



The **Regulation** and
Quality Improvement
Authority

**Review by RQIA
of
Northern Ireland Single Assessment Tool
Stage One
Overview Report
October 2011**

informing and improving health and social care
www.rqia.org.uk

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Section 1

1.0 The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulatory body for Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

The vision of RQIA is to be a driving force for positive change in health and social care in Northern Ireland through four core activities:

- Improving Care: we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.
- Informing the Population: we publicly report on the safety, quality and availability of health and social care.
- Safeguarding Rights: we act to protect the rights of all people using health and social care services.
- Influencing Policy: we influence policy and standards in health and social care.

RQIA encourages continuous improvement in the quality of services, through a planned programme of inspections and reviews.

This report summarises the findings from Stage 1 of a four part review of the Northern Ireland Single Assessment Tool (NISAT) commissioned by DHSSPS.

Stage 1 of this review process sets out the historic position of the five health and social care trusts in respect of:

- care management assessment procedures
- assessment tools in use by care professionals prior to the introduction of NISAT.

Stages 2, 3 and 4 of the review will concentrate on:

- training involved in the introduction and implementation of NISAT
- an audit of the Carer's Support and Needs Assessment component of NISAT
- a comparison will be undertaken of the impact of the introduction of NISAT. This will include an evaluation of the perceived benefits of using NISAT from the perspective of the trusts, practitioners, service users and carers.

2.0 Context for the Review

Older people often have complex needs which cannot be addressed by a single health and social care professional or service. Good communication, collaborative working and teamwork are critical to the delivery of co-ordinated care for the benefit of the older person.

In 2007, the Department of Health, Social Services and Public Safety (DHSSPS) appointed external consultants from the University of Ulster to develop a single assessment tool which would assess the health and social care needs of older people in Northern Ireland (NISAT). A single assessment is unique to the person, uses a standardised approach and is recorded on a single shared record.

The DHSSPS established a multi-disciplinary Regional Project Implementation Board of senior managers, to provide leadership and to ensure implementation of NISAT across the region. Resources were also provided by the DHSSPS to facilitate project management arrangements within individual trusts.

NISAT was formally launched in February 2009. At the launch the Minister outlined how the assessment tool would benefit older people. He said, ***“NISAT will give older people a real opportunity to have their voices heard and to be at the very heart of the assessment process”***.

He stressed that NISAT will be the only assessment tool to be used by Health and Social Care professionals. There will be collaborative working, with commitment, motivation and co-operation at all levels to make implementation happen.

It was originally expected that NISAT would be introduced into practice in the older people’s programme of care (POC) by June 2010.

NISAT aims to underpin the assessment process and to ensure that individuals (and as necessary their carers) receive services which are responsive to and appropriate for their needs. NISAT is structured with 10 domains which are completed according to the level and complexity of health and social care needs experienced by the older person. The assessment process seeks to improve the experience for individuals by maximising their participation and minimising duplication of information. The tool is designed to optimise multi disciplinary cooperation and to capture the information required to enable professionals to provide a holistic, person centred proportionate assessment of the older person focusing on the person’s abilities and strengths.

The tool has three primary components:

- (i) screening
- (ii) core assessment

(iii) complex assessments

Essential forms used in association with these three primary components are:

- client summary and action details
- consent to assessment and sharing of information
- review of actions agreed following initial assessment

There are also three additional components which can be used in conjunction with the above:

- a specialist assessment summary
- a general practitioner's and medical practitioner's report if assessed in hospital
- a Carer's Support and Needs Assessment which was required to be rolled out in accordance with 'Carer's Support and Needs Assessment' component, as set out by the DHSSPS, in circular HSS (ECCU) 2/2009.

As part of RQIA's three year review programme DHSSPS commissioned RQIA to review the implementation of NISAT across all five health and social care trusts.

2.1 Terms of Reference - Stage 1

The terms of reference for Stage 1 of the review were agreed as follows:

Stage 1 will take the form of a historic baseline study. The aim of the study is to describe the care management assessment processes in place across all five HSC trusts prior to the implementation of NISAT in relation to:

- care management assessment procedures for older people services and
- assessment tools in use by health and social care professionals to inform the care manager of a clients needs prior to the implementation of NISAT.

3.0 Methodology

Key areas to be reviewed were agreed with DHSSPS and mapped against legislative requirements, standards and recommendations for good practice.

The following policy and guidance documents were used to inform the overall purpose of the review:

- Recommendations made in People First: Community Care in Northern Ireland in the 1990s
 - The National Services Framework for Older People (Department of Health, London 2001)
 - Quality Standards: Assessment and Care Management (DHSSPS Social Services Inspectorate (SSI), 1999)
 - The Single Assessment Process (Department of Health, 2001)
 - Care Management, Provision of Services and Charging Guidance (DHSSPS HSC circular (ECCU) 1/2010)
1. A checklist assessment questionnaire was developed by RQIA to capture all existing practices in place across the five HSC trusts with regard to assessment and care management processes. The trusts were also asked to select the three most common assessment tools in use by professionals, prior to the implementation of NISAT, which inform care managers of a clients needs, and to evaluate the strengths and challenges of using these tools. A self-assessment questionnaire was forwarded to all trusts for completion. Responses were submitted to RQIA within a six week timeframe.
 2. Validation of the trust responses by the review team was obtained through focus group discussions with key trust personnel. This included representatives of the teams responsible for the operational management and delivery of older peoples services.
 3. Within each of the five HSC trusts an audit of four case notes of patients clients who had been provided with care and support in the community was carried out by members of the review team.
 4. Individual feedback reports were provided to each trust.
 5. An overview report of the Stage 1 findings across the five trusts was completed.

4.0 Membership of the Review Team

The review team consisted of a panel of RQIA inspectors and a medical practitioner with expertise in the provision of health and social care services for older people and of the assessment and care management arrangements.

For Stage 1 of this review the team comprised the following members:

Ken Fullerton	Consultant Physician in Geriatric Medicine, and Senior Lecturer at Queens University, Belfast
Theresa Nixon	Director of Quality Assurance, RQIA
Hall Graham	Head of Primary Care, RQIA
Priscilla Clayton	Inspector Quality Reviewer, RQIA
Emily Campbell	Inspector Quality Reviewer, RQIA
Maire Marley	Inspector Quality Reviewer, RQIA
Angela Belshaw	Project Manager, RQIA
Hilary Brownlee	Project Manager, RQIA
Louise Curran	Project Administrator, RQIA

5.0 Focus of the Review

Stage 1 of the review was to set out the historic position prior to the implementation of NISAT in terms of

- the trusts' reported position on the planning and delivery of services for older people
- a description of the assessment tools in place across the five HSC trusts to inform the care manager of the needs of the client prior to implementation of NISAT
- the evaluation by trusts of the strengths and challenges of assessment tools in use by various professionals involved in the care management process prior to implementation of NISAT
- the use of carer's support and needs assessment tool within older peoples services
- the historical position (at a selected date in time), of assessed met and assessed unmet need across the five HSC trusts prior to implementation of NISAT
- an audit of patients' clients' case notes.

Section 2

6.0 Population, Planning and Delivery of Services for Older People

6.1 Population

Prior to implementation of NISAT, the population of older people (65 years and over) in Northern Ireland, is estimated as 254,480 (Registrar General Annual Report 2009 - Section 2 Population)

Table 1- Population of Older People

Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	TOTAL
51970	67820	52020	45270	37400	254,480

Research has determined that by 2026 one in five people will be aged 65 or over and one in 14 people aged over 65 years will have a form of dementia, this will rise to one in six people over 80 years, and one in three over 85 years.

6.2 Planning and Delivery of Services for Older People

Trusts were asked to describe their structural arrangements for the provision of services for older people prior to the implementation of NISAT.

All five trusts reported that health and social care services for older people were delivered through primary care directorates and older peoples services. Each trust has developed a strategy which sets out plans for meeting the needs of service users over a five year period. A trust corporate plan or primary and social care annual management plan, sets out the key actions that will be taken forward.

Within each trust's primary care directorate there are a number of operational divisions. Services are planned on an annual basis around local trends and identified needs. All trusts have a range of forums in place for consulting with service users and carers and have been making changes to improve and modernise their systems and processes in order to deliver more effective and coordinated services for older people.

6.3 Access to Services for Older People across the five HSC Trusts

Trusts were asked:

- *to describe how older people accessed services and how services had been established in their trust area*
- *to describe the capacity team building arrangements to ensure that professionals were empowered to work in a collaborative way*

The reported approach taken by trusts to the delivery of services for older people is through the following means.

6.3.1 Referral and team building arrangements

Across all five HSC Trusts it was reported that there has been considerable progress in establishing a single point of referral for clients to access services.

All five HSC Trusts indicated they had developed or were in the process of developing:

- integrated care teams
- specialist rehabilitative teams
- intermediate care services

It was reported that the teams and services listed above generally share the following features:

- geographical alignment to defined populations
- single operational management structure with clearly defined governance arrangements managed by either a professional lead from nursing, social work or by an allied health professional
- common administrative support
- close working relationships with general practitioners and the local community

The trusts reported that the purpose of the teams and services was to

- prevent unnecessary hospital admission,
- promote faster recovery from illness,
- support timely discharge from hospital
- maximise independent living

These teams provide time limited care/rehabilitation programmes (usually up to six weeks) for older people either within their own homes or in designated intermediate care facilities.

It was reported that staff are encouraged to work in a collaborative way to address clients' assessed needs and the review team was advised that this has led to the development of a culture of sharing information and working collaboratively towards improving services.

6.3.2 Hospital and Community Interfaces

All trusts aim to provide safe and timely discharge of older people from hospital taking account of their assessed care needs. Trusts also aim to meet the target outcomes for discharges set out in the DHSSPS Priorities for Action.

Departmental guidance states that unless there are other compelling factors, decisions about longer term care should not be made in a hospital setting, where patients and their carers are at their most vulnerable. All five HSC trusts referred to patients as being medically fit for discharge, which complies with the definitions associated with the previous DHSSPS Priorities for Action target for the reduction in delayed discharges.

In order to achieve the DHSSPS targets, the review team noted a number of reported schemes and practices in place to provide local solutions to help ensure that older people do not remain in hospital, if they are deemed medically fit to go home.

6.3.3 Services Available to Bridge the Gap between Hospital and Community Care Services

Trusts were asked to describe any innovative schemes or practices that had been developed within services for older people to provide local solutions to bridging the gap between acute hospital care and primary care.

All five HSC trusts described their hospital discharge planning process as follows:

Once a decision is made by the responsible consultant or other authorised individual in conjunction with multi-disciplinary colleagues that the patient is clinically fit to leave hospital, the discharge process commences.

Generically, from self assessment and interview these processes include:

- pre-discharge multi-disciplinary assessments
- discharge meetings
- arrangements (where necessary) for older people to be transferred to intermediate care schemes, pending assessment

of need rehabilitation and necessary care packages being put in place

6.3.4 Services in Place to Facilitate Discharge from Hospital

All five HSC trusts indicated they had access to:

- step down beds in nursing residential care homes
- enhanced intermediate care services
- home from hospital schemes

Belfast Health and Social Care Trust

The Belfast Trust considers that the gap between acute hospital care and primary care has been bridged to a greater extent due to their reconfigured management structures. Managers within services for older people are now responsible for services across acute hospital, intermediate and primary care settings.

A dedicated hospital ward was established to provide investigation, assessment and rehabilitation focused care which has a well-established multi-disciplinary ethos and is linked to an Older Peoples Assessment Liaison Service (OPALS) clinician.

Northern Health and Social Care Trust

A Hospital Diversion Team: operates from 9.00am to 11.00pm; seven days per week. This team consists of a group of nurses with enhanced clinical skills actively linking with accident and emergency (A&E) departments and from consultants and from hospital ward staff (accept appropriate referrals).

Continuing care nurses: manage long-term conditions for example chronic obstructive pulmonary disease, by actively seeking out patients who are repeatedly re-admitted to hospital. This service also has direct access to rapid response domiciliary care services to prevent admission and facilitate timely discharge.

South Eastern Health and Social Care Trust

Community nurse rapid response teams have been set up across the trust and offer blood transfusions intravenous infusion, and intravenous antibiotics.

Specialist equipment, where required, is ordered, delivered and installed within a strict deadline to clients' own homes. Pressure relieving equipment is supplied for clients in private nursing homes and residential care homes.

Southern Health and Social Care Trust

Specialist nurses for older people: support the care of older people with more complex needs in private nursing homes. They assist with care planning in the nursing home to prevent unnecessary hospital admissions and to facilitate timely discharge from hospital.

A memory service liaison nurse: ensures arrangements are in place to facilitate timely hospital discharge for older people with dementia.

Western Health and Social Care Trust

Hospital discharge planning teams are in place across Altnagelvin, Erne, Tyrone County and Waterside Hospitals. These teams provide assessments for patients in hospital settings who liaise with a range of community services.

Case management services prevent unplanned admissions to acute hospital and facilitate early discharge for those patients with long term conditions e.g. asthma chronic obstructive pulmonary disease (COPD), diabetes and heart failure.

The review team noted that the trusts described a varied approach to delivering services to older people.

- Models of integrated care teams which are in place or in the process of being put in place represent good practice.
- Trusts reported the positive impact that integrated care teams have had upon staff in regard to their understanding and awareness of roles and responsibilities of other care professionals.
- Trusts reported that the modernisation of older peoples services had provided a catalyst for change and improvement in service delivery in all five HSC trusts.
- Trusts reported that much work has been undertaken to ensure that professionals were empowered to work in a more collaborative manner

7.0 Referral and Assessment Processes used by Care Managers

The purpose of a referral is to ensure that the comprehensiveness of the assessment undertaken is appropriate to the level of need of the older person.

Care management should be a dynamic process tailored to the circumstances and assessed needs of individuals and their family and community context. The care management process should aim to deliver safe and effective health and social care services in the setting which is most appropriate to the person's needs. Arrangements should be in place for negotiating with users and carers as to the most appropriate way of creating and implementing the care plan to achieve the objectives of the assessments.

Paragraph 12 of Circular HSC (ECCU) 1/2010 - Part 1 DHSSPS - 1 July 2010 states:

“Assessment of need is the systematic determination of health and social care needs in a manner which is proportionate to the individual's presenting circumstances. Assessment should reflect the perceptions and wishes of service users and carers as well as their strengths and preferences. Where appropriate, the assessment should accurately portray the contributions of carers and their needs. It should focus on maximising opportunities for service users to live independently at home, or in as near a domestic environment as possible, for as long as they wish, where this is safe and appropriate.”

Cases referred for assessment and determination of need are considered by staff at two levels:

- simple needs are identified (where the client requires assistance with one activity such as having a meal)
- complex needs are identified (where multiple risks are identified)

7.1 Trust reported Care Management Assessment processes in place across all HSC Trusts Prior to Implementation of NISAT

All five HSC trusts reported that they had a referral policy in place. In three of the HSC trusts (BHSCT, SEHSCT and WHSCT) all referrals are received through a central referral management system. There is a screening process in place and cases are then allocated to either a care manager or assistant care manager to undertake an assessment of need.

The Western Trust reported that the assessment process is usually undertaken by the care manager and commences when the patient is transferred from the acute hospital settings to intermediate care.

The Northern Trust reported that they operate a social work model for care management, with referrals made to a duty social worker. A screening process is commenced and the referral is allocated to a social worker for an assessment of need. Community nursing referrals are entered into an electronic system (Central Referral Management System) and screened by community nurses. Once the nursing assessment is completed, it may generate triggers for referral to other health and social care services.

The Southern Trust reported that referrals are received from a variety of points however it was reported to the review team at the validation meeting that work had commenced across the trust to have a single point of referral for older people. Within each professional group there is a system for screening referrals prior to allocation for initial assessment. Referrals to social workers are screened by a team leader or caseload holder and within nursing teams a professional judgment is made about the type of assessment to be carried out.

7.2 Links with the Hospital to facilitate Care Management Assessment across the five HSC Trusts

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. It is a complex, integrated process consisting of many parts. Accessing 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).

The review team noted that within the hospital setting trusts reported that appropriate referrals are made to each professional discipline. If the assessed care needs for some older people indicate they require a domiciliary care package or a care home placement, trusts reported that appropriate processes are in place to respond to this need.

Generally only summaries of other care professional's assessments are collated by a social worker and forwarded to the appropriate care manager. The designated care manager is then responsible for arranging the appropriate care package. The review team was advised by trusts that care arrangements service provision for clients are reviewed by the care manager usually within a six week timeline to ascertain if the care package in place still meets the client's and carer's assessed needs.

Variances were noted in this process across the five HSC Trusts as follows:

7.2.1. Belfast Health and Social Care Trust

The trust reported that management structures had been reconfigured prior to the review and managers are now responsible for services across acute hospital, intermediate and primary care settings. The care management assessment process is undertaken by the care manager and few long term decisions about care are made within the acute hospital setting. The trust reported that work was in progress to ensure that all care management documentation, policies and procedures were standardised across the trust. It was also reported at the validation meeting, that the trust intends to conduct a formal review of the care management process and that services will be redesigned to address any future service delivery needs.

7.2.2 Northern Health and Social Care Trust

Some professional assessments are carried out within the hospital setting. The hospital social worker convenes a multi-disciplinary discharge planning meeting and the summary report of the multidisciplinary assessments are used to assess the needs of the patient in respect of discharge planning.

7.2.3 South Eastern Health and Social Care Trust

The primary care manager has overall responsibility for the assessment and care management processes. It was reported to the review team that the majority of professional assessments begin in hospital, and GPs can link into cases. The care manager has direct input into the assessment process and attends pre-discharge meetings. The care manager has authority to carry out an assessment at any time within a six to eight week period, either in the acute setting or when a patient has been referred to a rehabilitation scheme.

7.2.4 Southern Health and Social Care Trust

Some professional assessments take place within the hospital setting. However, the care management process commences when patients are transferred from acute hospital settings to either an intermediate or an enhanced intermediate care setting.

7.2.5 Western Health and Social Care Trust

There are hospital discharge planning teams in Altnagelvin, Erne, Tyrone County and Waterside Hospitals. These teams provide assessments for patients in hospital settings and liaise with community services. Care managers use a standardised risk analysis assessment tool and also compile the summary of need report and forward copies of this to the client carer and the potential provider.

7.3 Findings of Review Team

The review team noted that trusts reported:

- links into the acute hospitals to facilitate care management assessment when patients with complex needs are identified
- some care management assessments are carried out in the hospital setting
- an acceptance by other care professionals of the importance of a care manager referral for a client's assessment of needs.
- professional disciplines use different professional assessment tools and only summaries of these assessment findings are sent to the relevant care manager
- the establishment of 'step-down' and intermediate care provision avoids, where possible, long term care decisions being made in hospital
- the lack of timeliness in receiving paper based assessment information from other care professionals continues to present a challenge for care managers
- there was a challenge for care managers to review individual 'care arrangements, service provision ' within a six week time frame

8.0 Trusts View of Selected Assessment Tools prior to the Implementation of NISAT

Assessment tools currently in use in each trust are essentially unique. Therefore trusts were asked to evaluate the strengths and challenges of a maximum of three of their most common assessments tools in use by professionals, prior to the implementation of NISAT (Some trusts selected only two assessment forms).

Trusts were asked to evaluate their assessment tools against six broad themes:

- 1. Involvement of the individual in the assessment process*
- 2. A person-centred approach highlighting abilities, strengths and future wishes*
- 3. The effects of personal circumstances on quality of life*
- 4. The usability of the instrument*
- 5. Supporting integrated working and holistic assessment*
- 6. Application of consent guidance*

8.1 EasyCare Northern Ireland Assessment Tool (Appendix 2, Table 1)

The EasyCare assessment tool is in use by the Belfast and South Eastern trusts.

EasyCare Northern Ireland Assessment Tool (EasyCare) is considered to be a comprehensive screening tool for older people in a community setting and has been adapted as an online assessment tool. The tool addresses the effects of personal circumstances on quality of life through the administration of a geriatric depression scale which provides opportunity for the client to indicate through self-assessment their level of depression. Reviewers suggested that level of depression alone, is not the best indicator of quality of life.

Both trusts agreed:

- the individual is involved in the assessment process mainly through engaging in the answering of the assessment questions
- the tool does not promote a person centred approach to assessment
- the tool has the ability to capture an individual's abilities but not strengths
- the tool supports integrated working and holistic assessment
- the tool facilitates the provision of consent to sharing assessment information between disciplines

The Belfast Trust reported that EasyCare captures the source of information collated, for example - client/carer or practitioner but it does not capture the method, for example - whether information was obtained face-to-face or by telephone.

8.1.1 Strengths of the Tool

- helps to promote standardisation of practice
- helps to reduce duplication of information
- has been adapted for electronic use

8.1.2 Challenges of the Tool

- the information collated is limited and does not allow for analysis required to support decision making and care planning
- it does not capture the method of contact, for example, face-to-face or telephone
- absence of a section to record risk was noted by South Eastern Trust
- Belfast Trust reported that integrated care teams have not fully maximised the potential of this tool

The South Eastern Trust reported a concern in regard to determining the capacity of the older person to give consent and this continues to be a challenge to staff.

8.2 Roper, Logan Tierney Assessment Tool (Appendix 2, Table 2)

The Roper, Logan and Tierney (RLT) assessment tool is used by nurses in all five HSC trusts. It is based upon 12 activities of daily living. It identifies the individual's nursing care needs and the type of nursing support required to meet those needs. It is described as a holistic assessment of problems that are identified by questioning and observing a patient's ability to manage with the activities of daily living.

All five HSC trusts agreed that the tool:

- does not lend itself to the contribution of the older person to their assessment and care plan
- is not person-centred
- does not support integrated working, as it was designed and used solely by nursing staff
- has no consent form within the assessment documentation

Three trusts (Belfast, Northern and Southern) reported difficulties with consistently identifying information obtained during the RLT assessment. Examples:

- approach used to undertake the assessment
- source of the information

The Belfast Trust reported that the tool goes some way to capture the older person's strengths and abilities, but does not address future wishes regarding assessments of care. The Western Trust noted that the tool only captures the expressed wishes of the older person at the end stage of life.

The assessment summary is shared with other professionals and the Western Trust reported that the care manager receives the full assessment booklet along with the summary.

8.2.1 Strengths of the Tool

- familiarity for nursing staff, as the tool is embedded in nursing culture
- practical and easy to use in clinical settings
- the assessment can be carried out in a short timeframe
- can inform decision making with regard to onward referral
- outcomes of the assessment are shared with other professionals

8.2.2 Challenges of the Tool

- does not support integrated working
- information captured in the RLT is open to significant interpretation by practitioners (NHSCT)
- the RLT assessment tool in its presentation is quite basic (BHSCT)

In regard to seeking consent, the Belfast Trust reported that this would be obtained on a specific consent form and the Western Trust stated that patients who are 'care managed' are asked to sign a separate consent form to allow their information to be shared.

8.3 Care Management Assessment Tool (CMA) (Appendix 2, Table 3)

The Northern, Southern and Western trusts reported using this assessment tool.

Please note that the Northern Trust refers to this tool as the **Multi-disciplinary Assessment Tool**

The care management assessment tool makes provision for identifying individuals' perceptions of their main needs and preferred method of meeting these needs. The resulting care plan is agreed and signed by the client and a social worker. This tool is a process of assessment rather than a single instrument and requires a key worker for each client, with contributions from various professionals.

The three trusts agreed that:

- the tool facilitates care planning and risk assessment
- the tool supports integrated working and holistic assessment
- allows information to be shared and basic consent obtained once the person is in the care management process
- the tool does not support a person-centred approach to assessment
- information captured about individuals' wishes and preferred options is limited
- demographic data is replicated on each care management form

The Southern and Northern trusts reported that the effects of personal circumstances on quality of life are not captured in the Care Management Assessment Tool. However the Western Trust responded positively to this question.

The Southern and Northern Trusts stated that they are not satisfied that the tool facilitates involving the individual in a holistic way in the assessment process.

8.3.1 Strengths of the Tool

- captures information about the client from many sources
- triggers for further specialised professional investigation
- supports integrated working however staff find that this aspect of the tool is not well evidenced

8.3.2 Challenges of the Tool

- it is time consuming to administer
- the lack of timeliness of other professional assessment input in order to facilitate care planning

The Southern Trust considers that guidance on the issue of consent is not addressed in the Care Management Assessment tool.

8.4 Social Enquiry Report (SER) (Table 4, Appendix 2)

This tool was utilised only by South Eastern Trust. In its evaluation, the trust indicated that the Social Enquiry Report (SER) assessment tool:

- has a section for assessing and recording identified client needs. However, the extent of the older person's input into the assessment and outcomes are not clear

No strengths were reported.

Challenges of the Tool

- does not capture the effect of personal circumstances on quality of life
- is not designed to support integrated working and holistic assessment
- the issue of consent is not addressed in the tool

8.5 Adult Social Care Report

This tool was used only by Southern Trust social workers and their evaluation indicated that the tool:

- was easy to use
- enables the views of older people to be recorded
- has a clear link to care planning and risk assessment
- has options for individuals to add information

No strengths were reported.

Challenges of the Tool

- does not capture the effect of disability on the person's quality of life
- does not facilitate referral to specialists or agencies

8.6 Comments of the Review Team on the Selected Assessment Tools in use prior to the Implementation of NISAT

In reviewing the assessment tools used by trusts prior to the implementation of NISAT the review team noted that:

- the assessment tools in use reflected a clear link to care planning
- professional disciplines found their assessment tools easy to use and facilitated the sharing of information with others as required. However, there is a challenge in providing this information to care managers in a short time frame.
- selected assessment tools are embedded in the 'professional' culture (example RLT)
- the assessment tools varied in length, structure and content
- there was duplication of client information across the tools
- the issue of obtaining consent is not clear in some tools

9.0 Use of NISAT Carer's Support and Needs Assessment Tool

Each trust was asked to describe the current position and planned programme for rolling out the NISAT Carer's Support and Needs Assessment Tool within older peoples services in line with DHSSPS Circular HSS (ECCU) 2/2009.

The "carer's support and needs assessment" component of NISAT was piloted in the Northern Trust during 2009 and the report by the trust to the DHSSPS made the following recommendation:

“The NISAT Carer's Support and Needs Assessment Tool should be the assessment tool of choice and rolled out regionally to ensure a standardised approach to carer's assessments for adult programmes of care.”

The DHSSPS fully supported this recommendation and in 2009 HSC Trusts were advised to:

- make all staff aware of the contents of Circular HSS (ECCU) 2/2009
- ensure that the Carer's Support Needs and Assessment Tool was the only assessment tool to be used for assessing the needs of carers across all adult programmes of care
- ensure that trust training programmes for staff undertaking carer's support and needs assessments are informed by the contents of the circular

9.1 Current use of NISAT Carer's Support and Needs Assessment Tool within Older People's Services

All five HSC trusts reported that NISAT Carer's Support and Needs Assessment Tool was:

- at differing stages in terms of roll out across the trusts
- offered to all carers at the initial screening stage of the referral process
- in some areas was not taken up by carers as much as anticipated
- carers sometimes preferred to take up the offer of an assessment of need at different points of the caring process

9.1.1 Collection of Data

Information is being collected in relation to the number of carers assessments offered, completed or declined. The analysis of this data provides information to trusts on the extent of unmet need for carers.

9.1.2 Concerns Raised by Trust regarding NISAT Carers Support and Needs Assessment Tool:

The Carer's Support and Needs Assessment Tool is in use across all five HSC Trusts and trusts are beginning to use the information from the assessment to determine the extent of unmet need for carers

The review team noted the reported concerns of the Trust:

- insufficient information has been captured by the trust from the carers' assessment
- provision has not been made for storage of the completed forms when the client has been discharged from the service
- uptake by carers is not as high as anticipated and the trust is beginning to develop ways of ensuring that uptake of the carers' assessments increases
- some care professionals are not giving a clear explanation of the purpose of the tool to carers
- completion of the carer's assessment has the potential for raising carers' expectations. The wants and needs of carers may not be met in a service in which resources are stretched
- health and social care professionals have not grasped the need to repeat the carers' assessment

9.2 Recording of Service Users' Experience of Assessment Processes prior to NISAT Implementation

Trusts were asked to describe any survey or initiative that had been developed to evaluate user experience of older people's services with particular focus on experience of the assessment process prior to implementation of NISAT.

The trusts described a range of information/planning forums/user forums in place. The trusts reported that the information obtained at these forums influences the planning and delivery of services. However, at the time of this review, there had been no development of a survey or initiative to evaluate user experience of services provided for older people within or across trusts.

The Western Trust submitted evidence of a users' satisfaction survey within the physiotherapy service that was carried out early in 2010. However, the outcome of the satisfaction survey was not available at the time of this review.

10.0 Historic Position of Assessed Met and Unmet Needs as provided by HSC Trusts prior to the Implementation of NISAT

The expected outcome of a care management assessment process is the provision of a care package. The number of care packages in place can be taken as a direct measure of the success of the community care policy.

Therefore trusts were asked to complete a historic statistical profile of the state of community care at 31 March 2010. This date was selected because it would represent a total number of care packages in place and identified unmet need prior to the implementation of the new assessment tool. The profile was to include the total number of care packages in place (see table 2) and the identified unmet needs (see table 3).

The DHSSPS Review of Community Care 'First Report' (2002)¹ commented that; there was no clarity about the relationship between current service provision and potential and unmet demands. It was also stated that in order to establish an appropriate level of provision of health and social services, the identification of total need, both met and unmet as well as all need in the community yet to be assessed, would be required.

As there continues to be a lack of direct and reliable data available about current service provision and potential unmet need, this review replicated the statistical method of collecting information used in the Review of Community Care 'First Report' hospital and community waiting list information and delayed discharge figures were used.

The total number of care packages within services for older people across all five HSC Trusts prior to implementation of NISAT totalled 32,160 (31 March 2010).

¹ Review of Community Care, First Report (DHSSPS, April 2002)
http://www.dhsspsni.gov.uk/review_of_community_care.pdf

Table 2: Care Packages in place across HSC Trusts (31 March 2010)

Type of care packages	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Residential Home	785 (9%)	764 (12%)	718 (12%)	319 (5%)	418 (9%)
Nursing Home	1,492 (17%)	1,632 (25%)	1,352 (22%)	1,251 (21%)	916 (19%)
Domiciliary Care	6,598 (74%)	4,072 (63%)	4,149 (67%)	4,288 (73%)	3,406 (72%)
Total number of care packages	8,875	6,468	6,219	5,858	4,740
Total number of care packages across all trusts	32,160				

Table 3: Unmet need within Community Services for Older People across HSC Trusts (31 March 2010)

Unmet need in community	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Totals %
Individuals waiting at home for an 'intensive home care package'	23 (32%)	2 (100%)	7 (14%)	0	252 (50%)	284 (50%)
Individuals waiting at home for admission to nursing home/ residential care	10 (14%)	0	4 (8%)	0	0	14 (2%)
Individuals waiting for domiciliary services	4 (5%)	0	26 (53%)	0	44 (11%)	74 (13%)
Individuals waiting at home for specialist equipment	36 (49%)	0	12 (24%)	56 (100%)	87 (23%)	191 (34%)
Totals	73	2	49	56	383	563

10.1 Documentation by Trusts of Unmet Need - in the Community

All five HSC Trusts reported that unmet need is identified within their performance management reporting process. The review process comprises weekly and monthly reviews by a panel of community managers. Trusts also reported that patients who are waiting for delivery of the main components of a care package are regularly reviewed.

The following are examples and brief explanations by trusts of their care packages arrangements.

10.1.1 Belfast Health and Social Care Trust

Patients who are waiting for delivery of the main components of a care package are regularly reviewed. At the time of the review the trust reported that there were 23 patients waiting at home for 'intensive' home care packages. Ten people waiting at home for admission to nursing or residential care homes were provided with domiciliary care whilst they waited a care home placement of their choice. Those identified as waiting for full care packages were waiting for an increase to their existing package. (See table 3 for details.)

10.1.2 Northern Health and Social Care Trust

Improvements in the supply of community equipment have been put in place. This resulted in no client having to wait for equipment unless there are complexities in sourcing a specific specialist item to meet a patient's needs. (See table 3 for details.)

10.1.3 South Eastern Health and Social Care Trust

The trust reported that 12 people were awaiting specialist equipment, which in the main was specialist seating. It was reported that each seat is produced to exact client specifications, with a minimum delivery time of six weeks, however in some instances this can be up to three months (See table 3 for details).

10.1.4 Southern Health and Social Care Trust

A system has been put in place to provide urgent review and risk assessment. These reviews and assessments are carried out by the locality manager of clients whose needs have changed suddenly or dramatically. The trust reported that all 56 people who were waiting for specialist equipment had been assessed and the procurement process had commenced.

10.1.5 Western Health and Social Care Trust

The 252 patients who were waiting at home for intensive home care packages had been assessed as priority one or two using the domiciliary care regional access criteria set out in DHSSPS Circular ECCU 2/2008 (27 May 2008)².

It was highlighted by the trust that the majority of clients had part of their care packages in place and remained on the waiting list until the full assessed care package was provided. An action plan has been developed to address those clients who have been waiting longest for the remainder of their care package to be provided.

² DHSSPS Circular ECCU 2/2008: Regional Access Criteria for Domiciliary Care
http://www.dhsspsni.gov.uk/eccu_2_2008.pdf

The trust stated that no-one was placed at risk, as temporary care packages are set up using identified 'temporary hours'. They also noted that team managers continue to meet the needs of people who require community care within the budgetary targets that have been set.

10.1.6 The review team noted:

- That trusts reported that unmet needs of clients were regularly reviewed and acted upon

11.0 Audit of Clients Case Notes

11.1 Aims of the Audit of Clients Case Notes

The purpose of the audit of clients case notes was to map the discharge pathway and the assessment processes of clients who had been provided with continuing care and support in the community. Reviewers examined a random selection of four case notes in each of the five HSC trusts.

The audit of clients case notes was undertaken to ascertain whether:

- the community care package that had been put in place matched the needs recorded in the completed assessment forms
- it was recorded in the case file that the patient was deemed medically fit for discharge as defined by the Priorities for Action target for the reduction in delayed discharges (Health and Social Care Board, April 2010)³
- the tools that were used to assess need for the patient were the same tools that had been selected by the trusts as being comparable with NISAT
- assessments were carried out efficiently and effectively with evidence of on-going multidisciplinary input.

11.2 Findings of Clients Case Notes Audit

- patient case notes and up to date care plans are held in the patient's home therefore it was not possible to check if the care packages put in place matched the assessed needs of the client.
- There was insufficient information available on the file audit to determine the patient's medical fitness for discharge.
- The selected assessment tools were in use by the various professional groups.

³ Health and Social Care Board, Public Health Agency Commissioning Plan 2010/2011
<http://www.hscboard.hscni.net/publications/Commissioning%20Plans/500%20HSCB%20Commissioning%20Plan%202010-2011%20PDF%20974KB.pdf>

Section 3

12.0 Findings from Stage 1 of the Review

The purpose of this review was to set out the historic position of trusts in terms of planning, access, referral, and care management assessment processes in place for older people prior to the implementation of NISAT.

The findings of this review have been informed by commentary from the trusts in respect of the above.

All trusts reported that they have been making changes to improve and modernise their management ,operational systems and processes in order to deliver more effective and coordinated services for older people.

All five HSC Trusts reported a range of forums in place for consulting with service users and carers.

The review team found that all trusts reported on the establishment of 'step-down' and intermediate care provision to avoid long term care decisions being made about patients needs while they were in hospital.

All five HSC Trusts reported considerable progress in establishing a single point of referral to older peoples service and an ease of referral by the care manager for assessment of needs to other care professionals.

The challenge of the timely sharing of assessment information continues to be problematic for care managers.

The review team noted that professional assessments were generally carried out in isolation and only summaries of professional assessments were being shared with care managers.

The review team noted that trusts reported on the model of integrated care teams as having a positive impact on staff in regard to their understanding and awareness of roles and responsibilities of other care professionals. Trusts also reported that these teams have facilitated the sharing of assessment information in a more timely way.

The assessment tools selected by trusts demonstrated that there was duplication of collated information about clients, however the assessment tools also reflected a clear link to care planning.

The next stage of this review (stage 2) will focus on the Carer's Support and Needs Assessment component of NISAT.

13.0 Apendices

Appendix 1 Glossary of Terms

Assessment	A person-centred process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated, undertaken with the individual, his/her carer and relevant professionals.
Care management	Is a whole concept which embraces the key functions of: case finding; case screening; undertaking proportionate; person-centred assessment of an individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.
Care package	A combination of services designed to meet a person's assessed needs.
Care plan	The outcome of an assessment. A description of what an individual needs and how these needs will be met.
Care planning	A process based on an assessment of an individual's need that involves ascertaining the level and type of support required to meet those needs, and the objectives and potential outcomes that can be achieved.
Carers	People who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Case management	Describes the activity, included within the concept of care management, of advocating and co-ordinating services for a service user who needs this high level of support.
Domiciliary/home care services	The range of services put in place to support a person in their own home.
Hospital discharge	The process of leaving hospital after admission as an in-patient.
Intermediate care	A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable people to return home following hospitalisation; or to prevent admission to a long term residential care or nursing home; or intensive care at home to prevent unnecessary hospital admission.
Long term condition	Illnesses which lasts longer than a year, usually degenerative, causing limitations to one's physical, mental and/or social well-being. Multiple long term conditions make care particularly complex.
Monitoring	On-going oversight of people's needs and circumstances to ensure the quality and continued appropriateness of support and services to meet the agreed outcomes for the individual and, where appropriate, his/her carer(s). The person receiving the services, his/her authorised representative and carer(s), where appropriate, and service providers all have a part to play in formal and informal monitoring.

Appendix 2 Assessment Tools

Table 1: Evaluation of the EasyCare Assessment Tool

Assessment Tool: EasyCare			
Key Area: 1. Involvement of the individual in the assessment process			
	Yes (✓)	No (✓)	
BHSCT	✓		The tool captures information on the source of information i.e. client/carer or practitioner. It does not capture the method i.e. whether face-to-face, telephone etc.
NHSCT			
SEHSCT	✓		No additional comments
SHSCT			
WHSCT			
Key Area: 2. A person-centred approach highlighting abilities, strengths and future wishes			
	Yes	No	
BHSCT		✓	One high level question that captures a clients self-expressed goal
NHSCT			
SEHSCT		✓	The tool only captures abilities
SHSCT			
WHSCT			
Key Area: 3. The effects of personal circumstances on quality of life			
	Yes	No	
BHSCT	✓		The tool incorporates a 'Geriatric Depression Scale' (4 item version) providing opportunity for the client to indicate through self assessment their level of depression.
NHSCT			
SEHSCT		✓	
SHSCT			
WHSCT			
Key Area: 4. The usability of the instrument			
	Yes	No	
BHSCT	✓		Good and is supported by an electronic version which allows for sharing of information between disciplines
NHSCT			
SEHSCT		✓	No risk assessment section

SHSCT			
WHSCT			
Key Area: 5. Supporting integrated working and holistic assessment			
	Yes (✓)	No	
BHSCT	✓		Predominately used by S/Ws, Social Care Co-ordinators and OTs within Integrated Care Teams but is not used by nursing staff. Staff within the IC Teams have therefore have not fully maximized the potential of this tool.
NHSCT			
SEHSCT	✓		
SHSCT			
WHSCT			
Key Area: 6. Application of consent guidance			
	Yes (✓)	No	
BHSCT	✓		Sharing of assessment information
NHSCT			
SEHSCT			Consent to sharing assessment information only. Within the tool it is to the level of consent is not obvious.
SHSCT			
WHSCT			

Table 2: Evaluation of the Roper, Logan Tierney Assessment Tool

Assessment Tool: Roper, Logan and Tierney (RLT)			
Key Area: 1. Involvement of the individual in the assessment process			
	Yes (✓)	No (✓)	
BHSCT		✓	The assessment tool in its presentation is quite basic. It is based on a holistic assessment of problems identified in the patients' ability to manage with activities of daily living.
NHSCT		✓	The information from this assessment is captured by the practitioner asking questions and noting observations.
SEHSCT		✓	No additional comments
SHSCT		✓	The source of information and method of assessment used are not consistently identifiable using the RLT assessment tool.
WHSCT		✓	The tool does not lend itself to the contribution of the older person to their assessment and care plan. It is not a patient centered assessment tool
Key Area: 2. A person-centred approach highlighting abilities, strengths and future wishes			
	Yes	No	
BHSCT	✓	✓	The tool captures the older person's strengths and abilities but not future wishes regarding care
NHSCT		✓	No additional comments
SEHSCT		✓	No additional comments
SHSCT		✓	No additional comments
WHSCT		✓	Only captures the clients' expressed wish when dying
Key Area: 3. The effects of personal circumstances on quality of life			
	Yes	No	
BHSCT		✓	No additional comments
NHSCT		✓	No additional comments
SEHSCT		✓	No additional comments
SHSCT		✓	No additional comments
WHSCT	✓		No additional comments
Key Area: 4. The usability of the instrument			
	Yes	No	
BHSCT	✓	✓	The tool contains a number of statements that the professional uses as prompts to undertake a nursing assessment of the patient's daily living activities. It allows for a nursing problem to be identified in doing so

			<p>identifies actual & potential risks which are then linked to the care planning process.</p> <p>By identifying problems it can inform decision making processes with regards to the need for onward referral by the assessor. NB: this is reliant on clinical judgment of practitioner.</p> <p>Summary assessment and action plan is not captured on assessment tool but would be captured within subsequent care plan document/process.</p>
NHSCT		✓	Information captured is open to significant interpretation by practitioners.
SEHSCT		✓	No identification of any risk factors
SHSCT		✓	<p>The tool provides a clear link to care planning but not to the identification and assessment of risk.</p> <p>Information collated using the RLT assessment tool requires a clinical evaluation by healthcare professionals in the first instance.</p>
WHSCT	✓	✓	<p>The tool contains a number of statements that the professional uses as prompts to undertake a nursing assessment of a patient's daily living activities.</p> <p>It facilitates a clear link to identification of risk and care planning. The assessment tool allows for a nursing problem to be identified at each of the 12 activities of daily living.</p> <p>Following assessment a referral is made to specialists or agencies depending on outcome of the assessment. This is reliant on clinical judgment following assessment.</p> <p>While the format is easily understood, the Care Manager receives an entire eight page document, with a summary on the final page.</p>
Key Area: 5. Supporting integrated working and holistic assessment			
	Yes (✓)	No	
BHSCT	✓		<p>The tool has prompts at each of the 12 sections to allow information to be captured relevant to the activity of daily living being assessed.</p> <p>Assessment tool is nurse specific but shared with Care Managers at point of referral.</p>
NHSCT		✓	No additional comments
SEHSCT			The tool is very specific to community nursing
SHSCT		✓	No additional comments
WHSCT		✓	The Tool has prompts at each of the 12 sections to allow information to be captured relevant to the activity of daily living being assessed. It is designed and used by nursing staff only.

Key Area: 6. Application of consent guidance

	Yes (✓)	No	
BHSCT		✓	Consent Form is not contained within the assessment documentation but would be obtained on specific consent form.
NHSCT		✓	No additional comments
SEHSCT		✓	No capacity for obtaining consent when using this tool
SHSCT		✓	No additional comments
WHSCT		✓	The word consent does not appear on the document. Patients who are 'care managed' are asked to sign a consent form to allow information to be shared.

Table 3: Evaluation of the Care management/Multi-disciplinary assessment Tool (Northern, Southern and Western Trust)

Assessment Tool: Care management Assessment Tool/Multi-disciplinary assessment (CM)			
Key Area: 1. Involvement of the individual in the assessment process			
	Yes (✓)	No (✓)	
BHSCT			
NHSCT		✓	
SEHSCT			
SHSCT		✓	The source of information and method of assessment used are not consistently identifiable using the CM assessment tool.
WHSCT	✓		The documentation makes provision for identifying clients' perceptions of their main needs and their preferred method of meeting these needs. The resulting care plan is agreed and signed by the client and the social worker following the completion of the documentation.
Key Area: 2. A person-centred approach highlighting abilities, strengths and future wishes			
	Yes	No	
BHSCT			
NHSCT		✓	Very limited information is captured about clients' wishes and preferred options
SEHSCT			
SHSCT		✓	Future wishes of older people regarding their care would only be captured in the short term
WHSCT		✓	Does not capture information about strengths and abilities.
Key Area: 3. The effects of personal circumstances on quality of life			
	Yes	No	
BHSCT			
NHSCT		✓	
SEHSCT			
SHSCT		✓	
WHSCT	✓		
Key Area: 4. The usability of the instrument			

	Yes	No	
BHSCT			
NHSCT		✓	No additional comments
SEHSCT			
SHSCT		✓	The tool facilitates care planning and risk assessment
WHSCT	✓	✓	<p>The tool contains a number of statements that professionals use as prompts to undertake an assessment of a patient's daily living activities/needs. The specialist assessment is available in a format that is easily understood by care managers.</p> <p>There are only a small number of structured questions around the area of Legal and Financial arrangements.</p> <p>The Care Manager must go through all the information gathered from the different professional assessments, to complete the CM5 Summary at the end.</p> <p>The tool has a number of components and the demographic data that is recorded at the beginning of this process in the CM1 is replicated on each CM form throughout the entire process.</p>

Key Area: 5. Supporting integrated working and holistic assessment

	Yes (✓)	No	
BHSCT			
NHSCT	✓		
SEHSCT			
SHSCT	✓		Integrated working is not as well evidenced as it could be. The tool can be applied by care managers and specific key workers.
WHSCT	✓		The CM tool is used within the care management process that requires a key worker for each client with contributions from various professionals.

Key Area: 6. Application of consent guidance

	Yes (✓)	No	
BHSCT			
NHSCT	✓		Consent is obtained in the most basic of detail. No consideration is given to the process of obtaining it.
SEHSCT			
SHSCT		✓	
WHSCT	✓		No additional comments

Table 4: Evaluation of the Social Enquiry Report (SER)

Assessment Tool: Social Enquiry Report (SER)/Adult Social Care Report			
Key Area: 1. Involvement of the individual in the assessment process			
	Yes (✓)	No (✓)	
SEHSCT		✓	Section for identified client needs but not clear on older persons input into the assessment and outcomes.
Key Area: 2. A person-centred approach highlighting abilities, strengths and future wishes			
	Yes	No	
SEHSCT	✓	✓	No additional comment
Key Area: 3. The effects of personal circumstances on quality of life			
	Yes	No	
SEHSCT		✓	
Key Area: 4. The usability of the instrument			
	Yes	No	
SEHSCT	✓		
Key Area: 5. Supporting integrated working and holistic assessment			
	Yes (✓)	No	
SEHSCT		✓	
Key Area: 6. Application of consent guidance			
	Yes (✓)	No	
SEHSCT		✓	

Table 5: Evaluation of the Adult Social Care Review Schedule (ASCS)

Assessment Tool: Adult Social Care Report			
Key Area: 1. Involvement of the individual in the assessment process			
	Yes (✓)	No (✓)	
SHSCT	✓		The schedule evidences views of service users and from professional staff/assessments. It also records agreed views.
Key Area: 2. A person-centred approach highlighting abilities, strengths and future wishes			
	Yes	No	
SHSCT	✓	✓	No additional comment
Key Area: 3. The effects of personal circumstances on quality of life			
	Yes	No	
SHSCT	✓		No additional comments
Key Area: 4. The usability of the instrument			
	Yes	No	
SHSCT	✓	✓	There are options for service users to add information not captured in the schedule.
Key Area: 5. Supporting integrated working and holistic assessment			
	Yes (✓)	No	
SHSCT	✓		No additional comments
Key Area: 6. Application of consent guidance			
	Yes (✓)	No	
SHSCT		✓	No additional comments



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