate the contribution of General Medical Practitioners and other medical staff to ensuring that treatable conditions were identified and addressed, and to support the role of the GP as gate-keeper to a number of services. A *Carer's Support and Needs Assessment* was created so as to standardise the assessment of the needs of family carers in relation to supporting them in their caring role (Guberman *et al.*, 2003).

Tool design

Various steps were taken to develop the validity, reliability and usability of the tool (Carpenter *et al.*, 2005) to improve the quality of assessment (Seddon *et al.*, 2010). However, NISAT was not designed as a predictive assessment tool (Taylor, 2010) that might give scores for domains of functioning. These steps included the use of vignettes to develop validity and reliability in relation to the *Core Assessment* (McCormack *et al.*, 2007*c*, 2007*d*) and trained actors interviewed by pairs of professionals in relation to the reliability of the *Complex Assessment* (McCormack *et al.*, 2008*e*). The three actors were each given a brief for one of three typical scenarios of what are currently known as 'care managed' cases, drawing on our own professional experience and that of the Stakeholder Group.

Usability was developed through the extensive consultation process (McCormack *et al.*, 2008*d*). The focus of the tool is a holistic, staged assessment designed to incorporate, as appropriate, summaries of specialist assessment. The focus is not detailed measurement of change that might properly be the focus of some specialist assessments carried out by the appropriate profession. Domains of the *Core Assessment* incorporate some scales, some dichotomous *yes–no* questions and some free text. These simple scales incorporated in the *Core Assessment* (Figure 5) are not in-depth specialist scales. The scales used here are person-focused and are used primarily to gather information about how the older person rates his or her own condition, as confirmed by the assessor. By seeking to capture the older person's perspective, the tool supports their

How do you view your ability in relation to the following?
□ Level 1 = I am able
□ Level 2 = I am able with difficulty (e.g. noise levels, language barriers, lack of assistance, other)
□ Level 3 = I need assistance, equipment or aids
□ Level 4 = I am not able (please give reason)

Speaking	Level	Details
Understanding others	Level	Details
Hearing	Level	Details
Seeing	Level	Details

Figure 5 Extract from *Domain 5—Communication & Sensory Functioning* to illustrate use of scales (DHSSPS, 2008, p. 13, Core Assessment; McCormack *et al.*, 2008*c*, reproduced with kind permission of the Department of Health, Social Services and Public Safety for Northern Ireland)

Have you noticed changes in your memory and / or thinking skills? Yes/No
If yes, please specify
□ When you first noticed this
□ When others first noticed this
□ Nature of the changes
□ Frequency of episodes
□ Other

How do any difficulties or conditions you may have affect your day to day life? Please consider
□ Forgetting important daily tasks/appointments
□ Fear/anxiety
□ Ability to recognise others/surroundings
□ Disorientation
□ Ability to communicate
□ Risk to self/others
□ Unpredictable behaviour
□ Isolation
□ Loss of choice and decision-making
□ Other
<continues>

Figure 6 Extract from *Domain 3—Awareness & Decision Making* to illustrate use of closed questions and open prompts (DHSSPS, 2008, p. 10, Core Assessment; McCormack *et al.*, 2008*c*, reproduced with kind permission from the Department of Health, Social Services and Public Safety for Northern Ireland)

participation in assessment and also enables the professional to have a clearer picture of the older person's perspective and level of awareness of the situation. An innovative feature was to provide each sub-domain with *prompts* to aid the completion of free-text boxes, rather than having extensive lists of questions that had to be answered (Figure 6). This feature was viewed as supporting the priorities of older people so that a more flowing picture of need could be portrayed whilst also giving structure to the assessment and ensuring appropriate scope and depth of data gathering according to the judgement of the professional involved.

Discussion

Development process

There were many challenges in developing a unified assessment tool for the health and social care of older people (Glasby, 2004) that would have professional ownership, embody best practice and meet the wider need for service management. NISAT was designed to be capable of integrating the assessment of health and social care needs of people over sixty-five in primary, acute and community care settings in relation to holistic, community care needs along the continuum from simple to complex. The Department of Health and Social Services (1990) describes assessment as the cornerstone of good-quality community care. It built on the best of previous practice through a thorough evaluation of existing care management documentation (McCormack *et al.*, 2007*a*). It was shaped by an international perspective on best practice by a thorough literature review (McCormack *et al.*, 2007*b*) using advanced searches on electronic databases (Taylor *et al.*, 2007). NISAT also strengthened the person-centred focus of assessment of older people and introduced assessment stages broadly proportionate to needs.

The development process was not without contention, however, and there was much lively debate. For example, there was a view from one health and social care commissioning body that *Contact Screening* should always be undertaken by professionals. We found that two of the eleven trusts delivering community health and social care services (not within the area of that particular commissioner) had non-professional social care staff undertaking some social care assessment not only at the level we were describing as contact screening level, but also at a level beyond that. The principle was adopted that only a professional can be responsible for an assessment, even though parts of it might be delegated to non-professional social care staff. Our development was also shaped by emerging models of practice such as call centres employing specially trained non-professionals to ensure timely response and accuracy of initial recording at the screening stage.

Issues for older people and their carers

NISAT is innovative in that the wording of the *Core Assessment* is addressed to the older person (Haywood *et al.*, 2005), even though it was expected that it will be completed with a professional present as part of an interactive, narrative process (Gibson, 2004). This is in keeping with the philosophy of person-centredness (Cornes and Clough, 2004; Manthorpe *et al.*, 2007; Powell *et al.*, 2007) that underpinned the development. This was designed as a prompt to the professional to retain a client focus. This might be viewed as assuming that the form will be physically

on the table during assessment sessions. However, the process is not prescriptive. Once professionals are familiar with the tool, they might still complete the *Core Assessment* after the interview, rather than during it. NISAT has been designed to be computer-compatible and, in time, it may be that a computerised version will be *on the table* with the older person on some sort of portable electronic device. The wording of the questions should point them towards greater client focus in the interaction, thus supporting professionals in using their knowledge and skills in assessment (Crisp *et al.*, 2007; Taylor and Donnelly, 2006*a*).

Service needs

There is an inherent tension in designing an assessment tool that will support both professional decision making and also aggregate data for service monitoring and improvement (Keene and Li, 2005; Mackenzie *et al.*, 2005). NISAT was designed to fulfil both these purposes. Standardising the definition of the scope of various levels of assessment will facilitate the gathering of data about needs and services across Northern Ireland. Previously, each of the eleven trusts delivering community health and social care services created its own assessment tool and system. Although these were designed to meet the same care management requirements of the community care policy initiative, there was much variation in depth and scope of assessment across trusts.

The tool sought to embody an approach promoting recovery, treatment and enabling rather than drawing older people into chronic and long-term care inappropriately. A key learning point was incorporating an increased focus on preventive measures within an assessment tool. Our focus in social work in recent decades has increasingly come to be on the most complex end of the spectrum of health and social care needs. By designing the *Core Assessment* to be completed by any health and social care professional in any setting, the introduction of NISAT should enable diversion of older people away from institutional and unnecessarily dependent interventions through clearer identification of need at an earlier stage. This should also ensure that social workers consider the range from preventive to complex work.

Professional issues

The essence of NISAT was to facilitate multi-professional working, as exemplified by the nature of the Steering Group, Project Team and the range of stakeholders engaged. The development was grounded in concepts from policy, research and theoretical literature that were deemed to be essential to support good professional practice in assessment. Generally, there was

more thorough work on utilising published research on assessment of older people and on tool development than on specific domain issues for which we relied more on the wealth of practice wisdom that was available to use through our networks. There were many challenges in the task of developing a common understanding that would pave the way for increased multi-professional working (Dickinson, 2006; Lymbery, 2006). This was a particular challenge for a tool that was designed to be used in a multiplicity of team configurations and professional practice settings in primary, acute and community health and social care. The tool will facilitate information transfer between health and social care professionals working with older people who can all use the same common *Core Assessment*, complemented by *Complex Assessment* and specialist assessments as appropriate.

An interesting reflection is the extent to which social workers fulfil specialist roles. In a situation in which the care manager is a profession other than social work, one might ask what the social work contribution entails. In practice, most professions look towards social work for a professional lead and specialist knowledge where there is suspected or alleged abuse (Killick and Taylor, 2009), where there are particularly vulnerable individuals, where a change of domicile is required, for carer assessment and, more generally, where social care services (such as day-care or home care services) are being considered (Fleming and Taylor, 2007, 2010; Nancarrow *et al.*, 2009; Taylor and Donnelly, 2006*b*; Taylor and Neill, 2009). One particular strength of social work is our attention to the holistic picture of client and family needs, strengths and circumstances. However, if we, as social workers, are to develop our professional credibility and competence, greater attention needs to be given to the use of specialist assessment tools to contribute to holistic, integrated assessment just as in other professions (Kane, 2006). This might include specialist assessment in areas such as family relationships and functioning and issues for carers such as health, stress and social integration.

Implementation and evaluation

Implementation of NISAT commenced in spring 2009. There is a process in place for suggested changes to be collated centrally so that development of the documentation will be standardised across Northern Ireland in phases. This paper has been produced from the perspective of developing NISAT rather than evaluating it. The aim has been to outline the context, purpose and development process as an aid to future evaluative endeavours and to stimulate communication and debate so as to prompt reflection to inform developments elsewhere.

At the time of writing, implementation has been progressing for approximately eighteen months on a phased basis across parts of the health and social care service. Informal comments drawn from both those championing

the process and from practitioners using NISAT suggest that the basic stages and design are sound despite the usual grumbles that accompany most change processes. Shorter-term interventions (including some that are multi-professional) seem to be managed more effectively without bringing people into the complexities of *care management*. Professional assessors seem to find the domains in the *Core Assessment* component a suitable scope to summarise their comments on that topic. It has been found beneficial to have a statement near the start about how much the older person is able to participate in their assessment and limitations to this.

Crucially, NISAT seems to be effective at that critical point of hospital discharge. Professionals are being encouraged to use the Summary (after Core or Complex Assessment components) to include an appropriate level of detail about need, unmet need, risk and acceptance of risk as well as Action Points to feed into the care plan. NISAT is now embedded in Departmental Guidance on Care Management (Department of Health, Social Services and Public Safety, 2010) and is acclaimed as a distinctive highlight of social work in Northern Ireland (Holland, 2010). The *Carer's Support and Needs Assessment* component has subsequently been piloted with carers for other client groups and adopted more widely.

There are perhaps two main lessons from the informal learning during the early stage of implementation. First, despite extensive *process mapping*, the diversity of referral and care pathways—across primary, acute and community care—are so myriad and complex that they continue to present a challenge. Any attempt to design a single assessment process that sought to define team or job roles and every referral pathway would have been incredibly complex. It was wise that we were not attempting to design a single assessment *tool*, not a *process*! Second, a unified assessment tool challenges professionals to work more closely together. That challenge is still being addressed during implementation, despite the work undertaken during development to identify anticipated issues and provide guidance and support to address these. Achieving progress in multi-professional working at this level of complexity requires a joint practice development process, beyond simply attending training courses, even if they are multi-professional and interactive in nature.

Conclusion

With time, it will become clearer to what extent the Northern Ireland Single Assessment Tool has supported the development of effective and efficient systems of health and social care. The participatory approach used ensured that a wide range of health and social care staff, voluntary organisations, older people and their family carers were involved in the creation of NISAT, hopefully for the ultimate benefit of older people and their families.

Acknowledgements

I would like to acknowledge the contribution of my esteemed colleagues in the Project Team at the University of Ulster: Brendan McCormack, Professor of Nursing Research; Joanne McConville, Project Officer; Paul Slater, Research Fellow; and also Bridget Murray, Lecturer in Rehabilitation Sciences, who, sadly for us, moved on to a better place before this paper reached publication. We would like to acknowledge the support of the Director and staff of the Primary and Community Care Directorate at the Department of Health, Social Services and Public Safety for Northern Ireland, which commissioned this work, and the Chief Officers for Social Work, Medicine, Nursing and Allied Health Professions for the support of their Offices. Sincere thanks are due to the many professionals, older people and family carers who contributed to the development process and without whose support this project would not have been possible. Views expressed are those of the author.

References

Abendstern, M., Hughes, J., Clarkson, P., Sutcliffe, C. and Challis, D. (2011) 'The pursuit of integration in the assessment of older people with health and social care needs', *British Journal of Social Work*, **41**, pp. 467–85.

Audit Commission (1997) *The Coming of Age: Improving Care Services for Older People*, London, Audit Commission.

Bahri, P. (2010) 'Public pharmacovigilance communication: A process calling for evidence-based, objective-driven strategies', *Drug Safety*, **33**(12), pp. 1065–79.

Beresford, P. (2008) 'Time to get real about personalisation', *Journal of Integrated Care*, **16**(2), pp. 2–4.

Carpenter, G. I., Challis, D. and Swift, C. (2005) 'Single Assessment for Older People: Comparison of the MDS-HC with current auditable methods in the home care setting', *Journal of Integrated Care*, **13**(5), pp. 35–41.

Carr, S. (2007) *Choice, Control and Individual Budgets: Emerging Themes*, Research Briefing 20, London, Social Care Institute for Excellence.

Carr, S. (2010) *Enabling Risk, Ensuring Safety: Self-Directed Support and Personal Budgets*, Adult Services Report 36, London, Social Care Institute for Excellence.

Carr, S. and Challis, D. (1999) 'Assessment and care management: Developments since the community care reforms', in *With Respect to Old Age*, Cm. 4192-II/3, London, The Stationery Office.

Challis, D., Weiner, K., Darton, R., Hughes, J. and Stewart, K. (2001) 'Emerging patterns of care management: Arrangements for older people in England', *Social Policy and Administration*, **35**(6), pp. 672–87.

Christiansen, A. and Roberts, K. (2005) 'Integrating health and social care assessment and care management: Findings from a pilot project evaluation', *Primary Health Care Research and Development*, **6**(3), pp. 269–77.

Cornes, M. and Clough, R. (2004) 'Inside multi-disciplinary practice: Challenges for single assessment', *Journal of Integrated Care*, **12**(2), pp. 3–13.

Crisp, B. R., Anderson, M. R., Orme, J. and Lister, P. G. (2007) 'Assessment frameworks: A critical reflection', *British Journal of Social Work*, **37**(6), pp. 1059–77.

Department of Health (1998) *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*, Gateway ref. Cm. 4169, London, TSO.

Department of Health (2001) *National Service Framework for Older People*, London, Department of Health.

Department of Health (2002) *The Single Assessment Process*, London, HMSO.

Department of Health (2003) *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, LAC (2002)13, London, Department of Health.

Department of Health (2004) *Assessment Tools and Accreditation*, London, Department of Health.

Department of Health (2005) *Independence Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England*, Cm. 6499, London, Department of Health.

Department of Health (2006) *Our Health, our Care, our Say: A New Direction for Community Services*, Cmnd 6737, London, The Stationery Office.

Department of Health (2007*a*) *Commissioning Framework for Health and Well Being*, London, Department of Health.

Department of Health (2007*b*) *Guidance on Joint Strategic Needs Assessment*, London, Department of Health.

Department of Health (2007*c*) *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making*, London, Department of Health.

Department of Health (2008) *Transforming Social Care*, LAC (2008)1, London, Department of Health.

Department of Health (2009*a*) *Transforming Adult Social Care*, LAC (2009)1, London, Department of Health.

Department of Health (2009*b*) *Working to Put People First: The Strategy for the Adult Social Care Workforce in England*, London, Department of Health.

Department of Health and Social Services (1990) *People First: Community Care in Northern Ireland for the 1990′s*, Belfast, Her Majesty's Stationery Office.

Department of Health, Social Services and Public Safety (DHSSPS) (2008) *The Northern Ireland Single Assessment Tool (NISAT)*, Belfast, DHSSPS.

Department of Health, Social Services and Public Safety (2010) *Circular HSC (ECCU) 1/2010 Care Management, Provision of Care and Charging*, Belfast, DHSSPS.

Dickinson, A. (2006) 'Implementing the Single Assessment Process: Opportunities and challenges', *Journal of Inter-Professional Care*, **20**(4), pp. 365–79.

Dickinson, A., Windle, K., Mahadevan, G., Lewis, J. and Knopp, N. (2006) *Evaluation of the Single Assessment Process Pilot Phase in Hertsmere*, Hertfordshire, University of Hertfordshire.

Duffy, S., Waters, J. and Glasby, J. (2010) 'Personalisation and adult social care: Future options for the reform of public services', *Policy and Politics*, **38**(4), pp. 493–508.

Dwyer, S. (2005) 'Older people and permanent care: Whose decision?', *British Journal of Social Work*, **35**, pp. 1081–92.

Ellis, K. (2007) 'Direct Payments and social work practice: The significance of "street-level bureaucracy" in determining eligibility', *British Journal of Social Work*, **37**, pp. 405–22.

Emilsson, U. L. (2005) 'Recognizing but not acknowledging: On using research information in social work with elderly people suffering from dementia', *British Journal of Social Work*, **35**, pp. 1393–409.

Fleming, G. and Taylor, B. J. (2007) 'Battle on the home care front: Perceptions of home care workers of factors influencing staff retention', *Health and Social Care in the Community*, **15**(1), pp. 67–76.

Fleming, G. and Taylor, B. J. (2010) 'An evaluation of day support: A community rehabilitation service?', *International Journal of Disability, Community and Rehabilitation*, **9**(1), available online at *www.ijdcr.ca/VOL09_01/articles/taylor.shtml*.

Gibson, F. (2004) *Past in the Present: Using Reminiscence in Health and Social Care*, Baltimore, MD, Health Professions Press.

Glasby, J. (2004) 'Social services and the Single Assessment Process: Early warning signs?', *Journal of Inter-Professional Care*, **18**(2), pp. 129–39.

Glasby, J. (2009) 'Individual Budgets and the interface with health', *Journal of Management and Marketing in Healthcare*, **2**(4), pp. 355–65.

Glasby, J., Le Grand, J. and Duffy, S. (2009) 'A healthy choice? Direct Payments and healthcare in the English NHS', *Policy and Politics*, **37**(4), pp. 481–97.

Glendinning, C., Challis, D., Fernandez, J. L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) *IBSEN: Evaluation of the Individual Budgets Pilot Programme: Final Report*, Social Policy Research Unit, University of York.

Guberman, N., Nicholas, E., Nolan, M., Rembicki, D., Lundh, U. and Keefe, J. (2003) 'Impacts on practitioners of using research-based carer assessment tools: Experiences from the UK, Canada and Sweden, with insights from Australia', *Health & Social Care in the Community*, **11**(4), pp. 345–55.

Hardy, B., Young, R. and Wistow, G. (1999) 'Dimensions of choice in the assessment and care management process: The views of older people, carers and care managers', *Health and Social Care in the Community*, **7**(6), pp. 483–91.

Haywood, K. L., Garratt, A. M. and Fitzpatrick, R. (2005) 'Older people specific health status and quality of life: A structured review of self-assessed instruments', *Journal of Evaluation in Clinical Practice*, **11**(4), pp. 315–27.

HM Government (2008) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*, London, HM Government.

Holland, S. (2010) 'Viewpoint: In conversation with Sean Holland', *Professional Social Work*, **17**(9), p. 19.

Innes, A., Macpherson, S. and McCabe, L. (2006) *Promoting Person-Centred Care at the Front Line*, York, Joseph Rowntree Foundation.

Kane, R. and Kane, R. (2000) *Assessing Older People*, New York, Oxford University Press.

Kane, R. A. (2006) 'Standardised measures commonly used in geriatric assessment', in B. Berkman (ed.), *Handbook of Social Work in Health & Aging*, Oxford, Oxford University Press, pp. 737–48.

Keene, J. and Li, X. (2005) 'A study of a total social services care population and its interagency shared care populations', *British Journal of Social Work*, **35**, pp. 1145–61.

Killick, C. and Taylor, B. J. (2009) 'Professional decision making on elder abuse: Systematic narrative review', *Journal of Elder Abuse and Neglect*, **21**, pp. 211–38.

Leece, D. and Leece, J. (2006) 'Direct Payments: Creating a two-tiered system in social care?', *British Journal of Social Work*, **36**, pp. 1379–93.

Lubben, J. (2006) 'Abbreviated and targeted geriatric assessment', in B. Berkman (ed.), *Handbook of Social Work in Health and Aging*, Oxford, Oxford University Press, pp. 729–36.

Lymbery, M. (2006) 'United we stand? Partnership working in health and social care and the role of social work in services for older people', *British Journal of Social Work*, **36**, pp. 1119–34.

MacKenzie, M., Carpenter, I. and Kotiadis, K. (2005) 'Profiling intermediate care patients using the Single Assessment Process: A road to better service provision?', *Journal of Integrated Care*, **13**(4), pp. 43–8.

Manthorpe, J., Clough, R., Cornes, M., Bright, L., Moriarty, J. and Iliffe, S. and OPSRI (Older People Researching Social Issues) (2007) 'Four years on: The impact of the National Service Framework for Older People on the experiences, expectations and views of older people', *Age and Ageing*, **36**, pp. 501–7.

Manthorpe, J., Iliffe, S. and Eden, A. (2004) 'Early recognition of and responses to dementia: Health professionals' views of social services' role and performance', *British Journal of Social Work*, **34**, pp. 335–48.

McCormack, B., Taylor, B. J., McConville, J., Slater, P. and Murray, B. (2008*a*) *Developing the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B., Taylor, B. J., McConville, J., Slater, P. and Murray, B. (2008*b*) *Guidance Document for the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B., Taylor, B. J., McConville, J., Slater, P. and Murray, B. (2008*c*) *The Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety (subsequently published as DHSSPS (2008)).

McCormack, B., Taylor, B. J., McConville, J., Slater, P. and Murray, B. (2008*d*) *The Usability of the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B. G., Taylor, B. J., McConville, J. E., Slater, P. F. and Murray, B. J. (2007*a*) *An Evaluation of Assessment Tools Used in Northern Ireland for Older People with Complex Health and Social Care Needs*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B. G., Taylor, B. J., McConville, J. E., Slater, P. F. and Murray, B. J. (2007*b*) *The Development of Assessment Tools for the Health and Social Care of Older People: A Literature Review*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B. G., Taylor, B. J., McConville, J. E., Slater, P. F. and Murray, B. J. (2007*c*) *The Reliability of the Core Component of the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, DHSSPS.

McCormack, B. G., Taylor, B. J., McConville, J. E., Slater, P. F. and Murray, B. J. (2008*e*) *The Reliability of the Complex Component of the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety.

McCormack, B. G., Taylor, B. J., McConville, J. E., Slater, P. F. and Murray, B. J. (2007*d*) *The Validity of the Core Component of the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*, Belfast, Department of Health, Social Services and Public Safety.

Moriarty, J., Rapaport, P., Beresford, P., Branfield, F., Forrest, V., Manthorpe, J., Martineau, S., Cornes, M., Butt, J., Iliffe, S., Taylor, B. and Keady, J. (2007) *Practice Guide 11: The Participation of Adult Service Users, Including Older People, in Developing Social Care*, London, Social Care Institute for Excellence.

Nancarrow, S., Moran, A. and Parker, S. (2009) 'Understanding service context: Development of a service pro forma to describe and measure elderly peoples' community and intermediate care services', *Health and Social Care in the Community*, **17**(5), pp. 343–446.

Needham, C. (2008) 'Realising the potential of co-production: Negotiating improvements in public services', *Journal of Social Policy and Society*, **7**(2), pp. 221–31.

Needham, C. (2010) 'Personalised public services: A new state–citizen contract?', *Public Money and Management*, **30**(3), pp. 136–8.

Philip, I. (1997) 'Can a medical and social assessment be combined?', *Journal of the Royal Society of Medicine*, **90**(32), pp. 11–13.

Postle, K. (2002) 'Working "between the idea and the reality": Ambiguities and tensions in care managers' work', *British Journal of Social Work*, **32**, pp. 335–51.

Powell, J., Robison, J., Roberts, H. and Thomas, G. (2007) 'The Single Assessment Process in primary care: Older people's accounts of the process', *British Journal of Social Work*, **37**, pp. 1043–58.

Royal Commission on Long Term Care (1999) *Rights and Responsibilities: With Respect to Old Age*, London, The Stationery Office.

Scottish Executive (2001) *Guidance on Single Shared Assessment of Community Care Needs*, Circular No. CCD 8.2001, 29 November.

Seddon, D., Robinson, C. and Perry, J. (2010) 'Unified assessment: Policy, implementation and practice', *British Journal of Social Work*, **40**, pp. 207–25.

Simmons, L. (2007) *Social Care Governance: A Practice Workbook*, Belfast, Department of Health, Social Services and Public Safety (Clinical and Social Care Governance Support Team) and London, Social Care Institute for Excellence.

Social Services Inspectorate (1999) *Quality Standards: Assessment and Care Management*, Belfast, Department of Health and Social Services.

Social Services Inspectorate (2001) *Improving Older People's Services: Policy into Practice*, London, Department of Health.

Stewart, K., Challis, D., Carpenter, I. and Dickinson, E. (1999) 'Assessment approaches for older people receiving social care: Content and coverage', *International Journal of Geriatric Psychiatry*, **14**(2), pp. 147–56.

Tanner, D. (2003) 'Older people and access to care', *British Journal of Social Work*, **33**, pp. 499–515.

Taylor, B. J. (1998) 'Service needs and individual qualifications: Training social workers for the community care policy initiative and post-qualifying credits', *Social Work Education*, **17**(1), pp. 77–93.

Taylor, B. J. (1999) 'Developing partnership between professions in implementing new children's legislation in Northern Ireland', *Journal of Inter-Professional Care*, **13**(3), pp. 249–59.

Taylor, B. J. (2006*a*) 'Factorial surveys: Using vignettes to study professional judgement', *British Journal of Social Work*, **36**(7), pp. 1187–207.

Taylor, B. J. (2006*b*) 'Risk management paradigms in health and social services for professional decision making on the long-term care of older people', *British Journal of Social Work*, **36**(8), pp. 1411–29.

Taylor, B. J. (2010) *Professional Decision Making in Social Work*, Exeter, Learning Matters.

Taylor, B. J. and Donnelly, M. (2006*a*) 'Professional perspectives on decision making about the long-term care of older people', *British Journal Social Work*, **36**(5), pp. 807–26.

Taylor, B. J. and Donnelly, M. (2006*b*) 'Risks to home care workers: Professional perspectives', *Health, Risk & Society*, **8**(3), pp. 239–56.

Taylor, B. J. and Neill, A. (2009) 'Sheltered housing and care for older people: Perspective of tenants and scheme managers', *Quality in Ageing: Policy, Practice and Research*, **10**(4), pp. 18–28.

Taylor, B. J., Wylie, E., Dempster, M. and Donnelly, M. (2007) 'Systematically retrieving research: A case study evaluating seven databases', *Research on Social Work Practice*, **17**(6), pp. 697–706.

Weinberg, A., Williamson, J., Challis, D. and Hughes, J. (2003) 'What do care managers do? A study of working practice in older peoples' services', *British Journal of Social Work*, **33**, pp. 901–19.

Weiner, K., Stewart, K., Hughes, J., Challis, D. and Darton, R. (2002) 'Care management arrangements for older people in England: Key areas of variation in a national study', *Ageing and Society*, **22**(4), pp. 419–39.

Welsh Assembly Government (2002) *Creating a Unified and Fair System for Assessing and Managing Care*, Cardiff, Welsh Assembly Government.

Welsh Assembly Government (2007) *Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action*, Cardiff, Welsh Assembly Government.