

**Developing Assessment Tools for Planning Community Health and Social Care
for Older People: A Literature Review**

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INTRODUCTION

The objective of this literature review is to identify approaches used elsewhere to assessment of older peoples' health and social care. This will be used together with a survey of the tools currently in use for care management in Trusts across Northern Ireland to develop a single holistic, reliable and valid assessment tool that encapsulates key policy issues, and principles from best practice such as person-centred care.

This report examines the policies leading to the development of single assessment instruments; identifies factors that are influential on the development of such instruments, such as theories of needs assessment; and examines the findings of research conducted aimed at mapping the implementation process surrounding the single assessment process in the U.K. The National Service Framework for Older People (DoH, 2001), Single Assessment Process (DoH, 2003) and Quality Standards: Assessment and Care Management (SSI, 1999) were utilized as a framework to underpin the research activity and in examining the strengths and weaknesses of a variety of existing tools and frameworks.

Contemporary practice with older people emphasises the use of early and interdisciplinary assessment, diagnosis and treatment procedures to help postpone and reduce the burden of need for long term care; to inform decisions regarding the type of care required (Carpenter et al 2005; Knight, 2001). As well as being the cornerstone of effective care plans, assessment is linked to the identification of health and social care needs, the determination of eligibility for a variety of health and social care services, decisions to enter supported housing or a care home, and review of care provision ('care packages') (Stewart et al, 1999; RCN, 1997). Assessment is also connected with decisions about the allocation of funds to pay for care. In other words, assessment is vital for access to and the continuation of health services, care and rehabilitation.

Policy Context

The assessment of the older person's need for health and social care has been a cause for concern within the continuing care debate. Most prominent of these expressed concerns have been the quality of assessment for older people who are moving to, or living in, long term

care establishments (CSAG, 1998) and the growth in the utilisation of care homes (Audit Commission, 1997). Explanations for these problems focus on two points:

- A lack of a standardised and consistent process of assessment
- The shifting of responsibility for continuing care provision from the National Health Service to Independent sector providers (Royal Commission, 1999).

There are currently 275,000 older people of pension age living in Northern Ireland. This is expected to increase to over 304,000 by the year 2009 and 314,000 by 2014. The number of over 75s is set to increase by 50% from 106,000 to 149,000 in the same period of time. According to the Northern Ireland Statistics and Research Agency (2006), in the next 40 years the number of people over 75 living in Northern Ireland is set to increase by over 150%, *ceteris paribus*. However it has been suggested that timely high quality assessment may impact on this rise, leading to more effective rehabilitation and associated increased independence for older people (Audit Commission, 1997; Royal Commission, 1999).

In 1990, the government launched a series of initiatives to change the face of community care. Government white papers (Working with Patients DoH 1989a; Promoting Better Health 1989 DoH 1989b) cumulated in the enactment of the NHS and Community Care Act and in Northern Ireland the policy initiative: People First: Community Care in Northern Ireland (DHSS, 1990). The principles of this legislation and policy initiatives were derived the fundamental tenets of Sir Roy Griffith's report: Community Care: Agenda for Action (1988) which were basically deemed equally applicable in Northern Ireland (DoH 1990). Central to the People First report were the aims that

- (1) structures and resources should be made available to support the initiatives, the innovation and the commitment at local level and allow them to flourish
- (2) success stories in one area should be encouraged to become commonplace for achievements everywhere
- (3) responsibilities should be spelt out, performance and accountability should be insisted on, and evidence collected that action is taken to improve services (1990).

Six principles of action were drawn up in the People First policy initiative (DoH 1990). These were:

- To promote the development of domiciliary care day and respite services to enable people to live in their own homes whenever possible
- To ensure that service providers make practical support for carers a high priority
- To make proper assessment of needs and good case management the cornerstone of high quality care
- To promote the development of a flourishing independent sector along side good quality public services
- To clarify the responsibilities of agencies and so make it easier to hold them to account for there performance
- To secure better value for taxpayers money by introducing a new funding structure for community care.

(People First: Care in the Community in Northern Ireland, 1990)

People First called for close targeting of actions that give high priorities to support for families caring for dependent relatives; and noted the importance of arrangements for co-ordination and joint planning between Health and Social Service Boards and other agencies, including the voluntary organisations. It also aspired to secure a more appropriate balance of care between hospital and community services. These principles of action aimed to enhance the cost-efficiency of services, and, at the same time, increase the range of services that would be available to the public (Nolan and Caldock 1996; Urlenbrock 1996).

When first introduced there was explicit expectation that services would be dynamic and reactive to need. This expectation was based on two principles. First, care co-ordination teams were requested to identify the needs of individuals and to design a package of care around that person. Second, care co-ordinators were expected to respect the rights of older people to decide for themselves whether or not they would continue to live at home or transfer to some form of residential or nursing home accommodation (DoH 1993, 1994). It proposed that the provision of services should follow a process of assessment and care management that would include the active support and participation of the older person and the carer. It is this latter point that will form the crux of this literature review.

The People First Community Care policy initiative (DHSS, 1990) came into effect in 1993, and introduced a new era in community health and social services. There was significantly increased funding, the creation of public home care services (as opposed to home help services), and mechanisms to co-ordinate health and social care services. The policy included provision for professionals to purchase with public funds a range of institutional, respite, day and home care services for individuals from private or voluntary as well as statutory providers. The policy includes all adults from their 18th birthday that are deemed to require complex social and health care services, including older people, those with learning or physical disabilities, and people with mental health problems. The largest group, in terms of the number of clients and budget, is older people, followed by those with learning disability.

The laudable intentions of the community care policy proved difficult to implement fully according to studies in England (Trnobranski 1995; Audit Commission 1997). The Audit commission (1997) reported that as the number of older people admitted to institutional care increased this was not matched with an equal increase in home care services provided. Funding bodies found new and novel ways of limiting the uptake of services, such as raising threshold levels for entry to services. It was also reported that where older people required a considerable amount of care it was more likely that that care will be offered within some form of institutional accommodation (Gill et al 1997; Tempkin et al 1997; Vickor 1997; Wang et al 1997).

Care Management of Older People in Northern Ireland

In Northern Ireland, following the crisis over acute hospital beds in winter 1999-2000 the Minister for Health, Social Services and Public Safety asked for an urgent review of care in the community and its relationship with the admission and discharge of patients. The report (SSI, 2000) highlighted the fact that although the number of care-packages for older people in NI had increased by over 60% between 1995 and 1999, the percentage that was domiciliary (as opposed to institutional) had declined from 48% to 38%. Possible reasons for this decline are not discussed. One reason may be that with funding becoming scarcer in relation to increasing demand, those in greatest need were prioritised. People with less intense service need (who are more likely to be deemed suitable for home care) were more likely to receive no service. Indeed the report noted that *“there is also evidence of a higher*

level of unmet need which is reflected in delayed discharge from hospital and inadequate care packages to meet assessed care needs.” (SSI, 2000).

It is apparent that the hospital bed-blocking that grabs the attention of the media is but a small part of a much larger picture of unmet need. The SSI report highlighted the fact that in excess of £50 million would be required over a two-year period to meet the increasing demand for services to prevent delayed discharges (SSI, 2000, p.11). The increasing concern at delayed discharges is such that these are now monitored and published quarterly by the Department of Health, Social Services and Public Safety (referred to below as ‘the Department’).

http://www.dhsspsni.gov.uk/publications/2003/info_release_june2003.pdf).

The report highlighted the extent of unmet need, by ascertaining that on 14 January 2001, there were in Northern Ireland:

201 adults waiting to be discharged from hospital

some 792 adults waiting at home for an ‘*Intensive Home Care*’ package

over 310 adults waiting at home for admission to institutional care

223 adults waiting for home help services, and

2,800 adults and children awaiting specialist equipment.

A review of community care reported a number of key short-comings in the implementation of the principles of People First. The Review (Review of Community Care 2002) outlines ten areas (Strategic planning and Direction; Integrated Health and Social Care; the Hospital-Community Interface; Hospital Discharge Arrangements; Rehabilitation Approaches; Involving Users and Communities; Providing Support for Carers; Medicine Management; Independent Sector Provision; Human Resource Planning; Equality) of delayed implementation in Northern Ireland. For example, in many Trust areas the separation of primary health care and community care has been maintained and this has led to duplication of assessment. Difficulties in the Hospital/Community interface has resulted in delays in hospital admission and discharge and are seen as symptomatic of a much wider and more complex problem in funding planning and delivery of community care. The Review concludes that in the absence of this strategic implementation programme many trusts, voluntary organisation and professional groups on the ground have developed a range of

innovative schemes, and practice designs to meet local needs. The review findings show that many of the problems highlighted such as duplicated assessments, poorly planned human resource management, and lack of rehabilitation might be rectified through the use of a single assessment tool. The Review recommends the development of a single assessment tool that can be used to meet all levels of need whether in hospital or in the community setting. This assessment tool would be embedded in a process exemplified by good communication and used not only in the context of the individual but also in the assessment of need within the overall planning context in light of its implications for financial and performance management services.

National Service Framework for Older People

In March 2001, the Department of Health (England) published the 'National Service Framework for Older People', aimed at redressing the problems associated with the NHS and Community Care Act. The central value of the report was that 'just like the rest of us, older people want to enjoy good health and remain independent for as long as possible' (DoH, 2001, page 1). A number of recommendations aimed at fulfilling this principle were highlighted and these are identified in the NSF report but are not the remit of this project. One such recommendation advocated the implementation of the philosophy of person-centred care when working with older people and implicit within this was a core recommendation for the use of a reliable and valid assessment instrument that would ensure that the person was put at the very heart of the assessment process.

The Department of Health drew up a set of draft guidelines that were to be used as the template in the assessment process of older people by all health trusts. Local NHS organisations were to ensure that any existing approaches met the criteria set out (DoH, 2001) and regional differences were to be included as additional to these set criteria. The assessment process was to be implemented and evaluated, with the evidence of compliance presented to the DoH before April 2005 (DoH, 2001). The Department of Health 'Assessment Working Group' provided a more detailed outline of the process as a guideline for all health authorities (DoH, 2001). While the full details of this process are too lengthy to review here, the key stages of assessment for the single assessment process are outlined in the following sections.

Whilst the NSF for Older people does not apply to Northern Ireland policy, principles inherent in strand two of the NSF reflect the essence of the principles outlined in People First (1990), Community Care: From Practice to Policy (1998), Standards for Assessment and Care Management (2000), and The Review of Community Care (2002), surrounding the assessment process. As Northern Ireland prepares for the implementation of a single assessment instrument many of the lessons learnt for the implementation of the NSF single assessment process in the U.K. will help inform the development of the assessment instrument here. These findings will be outlined in more detail later in this document.

Comprehensive Assessment Process

Assessment involves collecting information about a person's circumstances and needs, and making sense of that information in order to decide what support, treatment or care to provide (Slater and McCormack 2005). It is a complex, integrated process consisting of many parts (See diagram 1). Central to this triangulation of information is the individual. They are the best source of opinions as well as being best placed to identify their achievable goals and assist in the development of a suitable care plan. To ensure the reliability of the information gathered, assessment information involves the triangulation of information, gathered from as many sources as possible but kept in proportion to the older person's needs (DoH, 2001). This may include carer (formal and informal) and family members. This information is to be collected and collated by a trained professional and cover at least the nine domains outlined in the NSF. These were:

- users perspective,
- clinical background;
- disease prevention;
- personal care and physical well-being;
- senses;
- mental Health;
- relationships;
- safety; and
- immediate environment and resources.

If required, other sources of information should be accessed including carers, health services, social services, housing services and other relevant professionals. This would help to confirm important findings, access information that the individuals may not be in a position to supply, identify non-assessed needs, and help in the generation of a holistic picture that may be lost by the reductionist nature of a more quantitative assessment process. This last point is vital to the whole process. The use of an assessment tool is an important strand of the assessment process but the holistic nature of the assessment process, using as many sources as possible, is paramount. The report *Community Care: From Policy to Practice* recommends the use of biography as an essential component assessment process rather than over reliance of purely quantitative measures, a tick box culture, that fails to identify unmet needs (1998).

The assessment process would take into account the individuals circumstances, identifying cultural, religious and race differences (DoH, 2001). Any resulting care plan should accommodate these differences accordingly (DoH, 2001). Investigation should be made with the individual in how these differences may influence their daily and weekly routines and arrangements made to facilitate these beliefs as best as possible.

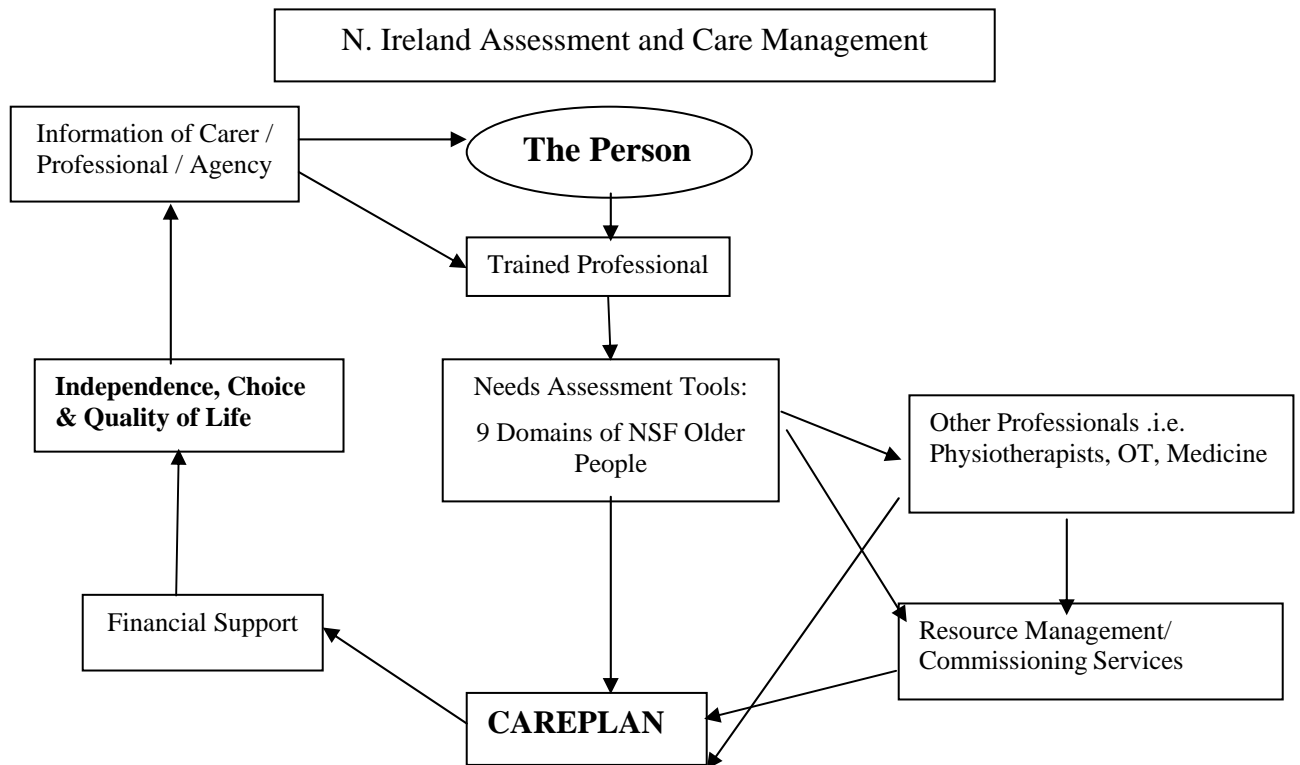


Diagram 1. Components of the Assessment Process

Specialist assessment would be employed as and when required. This self-empowerment helps ensure the care plan is workable, idiosyncratically tailored and improves adherence to treatment. A suitably qualified professional gathers information from the individual and carers.

Properly targeted assessment and the care plan development would help to promote independence through the prevention of deterioration and the achievement of realistic goals (DoH, 2002). As a result it would reduce the burden on services through appropriate allocation of resources according to needs as well as offering more choice to the individual. The whole process should be continuous with regular assessments updating information as the individual's circumstances change over time. Carpenter et al (2005) reported that the assessment instruments with unproven reliability and validity may jeopardise the interests of

older people and the need to raise assessment standards. A single proven assessment procedure would help to:

- Facilitate information sharing and standardised principles of best practice among multidisciplinary health professionals, such as nurses, occupational therapists and psychologists,
- Promote independent living among older people through prevention of deterioration and managing crises, freeing up services and ensuring that services remain appropriate to the needs.
- Flag up potential health or social problems beyond the immediate problem that may have an impact on the life expectancy and quality of the individual being assessed.
- Respect multi-cultural issues and make the assessor aware of the ways in which that race, culture, religion and needs impact on each other.
- Ensure that the scale and depth of assessment is kept in proportion to the older person's needs
- Provide information to support the determination of the nursing care contribution following the introduction of free nursing care in nursing homes.

(National Services Framework for Older People, DoH, 2001)

The proposals outlined in the NSF for Older people are not without their critics. Evans and Tallis (2001) argue that proposals are subservient to the political agenda of keeping older people out of hospital and they describe the system as 'unconvincing and over bureaucratic' (p.808). Ebrahim (2001) states that the government used statistical data in a post hoc fashion to justify decisions already arrived at. Knight (2001) argues that the framework is age-discriminant in its treatment of people over 75. Evans and Tallis (2001) argue that the framework's outline of a single assessment process does not address what particular problems it aims to resolve and would be a 'bureaucratic nightmare, with many boxes being ticked and few people being helped' (p.331). They concluded that the findings from a review of the single assessment process must be carefully scrutinised and transparent.

The Royal College of Nursing challenged the workability of aspects of the framework, in particular with regards to its commitment to free nursing care. Whilst the framework advocates free nursing, at the same time it introduced a financial ceiling. In addition, care

would not be 'free' unless provided by a registered nurse. Knight (2001) describes this as 'covert rationing' at the expense of a highly vulnerable sector of the community (p.323). Both the RCN and Knight insist that others carry out elements' of care plans for older people such as specialists or healthcare assistants and that the financial capping would jeopardize the older person's long-term care.

The Assessment Tool

Central to the assessment process is the assessment tool. Diagram 1 highlights the way in which the strands of the assessment process are inextricably linked to one another. This is intentional and a method of safeguarding the holistic, person-centred nature of the investigation. Any potential assessment tool should have both proven reliability and validity. This helps to provide a battery of standardised measures, add structure to the process and guide the investigator through the stages of assessment, ensuring all domains are addressed.

The guidelines set out in the National Service Framework for Older people (DoH, 2001) did not advocate the use of one single assessment tool in addressing all issues relating to older people. Rather it provided a framework aimed at the convergence of assessment methods and results over time irrespective of tools chosen for local use. Local agencies would be expected to demonstrate how their agreed approach to assessment complies with the NSF for older people.

A comprehensive assessment tool is required to address all nine areas identified in the 'National Services Framework for Older People'. To facilitate this process the Department of Health recommended a process of assessment where the assessment was broken down into four key stages: The Contact assessment; Overview assessment: Specialist assessment and Comprehensive assessment. In brief, a contact and overview assessment would be administered to collect basic personal information. This would act as a "generalist assessment", and be conducted by frontline Health and Social care professionals such as community nurses, social workers, occupational therapists and physiotherapists. Both the contact and overview instrument would help identify specialist areas of assessment when more in-depth information regarding the individual is required to make a care decision. Appropriately trained qualified professionals would be further involved in this

comprehensive investigation identified by the generalist assessment process. All three assessments would form the basis for a more comprehensive assessment. The full details of each stage are outlined in the section exploring the implementation of the Single Assessment Process. However implementation in England and Wales has been very limited in relation to embodying all of these four key stages. Most seem to have begun to work through the process but failed to establish the focus of Comprehensive assessment. One or two seem to have established some place for Comprehensive assessment but are rather vague about the earlier steps.

Caution should be exercised in interpreting the use of assessment tools as implying only quantitative measures. The holistic nature of assessment often means that quantitative measures of performance are not the only means of generating information. Slater and McCormack (2005) reported the importance of having a person's biography in the assessment process to ensure a comprehensiveness of the assessment, a view held by Clarke and colleagues (2003). The Inspection Report following the tragic death of Mr Frederick McLernon in Northern Ireland emphasised the importance of including the individual's own 'story' (or history) and perspective within a holistic assessment (SSI, 1998).

Current Care Management Arrangements in Northern Ireland

It is estimated that approximately half a million older people currently reside in care homes in the U.K. (Royal Commission, 1999) and this figure is set to increase as the older population rises in the coming years (NISRA, 2006). In general, the past decade has seen increasing recognition of chronic as opposed to acute health care needs. The continuing growth in the population of older people, both absolute and relative, presents policy issues across the globe. These demographic changes have put ever-increasing pressure on community care services for older people. However it has been suggested that timely high quality assessment may impact on this rise, leading to more effective rehabilitation and associated increased independence of older people (Audit Commission, 1997; Royal Commission, 1999). The interplay between hospital and community services has also become increasingly apparent. A multi-disciplinary inspection stressed "*It is important that patient discharge is planned in order to provide adequate and effective support systems and alleviate*

the risk of further deterioration to the patient's health, or re-admission to hospital" (SSI, 1997).

The Health and Social Services Boards determine policies for care management (including eligibility criteria for admission to institutional care in three of the four Boards) and parameters for the systems to be put in place by Trusts. Detailed procedures and staffing structures for assessment and care planning have been developed independently by the eleven Trusts that deliver community health and social services. Such policies, procedures and systems are pivotal in ensuring sound decision-making based on suitably comprehensive assessment, leading to effective care plans, whether at home or in an appropriate institution.

The timely and comprehensive assessment of needs is the cornerstone of the decision to enter a nursing or residential home and the development of an effective care plan whether for institutional or home care (DoH, 2001). The documentation currently used for assessment and care planning in each Trust is essentially unique and not validated. Most Trusts have revised their documentation on at least one occasion during the decade since the introduction of People First, many following the publication of the SSI report 'Community Care: From Policy to Practice' (1997). In general different documentation is used for different client groups, normally determined by programmes of care.

A Standard Assessment Process

In relation to older people, the National Service Framework (DoH, 2001) proposes that in Great Britain there shall be "a single assessment process" so as to further Standard Two: Person-centred Care (cf. Ford & McCormack, 2000). The basic principles of assessment and care planning apply with appropriate modification across all the adult client groups, and indeed children's services also (Taylor & Devine, 1993). A key aim is to ensure that the comprehensiveness of the assessment undertaken is appropriate to the level of needs of the older person. Properly targeted assessment and care plan development will help to promote independence through the prevention of deterioration and the achievement of realistic goals (DoH, 2002). As a result it will reduce the burden on services through appropriate allocation of resources according to needs as well as offering more choice to the individual. The whole

process should be continuous with regular assessments updating information to reflect change over time in individual circumstances.

Person Centred Care

The assessment process is seen as a basis principle of person-centredness (DoH 2001). However the exact nature of person-centredness is poorly understood (McCormack 2003). There are several differing models of person-centredness in health care settings, for example in medicine (Mead and Bowers, 2000) , in learning disabilities (Jenaro et al 2005) and in psychiatry (Williams et al 1999) and in particular person-centredness in relation to older people (McCormack 2001, 2003, Parker 2003, Nolan et al 2001, Titchen 2000, 2001). Common to all models of Person-centredness is the centrality of the relationship between the therapist (health professional/assessor) and the client (older person).

Torres (1986) highlights four core tenets that cross all health professions. These are defined as essentially carative: carative referring to the holistic well-being of the individual rather than the curative of the medical ailment alone. These four tenets are:

- The relationship between the therapist/assessor and client has a significant on the client ability to deal with needs and to cope
- The individual's internal frame of reference must be the focus of both verbal and non-verbal communication
- The therapist/assessor acts as a facilitator of human development
- In dealing with individuals in an interactive way, concepts such as self-awareness and tension are useful as a focus.

McCormack (2003) describes person-centredness or personhood as comprising of more than the functional abilities of the person. Many of human functional abilities such as sight, smell, taste and sexuality etc could be prescribed to members of species other than humans. Frankfurt (1989) argues that higher order attributes such as thought and decision making also fail to distinguish the person from other species. McCormack (2003) concludes that it is our ability to engage in reflective evaluation of actions that distinguishes what is truly person and therefore it is reflective evaluation that is person-centredness. Through this reflection the individual is able to derive a set of principles that guide decision making throughout life and

determines what one does in particular situations. In this way the person is able to see life as a whole and make decisions that are their own (McCormack 2003).

The NSF for Older People recommends that older people and their carers (formal and informal) should receive person-centred care and services which respect them as individuals and which are arranged around their needs (2000). Older people and their carers have not always been treated with respect and dignity (Health Advisory Service 2000, 1998) nor have they always been enabled to make informed decisions through proper provision of information about care across care sectors (Health Education Authority 1998). Person-centred care requires managers and professionals to: listen to the older people; respect their dignity and privacy; recognise individual differences and specific needs (Regan and Smith 1997) including cultural and religious differences; enable older people to make informed choices involving them in all decisions about their needs and care (Kanitsaki 1988); provide co-ordinated and integrated services responses; Involve and support carers (formal and informal) whenever necessary (DoH 2001).

To be considered a person-centred assessment, the process (and instrument) may reflect the uniqueness of the individual. This would not be limited to the content of the assessment instrument but apply to the method of recording the data. In nursing, and particular gerontological nursing, the influence of person centredness has been developed in the last 15 years (Kitwood 1997a, b; Nolan et al 1997, 2001; Titchen 2000, 2001; Johns 1994; McCormack 2003; Slater and McCormack 2005). Whilst each has differing perspectives to the exact nature of person centred care each acknowledge the importance of the biography of the older person as a core principle of person-centredness. By 'biography' the researchers mean the persons values and beliefs, biography and relationships, and seeing beyond the immediate needs and authenticity with the older person (Clarke et al 2003). If an assessment process is to be considered person-centred it must acknowledge the complexity of the 'person' and simply not rely on the measurement of functional abilities, or thought processes but see the client as a developing, evolving individual with a past, present and future (Slater and McCormack 2005). To fully understand the benefits of a person-centred assessment requires a understanding of the benefits and drawbacks of the various theories of assessment.

Theories of Needs Assessment

Three main theories of needs assessment exist: Functional Assessment theory; Selective Optimisation and Compensational theory: and Becoming Human theory. Each of these theories have their inherent benefits and drawbacks and each theory will be explored and outlined with their relevance to the assessment of older people considered.

Functional Assessment

This is based on the principles that old age can be measured and subsequently described in terms of ability to perform activities of daily living and the aging process can be characterised by terms such as functional ability and impairment (Kane and Kane 1983). These domains of assessment cover aspects of psychosocial functioning, including measurements of cognitive behaviours and participation in social activities (Kane and Kane 1983, Becker and Cohen 1984; Porter 1995; White and Goldenberg 1996).

Such instruments included measurement instruments like the Residential Assessment Instrument (R.A.I), the Barthel Index and the Sickness Impact Scale. All comprise of a series of ordered tasks (such as the ability to walk up stairs unaided, aided or not at all) and the person's ability to do each task is recorded (either on a Likert or Dichotomous scale). As assessment scales they provide high levels of reliability and validity and can be used to measure deterioration or improvement in the individual (Carpenter et al 2005). Their use has been linked to better planning in frail individuals (Russel 1986; Fries et al 1994; Maklan et al 1994) and it has been used in both U.S. settings and the U.K.

Carpenter et al (2005) compared the differences in findings gathered using a structured and unstructured assessment tool. The structured assessment tool was associated with greater completeness of recording of information; domains covered in the instrument were more thoroughly covered; more auditable, sensitive to measure change and more proven inter-rater reliability. However the structured format failed to facilitate the inclusion of additional information or unmet needs not included in the instrument.

Functional Assessment methods have been criticised as being prescribed in its domains, too narrow on its focus and failing to embrace 'positive aging' or quality of life of the older

people (Minkler 1996; Kiunick and Murray 1997; Stevernik et al 1998). Prescribed in that there is no opportunity for deviation beyond the set statements contained in each domain also no opportunity from the set domains. Too narrow in that functional assessment focuses on the inability to perform a task or the presence of a disability. This limits the positive aspects of the older person that could be embraced to promote positive living and better quality of life (Edmondson 1997). Schulz and Williamson (1993) supported this view and advocated a movement towards the adoption of a bio-psycho-social model of fragility and old age. In their model Schulz and Williamson merged the three dimensions and see the success for any form of assessment as dependent on the evaluation of all three dimensions of old age. For example physical disability has strong psychosocial and social impact on the individual beyond that measured by the simple ability to perform a certain task.

Baltes and Baltes (1990) support this view and reported that the success of assessment will depend substantially on an understanding of how frailty is perceived and understood by the older person and their formal/informal carers. This will influence future expectations (even negative) and determine the motivation and commitment of older people and caregivers to engage in positive or health enhancing behaviours. Baltes and Baltes coined this theory Selective Optimisation and Compensation theory (1990).

Selective Optimisation and Compensation Theory

This theory balances subjectivity and objectivity indicators based around three concepts:

- the nature of human aging
- individual strategies for successful aging
- and the carer or professional response.

The sequence of these concepts is important as it represents a resilience to a deteriorating aging process, as the individual compensates for losses by adapting their remaining facilities or through the adaptation of their environment (Baltes refers to this as Compensational mechanism or Optimisation). This reflects a balanced state where older people are enabled to come to terms with deteriorating levels of independence.

Therefore the thinking that underpins this theory would be that 'normal' or healthy aging is not dependent upon the absence of disability because it is possible for the two to co-exist as

long as the person retains the ability to compensate for the presence of loss, or is helped to do so by supportive services (Sherman 1993). Failure to compensate, either individually or through support services, does not mean that the person is in an unhealthy state but rather that they have not achieved a state of optimisation is only achieved via the redressing of this imbalance, and the maximisation of the abilities of the older person.

This theory, whilst attractive, has attracted criticism. Bowling (1993), Cole (1988) and Becker (1986) argue that within this model there is no set principles of what constitutes positive aging or aging well and that this term may be misconstrued as rewards for a life of self-control or correct living. Until a more appropriate conceptual framework that recognised the older person's quality of life is developed this method of assessment still is lacking comprehensiveness.

Human Becoming Theory

This theory is based on Existentialism and Humanistic philosophy. Human becoming theory explores the lived experience of the older person and the importance of the older person in making choices continuously and actively, regarding their future life course (Parse 1987, 1990, 1992).

To paraphrase Parse's theory, the older person is in a state of development where the individual's ability to move towards personal goals as the process of human becoming continues to unfold. Therefore health is seen as one aspect of a holistic person (Parse 1993). From this perspective the function of the identification of needs and the provision of care and services should aim to positively influence quality of life as experienced through the individual in what Parse's termed 'True Presence'. This is a term that Parse's used to describe the relationship that is formed between the older person and the carer. Similar theories have been purported by researchers exploring the quality of life issues of older people (Keys 1989; Porter 1995; Phillipson et al 1996; Joshi et al 1999). As a theory, Human Becoming theory contains strengths that are invaluable in terms of identifying some of the needs and experiences of older people, particularly in terms of measuring the quality of life.

Parse's theory is not without its criticisms – principally around the reliability and validity of the findings. This is due to the predominance of qualitative methods of data collection. Subjective findings tend to have poor measures of reliability and validity, limit comparisons over time and hinder the measure of improvements in physical or psychological capabilities. This method brings with it problems with the large amount of information collected, the time and resources required to collect this information and the reliance of subjective findings. Both reliability and Validity or core components of the guidelines of the assessment instrument as outlined in the National Service Framework for Older people Stand Two.

Selecting the most appropriate theory to underpin the development of the assessment instrument based on these three theories as proved controversial. Baltes and Baltes (1990) described this as a 'theoretical dilemma' and suggests that the objective aspect of the physical, psychological and social functioning and the subjective aspects of the life quality and meaningfulness for a "knot few researchers are prepared to try and untie". Stevernick and colleagues (1998) suggested that what is required is an appropriate theory of need assessment that is a benchmark of standards that fosters: a theory of individual behaviour that considers physical, social and psychological circumstances; a theory of life goals connected to a theory of individual behaviours; a theory of quality of life that relates to these requirements. Minkler (1996) concurred with these views and suggested what was needed was a compromise tailored to address the aim of the assessment tool, and that this be based on critical analysis of the literature.

Gormley (2003) conducted a critical review of the three theories of functional assessment, development and quality of life outlining their strengths and shortcomings and concluded with the recommendation that a multi-staged assessment procedure be used, proportionate to the complexity of the needs of the individual. The higher the complexity, the further the individual proceeded through the assessment process. This multi-staged assessment would draw on all the strengths of the needs theories. The researcher saw the inclusion of a multiple functional assessment as a given in this process. This core information would identify concepts that appear to have a disabling effect on the older person. The next stage would then draw on the lived experience surrounding the problems expressed, as well as identifying unmet needs, goals and aspirations.

A two stage process has been proved to be effective in needs assessment in studies by Phillipson et al (2002) and Bowling (2002). In these studies, stage one focused on a multi-dimensional strategy to identify the presence of disabilities and stage two has provided an opportunity to expand on how these disabilities have impacted on the individuals' life, and explore methods of compensation, and identify goals and unmet needs.

The process outlined in the NSF for Older People has recommended a four stage process (as outlined previously) and a review of the current findings regarding the implementation of the SAP across the U.K and Scotland employ this multi-staged approach (e.g. Blezard 2002; Hanley 2005). These four stages are classified as Contact Assessment; Overview assessment; Specialist (in-depth) assessment and Comprehensive assessment.

Stages of a Single Assessment Process

The implementation of SAP in England and Wales was done on a geographical basis through the work of Local Strategic Partnerships (LSP) with many areas completing their research by the end of 2004. In England, four methods were initially outlined to address the goals of the Single Assessment Process (SAP). The SAP was a 'process' not requiring the use of a single assessment tool, rather the addressing of key attributes, or domains and stages of assessment (DoH 2002). Most LSP decided on a process of staged assessment where individuals would receive a progressively more specialised assessment depending on there complexity of needs. These were termed Contact assessment: Overview: Specialist (or in-depth) and Comprehensive assessment. The number of the assessments stages completed would be kept in proportion to the complexity of the clients needs.

Contact assessment focused on the demographic details of the individual, such as demographic details, reason for referral, previous referral history. The Department of Health guidelines (2002) define the contact assessment as measuring basic personal information and the nature of the presenting problem is established and the potential presence of wider health and social care needs is explored. Nicholls (2004) reported length of the contact assessment to vary between 1 and 5 pages. This would form the core details of the individual and are often the details most prone to repeat assessment.

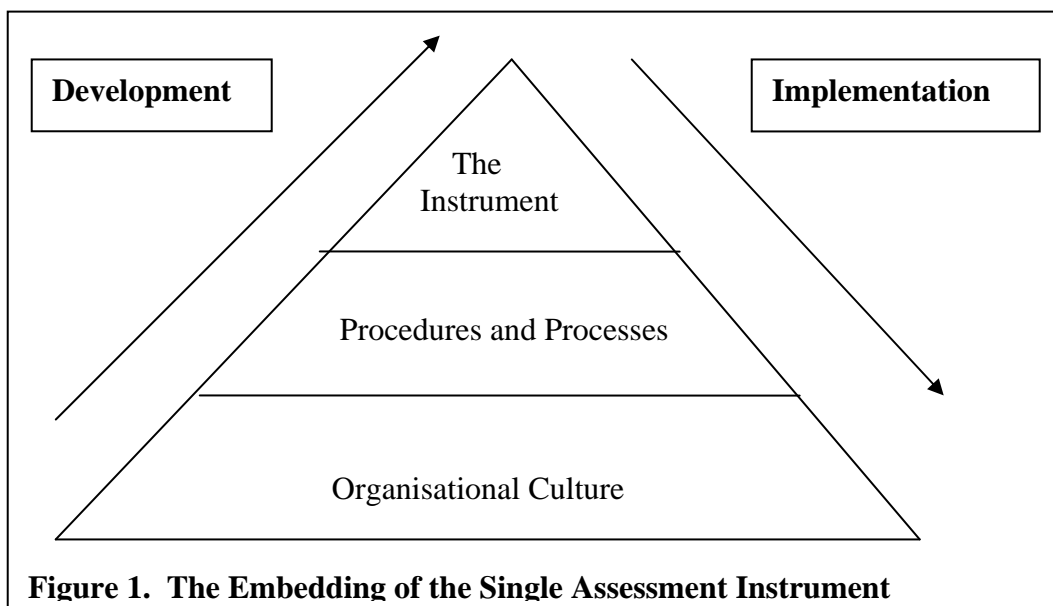
Overview assessment provided a brief synopsis covering all domains outlined in the National Service Framework for Older People and has been the main focus of the ‘off-the-shelf’ assessment tools (DoH 2002). This overview assessment could be completed by any ‘trained professional’ (mostly social workers, nurses and occupational therapist) and its depth was kept in balance with the needs of the individual. The length of the Overview instrument ranged from between 3 and 29 pages (Nicholls 2004). Within the overview assessment specialist assessment trigger questions would be included that would set in place a process for further assessments conducted by relevant professionals (such as community pharmacist or GP). It is envisaged that a Current Summary Record can be generated from the information contained in the overview assessment. This Current Summary Record will contain the means by which case information on an individual older person is stored and shared, subject to consent and confidentiality, among health and social care professionals. It draws on information collected during the assessment process but also covers care planning information including support and services that are provided (DoH 2004). Information gathered will include demographic details, carers involved, the older person’s perspective of current needs, clinical background, disease prevention, and assessment of individual needs, evaluation of needs and risk, summary of current care plan, additional personal information and administrative details (Nicholls 2005).

Specialist (or in-depth) assessment triggered by the overview would use standardised professional relevant assessment instruments. McCormack and Slater (2005) reported there to be over 400 such instruments currently in use. The Department of Health (2002) provided a list of such approved professional instruments relating to the needs of the person.

Lastly the comprehensive assessment drew all information together and included an element of previous three assessments, particularly the specialist assessment. This information is drawn together by a named care co-ordinator and fully evaluated, including information from multi-professional assessments and a thorough exploration of rehabilitation potential. From this a needs summary and care plan would be developed and recorded. Rather than being seen as a distinct tool or document the comprehensive assessment is the sum of the total information gathered. It should be completed when the person needs are such that they

require a level of support and treatment that is intensive or prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home.

For an assessment tool to succeed it must be facilitated by receptive procedures and processes and embedded in an organisational culture. Figure 1 displays the topography of the assessment process. The development of the instrument most pay cognisance to the organisational culture within which it is to be used. It is within this culture that the procedures and processes of the organisation are arrived at and the assessment instrument is used. Therefore the instrument should be developed from the organisational culture and take into consideration the processes and procedures as it is these ritual of work that determine the successful implementation of the instrument.



Implementing the Single Assessment Process

Research to date in the SAP has focused on the development of both the contact and overview assessment tool with its trigger questions linked to specialist assessment (Bradford SAP 2005; NOAT 2005; Tameside 2002). In these studies the domains of the National Service Framework either have been addressed through the use of approved 'off the shelf' assessment tools (such as Easycare in Bradford 2005), or through the development of an assessment tool for local use (NOAT in Northamptonshire 2005). The third option was the

adoption of a ‘checklist’ approach whereby ‘professionals ensure that the domains of the SAP guidance are covered during an overview assessment (DoH 2003, Richardson et al 2005).

Nicholls (2004) conducted a review of thirteen assessment instruments utilised as the contact and overview assessment. It was reported that twelve of the thirteen Trusts developed their own home-grown instruments. Three of the Trusts explored the use of the standardised instrument EasyCare and rejected it, only one Trust accepted it as their overview assessment. Richardson et al (2005) reported that following an initial embedding period the contact and overview assessment worked well. However the specialist and comprehensive assessments were proving more difficult to implement due to problems associated with a lack of clarity surrounding how they fit into the complete assessment.

Regardless of the method of instrument selection, whether off the shelf or developed, the overview instrument should not be seen as a panacea from all assessment problems. Instead it should be seen as it is – a tool to aid the assessment process. Glover (2005) suggested that the development of an assessment tool is seen as easier than challenging the values underpinning the assessment process itself.

Barriers to the implementation of the Single Assessment Process

Comparing the findings regarding the implementation of the single assessment process across settings has proven difficult due to two reasons. These are:

- Local Strategic Partnership’s project findings utilised unique strategies to implement change in their assessment process and as a result each LSP identifies a variety of barriers to the successful implementation of the instrument. For example Dickinson et al (2006) used qualitative method to explore opinions surrounding the instrument. In contrast Hanley et al (2005) utilised a more quantitative approach to assess the details of the assessment instrument.
- Different LSP implemented the single assessment process at different stages, compounding the problems of comparisons across differing methodologies used. For example Birmingham initially piloted the contact assessment (2004) Hertsmere Primary Care Trust implemented the contact and overview assessment as separate

strands of the assessment process (2006). Derbyshire implemented the contact and overview assessment with a focus on person-held records and the inclusion of electronic versions of the instrument (2004).

Most studies into the SAP have found participants to view the framework as attractive in principle. Testimony of health professionals regarding the introduction of SAP reported that the process would force interagency collaboration to be examined and that this would have a positive effect on the 'roles and responsibilities and identify where duplication is occurring' (Richardson et al 2005). However, almost all health professionals considered the SAP as unworkable in practice in its entirety (Richardson et al 2005). The crux of their criticism was that the complexities of the implementation process themselves distract from its purpose and ethos.

Common to all of the reported barriers were two distinct groupings of barriers: Organisational related barriers and: instrument related barriers. Organisational barriers include problems such as failure of joint practice: structural barriers such as failure to feel a sense of ownership of the instrument by front-line staff: Information Technology problems – the transfer of the findings to electronic based formats. Instrument related problems revealed can be categories into four groups: both the reliability and validity of the instrument; comprehensiveness of the instrument; and training issues. Each of these barriers will be examined in the following sections.

Organisational Related Barriers

In a review of lessons learnt from the implementation of the strands of the SAP a number of key issues arise. It was recommended that a national tool would have been preferable to a locally arrived at solution. The reason for this was the amount of energy and time consumed in arriving at the final instrument regardless of whether it was an off the shelf or locally derived instrument. The process of validating the instrument selection, agreeing instrument content and promoting ownership of the instrument among front line all required significant discussion and negotiation, and well as the eventual reaching of consensus between a large number of stakeholders.

Recent governmental policy advocates partnership working (The new NHS, Modern, Dependable 1997; Modernising Social Services 1998). Collaborations between health and social care boundaries have been defined as ‘a way of working with others on a joint project where there is a shared interest in positive outcomes’ (Sullivan and Skelcher 2002, p.1). The challenge of developing a suitable tool to be use by a variety of agencies in order to reflect the older person’s needs is dwarfed by that ensuring interagency cooperation in order to implement seamless care.

The cross professional working has the greatest potential to the successful implementation of the single assessment process and there as been no lack of commitment among health professional to achieving this goal and its principal are clearly evident in higher levels of management (e.g. joint appointments). However, achieving these goals has been difficult to achieve in practice with front line staff. The main difficulties as being principally due to:

- Different professional perspectives on problems.
- Different occupational cultures
- Confusion over professional roles (Dickinson et al 2006).

These findings are not new. In 1996 Caldock identified obstacles to interagency collaboration such as conflicting objectives, power struggles, budget allocation and professional mistrust.

Dickinson and colleagues (2006) highlighted nine areas that potentially hindered the implementation process. These were:

- Inadequate preparation of front-line workers for the SAP
- Lack of understanding of the purpose of the tool
- Subversion of the SAP by professional
- Lack of understanding of the roles of other professionals
- Feeling of ‘doing each others work’
- Distrust of the assessment of others (unless they know the person)
- Lack of information sharing
- Threat of role change
- Different styles of management.

A review of implementation problems conducted by Richardson et al (2005) considered the SAP as unworkable in practice in its entirety. This was broken down into two main criticisms: The size and complexity of the framework itself and the scale and complexity of the intra-interagency implementation.

Criticism of the SAP focused on four main interdependent areas:

1 Intra and Inter Agency Working and Sharing Information

Dickinson et al (2005) reported that intra/inter professional working provided the greatest benefit of the SAP and was key to its successful implementation. They reported that there was no lack of commitment from professional staff regardless of speciality and its principal are clearly evident in higher levels of management (e.g. joint appointments). However, achieving these goals has been difficult to achieve in practice with front line staff. Unclear professional role definitions, variations in commitment to - or priority of - SAP between specialities within locations (particularly among GP's), different styles of management, and poor leadership at all levels of both health and social care management as well as the research team, have all been identified as barriers to the implementation of the SAP.

2 Ownership

The ownership of the instrument by front line staff is crucial to full engagement with the instrument. LSP reports have reported that front line practitioner expressed a preference for their own locally derived instrument as these had been arrived at through a process of local development and refinement over time and a sense of ownership of the instrument. As a result there was considerable resistance to change unless these front line professionals were fully engaged in the development of the instrument. This engagement should not be confined to middle management level but also 'at the coal face'. This was achieved through agreed line of communication and feedback during the development and implementation process. Dickinson et al (2005) recommended that to improve ownership a degree of flexibility on domains covered by the instrument should be included to allow local agencies an opportunity to 'refine' the instrument and they should be encouraged to do so.

3 Electronic Solutions

The importance of a cohesive electronic communication system in the health service has recently been acknowledged by the Department of Health (CRDB 2005) based on the recommendations of a national SAP stakeholder workshop (Cited in Richardson et al 2005). To date most LSP are in the process of implementing a single IT solution across health trusts. The impact of this single method of communication has become more important as the different LSP report back findings and recommendation. The reliance of paper based systems is brought to life when one considers that a person with complex needs will be assessed by several professional often situated across different locations within a health trust. For this information to be shared required the repeated transfer of documentation from one agency to another, repeated assessment for the individual and carers, resulting often in repeated assessments, delayed care and inconvenience for the individual and the carers and extra work for the assessors. Even the process of client held records does not elevate these problems.

The benefits of electronic real time or short delayed information sharing would mean that most information would be available to the different agencies prior to assessment, speeding up the assessment process and avoid duplications (Richardson et al 2005). It would also help with information storage but would require careful management regarding data protection and informed consent. Client held records have been introduced in areas to help reduce this duplication in the interim. Interestingly coloured paper has been used as a background of the assessment to ease the identification of the assessment by health professionals (and if necessary ambulance staff) (Nicholls 2004). Assuming the advent of the new IT system in health settings there is a recognised need for training of personnel in the use of IT software and the updating of computer equipment. Glover (2005) recognised the potential of shared information both within and across agencies based on a common IT system, but this potential is conditional on the availability of up to date training and resources and a willingness to use it.

4 Instrument Related Issues

Most of the comments surrounding the implementation of the single assessment process focused on procedural and process issues. However a number of comments were reserved

for the instrument itself. The numbers of completed studies surrounding the statistical properties are presently limited due to the on going nature of the research into the SAP. The feedback received to date the majority of comments has focused on training and instrument contents.

Training/Standardise Training

The implementation of a new assessment instrument requires the acknowledgement of the starting position of existing members of staff. Therefore a standardised training procedure was required. Dickinson et al (2006) suggested that when training staff sufficient time must be provided that allowed staff to become familiar with the instrument prior to training, opportunity during the training to ask questions regarding unfamiliar domains or issues, opportunity to practice using the instrument, and that the training should focus on the practicalities of the assessment tool and not focus on the policy background of the SAP. The researchers suggested the use of traditional methods of training such as lecturing, as well as other methods such as clinical supervision and action learning sets.

The West Midlands Regional Single Assessment Process Group (2004) recommended the use of the training process to promote interagency working among assessors. This could be achieved through the clarification of roles and responsibilities in the completion of the instrument. Jankowska (2000) concurred with this view suggesting that the training process could be used to promote joint working among staff through joint training. This training should include significant partners, such as GP's. Further suggestions included clinical supervision, particularly among newly trained staff, honest feedback on assessments, and identify the need for refresher courses to keep up to date with developments in the instrument. Derbyshire and Derby Social Care and Health Communities (2004) advocated the use of on-going support and development services throughout the initial implementation of the instrument.

Content Agreement and Limiting Size of the Tool

The size of the assessment tool developed must be defined within clear borders – Size referring to the physical and procedural nature of the assessment tool. The use of domains to identify assessment needs has proven useful in the examination of professional roles and responsibilities as well as identifying where duplication occurs. However the SAP in its entirety is considered ‘unworkable’ and distracts from the ethos and objectives of the Single Assessment Process (Richardson et al 2005). In most sites of implementation, the contact and overview assessment were finally embedded into the assessment process after much review work. The Specialist and Comprehensive assessment is proving much more problematic due to confusion with how they fit with the overview assessment and other assessments, who should be completing them, and how the information should be shared among professional.

A major criticism of regionally developed contact and overview assessments has been the length of time taken to complete the assessment. The Northamptonshire Overview Assessment Tool has reported an average length of two hours to complete the assessment. Dickinson et al (2006) reported that the length their assessment instrument deterred further exploration of issues in the service-user. A key recommendation to emerge from their study was the simplification and shortening of the assessment instrument to only include essential information and/or the use of filter questions to help speed up the time taken to complete the assessment.

Conclusions

The need for a single assessment process is has emerged out of the governmental policy and academic findings surrounding older people. Recent governmental legislation has advocated the use of a single assessment instrument as part of a focus on the implementation of strand two, Person-centred Care of the National Service Framework for Older People (DoH 2001). The principles and benefits of a single assessment instrument advocated in strand two encapsulates the principles of Northern Ireland legislation outlined in documentation such as People First: Community Care in Northern Ireland (DHSS 1990) and Quality Standards: Assessment and Care Management (SSI, 1999). As the population of older people continues to increase in Northern Ireland there is a necessity to develop an assessment instrument that

removes the postcode lottery that currently exists regarding instrument use. A central component of this instrument must be person-centred care. Torres (1986) and McCormack (2001, 2003) recognise the importance of the relationship between the assessor and the user in the assessment process. This relationship must be facilitated through the structure of the assessment instrument.

Examination of the theories of needs assessment, and in particular needs relating to older people, advocates a balance of needs assessment that encapsulates both a tick box and written text format. This approach provides a structure for needs assessment whilst allowing for the identification of the individuality of the person and any unmet needs. Current assessment procedures in the U.K. that are currently in the process of implementing a single assessment process have utilised this multistage approach. However, for this approach must be embedded in the institutes current organisational culture if it is to be successfully implemented. Examination of the literature to emerge to date has helped identify these problems areas and through there identification it is hoped that a proactive approach will be adapted in this study.

In the following section the development of a single assessment instrument(s) will be outlined, mapping the criteria and process of reviewing existing instruments currently in use in Northern Ireland, and the subsequent process involved in the development of the resulting instruments.

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