

**Challenges and Benefits in Implementing Shared Inter-agency
Assessment across the UK: A Literature Review**

Emma Miller, MA, CQSW, PhD
Visiting Senior Research Fellow, University of Strathclyde
e.miller@strath.ac.uk

Kirsteen Cameron, BN, RGN, PhD
Business Analyst, Health Information Technology, Gartnavel Royal Infirmary,
Glasgow

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Abstract

Over the past ten years, each of the four countries in the UK has attempted to resolve continuing difficulties with duplication of assessment and lack of shared information in community care, by developing approaches to shared assessment. Relevant literature reviews have previously focused on challenges to partnership working between health and social care, and on different approaches to assessment. The literature review described here differs in three key respects. Firstly the literature was selected on the basis that it addressed shared assessment specifically. Secondly, it included evidence from the four countries within the UK, providing a cross-national basis to the evidence. Thirdly, this study was undertaken to identify whether benefits from shared assessment were evident, in addition to the challenges. While the evidence of benefits at this stage is relatively limited, it is clear that some have emerged, including two relating directly to relevant policy objectives: improved communication, service user and carer involvement; improved partnership and joined up working. As approaches to shared assessment are currently under review in Scotland, England and Wales, and implementation underway in Northern Ireland, and in light of the economic recession and demographic challenges, reflection on key aspects of the evidence may be timely.

Key words: Shared assessment, inter-agency collaboration, community care, partnership working, user involvement

Introduction

Working in partnership has been a theme in UK policy for many years, becoming a key priority for the New Labour government from 1997, despite a relatively underdeveloped evidence base (El Ansari, Phillips, & Hammick, 2001; Dickinson, 2006). Divisions between health and social care services, including cultural barriers associated with the medical and social models, are familiar in many Western countries. In the UK different sources and methods of financing the two sectors have been implicated in sustaining divisions between them (Lewis, 2001). Despite these challenges, considerable efforts continue to be invested in developing partnership between health and social care. One of the key areas of focus has been on how assessing the needs of the service user should be addressed. For the purposes of this article, key shifts in community care policy over the past twenty years will be identified, including shared assessment in the past decade, before relevant literature is explored on the impact of shared assessment.

In the early 90s, significant changes in community care in the UK included community care assessment and the vision of a one-door approach to community service delivery. Assessment of need and good case management were defined as fundamental to high quality care in the White Paper, 'Caring for

People' (1989) which preceded the NHS and Community Care Act (1990). However, while introduction of eligibility criteria for continuing care (DH, 1995) meant that social care became the responsibility of the local authority, health authorities remained responsible for the elements they provided. This meant that service users and carers could be subject to two sets of procedures: 'assessment and care management' and 'nursing process' (McNally, Cornes and Clough, 2003; Cornes & Clough 2004). The 1990 Act was also part of a wider programme for introducing 'government by the market' (Hudson & Henwood 2001), presenting further challenges for partnership working.

Since 2003, all four countries in the UK have introduced community care assessments that can be shared across relevant services. Each country has adopted a different term to denote their model. For ease of reference, the phrase 'shared assessment' is used generically in this article.

In Scotland, renewed efforts are currently being applied to increase adoption of shared assessment in adult community care. To address current inconsistencies in access to services, the Free Personal and Nursing Care Review Group (Scottish government, 2008a) recently recommended that the Single Shared Assessment (SSA) approach be adopted as the standard means of determining entitlement to care services. National minimum information standards (NMIS) for assessment were developed for the collection of core information, with room for local flexibility in application. There is an increased focus on outcomes in the standards, reflecting wider developments on building an outcomes approach into community care (Miller, Cook & Whoriskey, 2008). This review was undertaken to inform continued decision-making around these processes, with the aim of identifying lessons to be learned.

Methods

Search processes

This review of the literature on shared inter-agency assessment in the UK was conducted within a short timeframe, between December 2008 and March 2009. Although not a fully systematic review, efforts were invested in making the review inclusive of all peer reviewed empirical studies, focusing on shared assessment in adult community care in the UK. Papers which did not meet these criteria were included by exception, as detailed below. Limited academic databases were used as part of the search, including Ovid (Embase and Medline), Social Care Online and Oxford Journals, as well as Google Scholar. Reflecting the different terms used across the UK, search terms included 'shared assessment', 'unified assessment' 'single assessment' and 'single shared assessment'. As no studies came up in the search relating to Northern Ireland, a separate search was initiated via Google, leading to recent work on the Northern Ireland Single Assessment Tool (NISAT) which was developed during 2007.

From an original basis of more than four thousand papers identified through the initial broad search, 23 papers were included in the review, mostly based on qualitative research, with survey data in a few cases. Papers from outside the

UK were excluded, as were papers which focused on assessment relating to childrens' services and interagency working other than health and social care. All papers included had an empirical basis. Most of the research involved one or more staff groups, with service users and carers included in several studies. There was one Randomised Control Trial (Carpenter, Challis and Swift, 2007). Two reports were produced to inform implementation of single assessment in England (Abendstern, Clarkson, Challis, Hughes & Sutcliffe, 2008) and Northern Ireland (McCormack, Taylor, McConville, Slater & Murray 2007), and a further study about development of the NISAT was included (McCormack, Taylor, McConville, Slater & Murray, 2008) because peer reviewed studies from Northern Ireland were not yet available. The PhD thesis of the second author was included because of its relevance to developments in Scotland.¹

Analysis and Synthesis

Our analysis began by identifying key policy drivers outlined in the various papers, for each of the four countries. Following from this, to establish the context for the literature analysis, we also examined overarching policy documents, national guidance on shared assessment and associated eligibility criteria.

The themes identified were based on the content of the literature, while informed by wider literature on partnership and community care assessment. We noted the themes raised in each paper in a table, and whether identified as a challenge or benefit of shared assessment. Rather than including every issue raised, we used criteria for inclusion for analysis, based on prevalence. Fourteen themes were referenced by three or more authors. Of these, the five identified benefits were included because the study sought to establish evidence of benefits. Of the eight challenges, the three which were most extensively discussed were selected for further analysis. These also reflected key policy themes of relevance to the future of shared assessment in Scotland. Five challenges, which received less attention, were not included; limited timescale for implementation, difficulties in defining and agreeing information sharing between agencies, lack of shared IT capacity, cultural/professional boundaries and the time involved in completing shared assessments. The critical role of leadership was also highlighted as significant by a few papers.² We will now consider the key policy drivers referenced in the literature before going on to discuss the eight included themes.

Findings

The review aimed to identify the issues raised in the literature and did not attempt direct comparisons between the countries because none of the studies were cross-national. The sections that follow cover the broad themes in the literature, with reference to related policy documents, as shown in Table 1. Key challenges and benefits identified in the literature are then summarised, before implications are discussed.

¹ Information detailing the papers is available on request from the first author.

² Information covering these themes is available on request from the first author

Table 1: Shared assessment policy and practice in the four countries of the UK

Policy and practice

The key policy drivers varied by country. In Scotland the broad aims of collaboration were set out in the report *A Joint Future* (2000) including procedures for single shared assessments. In England, the *NHS Plan* (DH, 2000) and the *National Service Framework (NSF) for Older People* (DH, 2001) were key policy documents, with the latter also identified as a significant driver in Wales and Northern Ireland. All policy documents emphasised the importance of involving the assessed service user in decision-making.

Several studies referred to government guidance on implementation of shared assessment. While aspects of guidance relating to shared assessment in Scotland, England and Wales were prescriptive, such as the stage and components of assessment, specific tools were not recommended. All, apart from Ireland, left the actual tools used in practice to local discretion.

With regard to eligibility criteria, the Fair Access to Care Services (FACS) Guidelines (DH, 2002) were developed in England, based on individuals' needs and associated risks to independence, and included four eligibility bands - critical, substantial, moderate and low. When placing individuals in these bands, councils were not only to identify immediate needs but also needs that would worsen without timely help. The FACS guidelines, were separate in England but integrated within the Unified Assessment (UA) guidance in Wales. Ireland also operated eligibility criteria, but these were determined at the local level. At the time of writing, Scotland had introduced new mandatory eligibility criteria for local authorities in relation to services for older people, prompted by the Sutherland Review (Scottish Government, 2008a).

We now turn to consider the key benefits and challenges identified in the literature, associated with implementing shared inter-agency assessment.

Identified challenges

The most prevalent challenges were as follows:

Devising assessment documentation

A major theme concerned the development of documentation for shared assessment, mainly related to attempts to strike a balance between standardisation of tools and facilitation of local flexibility in tool development. While standardisation was associated with minimising cross-boundary difficulties (Seddon, Robinson & Perry, 2008), reducing duplication and increasing efficiency and effectiveness (Abendstern et al., 2008), it raised tensions in terms of professional and person-centred values, which were supported more by flexible approaches (Cameron, 2006). Although there were concerns that some social services agencies had not developed the skills and expertise required to develop tools (Glasby, 2004), there was evidence that 'fit' with local processes and ownership by practitioners supported successful

implementation in both England and Scotland (Cameron, 2006; Dickinson, 2006; Glover, 2005; Richardson et al., 2005).

Disparities were apparent in all three countries in the extent and nature of information gathered; with free text associated with the social model and tick boxes associated with the medical model (Abendstern et al., 2008, Cameron, 2006; Eccles, 2008; Richardson, Medina, Richardson, Sitzia & Brown 2005; Seddon et al., 2008). Lack of standardisation was associated in the literature with challenges to information management. For example, in Wales, inconsistencies made it difficult to establish robust performance management indicators, limiting comparisons across areas and across service user groups (Seddon et al., 2008). In England, Carpenter et al., (2005) recommended standardised assessment as a means of ensuring coverage of key domains and to produce more auditable results. However, their study did not take account of person-centred aspects. There was also evidence that over-attention to the format and structure of tools could be counterproductive to good assessment practice. The notion of a good assessment being the product of a good assessor appeared to be undermined by the effort required by getting the assessment tool right (Cameron, 2006).

Engaging key stakeholders

The key professionals involved in shared assessment were social workers, occupational therapists and community nurses (Challis et al., 2008). There were particular challenges in engaging GPs, clinicians and the acute sector generally. As the first point of contact, GPs are well placed to complete an initial or contact assessment and they hold health information fundamental to the shared assessment process (SAP) (Seddon et al., 2008). However, in practice, lack of GP engagement in England, Scotland and Wales led to duplication and limited potential to incorporate preventive work (Dickinson, 2006; Cameron, 2006; Eccles, 2008; Seddon et al., 2008).

The community care reforms were intended to encourage more joint working between primary and secondary health care (Abendstern et al., 2008). While there were examples of specific projects which successfully facilitated transfers of assessments between clinicians and care managers (Clarkson & Challis, 2004) and between community and nursing staff in hospital (Wilson & Clegg, 2005) overall collaboration between clinicians and those responsible for placement decisions remained low (Abendstern et al., 2008).

Identification of need/rationing

The requirement made of practitioners, to balance user-defined need against agency eligibility criteria in framing decisions, represents an issue of real conflict for practitioners (Abendstern et al., 2008). Practitioners face internal decision-making pressures, particularly where needs-led assessment is a requirement within resource constrained organisations. One study found that many practitioners became disengaged with the process because initial expectations that recording unmet need would influence services were not met (Cameron, 2006). Concerns and uncertainties about capacity to deliver services were

found to impact on interactions with service users and carers, and inhibited decision-making and recommendations (Eccles, 2008).

Although prioritisation does exist in the NHS, eligibility criteria and rationing are more evident in social services. The requirement to rationalise needs against costs and an awareness of limited resources and 'deserving cases', represents a significant difference between health and social care services and at times a barrier to effective collaborative working (Cameron, 2006). Evidence from the three countries implied that health staff found it difficult to understand where the limits lay (Challis, Clarkson, Hughes, Abendstern, & Sutcliffe 2006; MacNamara, 2006; Ridout & Mayers, 2006; Seddon et al., 2008). They were initially more likely to recommend intervention of services (Eccles, 2008). In some cases health staff found ways of circumventing the requirement to undertake financial assessments by referring to services without charge (Christiansen & Roberts, 2006). Although the gate-keeping role was more directly familiar to social work staff, few social workers relished the role as budget holder (Cameron, 2006).

Identified benefits

This section summarises the benefits of shared inter-agency assessment most prevalent in the literature.

Managing risk

Partnership working, including joint working on assessment and the sharing of information between agencies, may help prevent harm and crises to individuals at risk in the community (Torkington, Lymbery, Millward, Murfin, & Richell, 2004). Conversely, lack of shared assessment may involve risk to an older person (Glover, 2005). Risk, in line with eligibility criteria and FACS guidelines, can also be interpreted as risk to independence. Staff in Wales reported improvements in the way organisations considered and evidenced risks to a service user's independence through the use of a risk matrix (Seddon et al., 2008). Through a shared understanding of risk amongst health and social care practitioners, more effective strategies and robust evidence to inform care planning could be generated (Seddon et al., 2008).

Reducing duplication and increased co-ordination.

There was evidence that shared assessment reduced duplication. In one study, for example, district nurses were able to provide care more quickly by conducting a shared assessment rather than waiting for a social worker to be allocated to a case (Christiansen & Roberts, 2005). Assessment and care management processes, led by one person, improved co-ordination (Christiansen & Roberts, 2005). Improved patient information on admission to hospital reduced duplication and significantly improved communication while also reducing the time taken to complete paperwork as part of a hospital admission (Wilson & Clegg, 2005). Conversely, duplication and lack of coordination presented potential risks to a patient who was subject to multiple interventions and assessments (Glover, 2005).

Improved standards, practice and recording

In Scotland, it was found that the implementation of SSA meant that many practitioners gave significant thought to their professional assessment and the ways in which disciplines differed in their approaches to assessment (Cameron, 2006). Whilst in Wales, UA was found to encourage more creative approaches to both care and service delivery planning (Seddon et al., 2008). In one study in England, it was found that the SAP had resulted in improved recording of information about individuals through use of the new contact assessment, and there was positive feedback from primary care on the availability of comprehensive patient information (Wilson & Clegg, 2005).

Joint working/Interagency communication

According to McNally et al (2003) single assessment forced agencies to revisit and review local procedures for unified working. Wilson and Clegg (2005) noted early improvements in joint working between community health and social services. Benefits of shared assessment in hospitals included improved patient information on admission and improved communication between wards. Positive effects on practice through the SAP included more holistic working (Dickinson, 2006) and expanded expertise (Christiansen & Roberts, 2006). The benefits of joint training included overcoming professional boundaries, improved understanding of other professional roles, increased expertise and improved decision-making through information sharing (Cameron, 2006; Christiansen & Roberts 2006; Glover, 2005; McCormack et al., 2008; Torkington et al., 2004). Finally despite the considerable challenges involved, continuing commitment to joint working and information sharing was in evidence (Cameron, 2006; MacNamara, 2005; Eccles, 2008; Wilson & Clegg, 2005).

Patient communication/involvement

A number of studies included service user and carer perspectives (Challis, Clarkson, Hughes, Abendstern & Sutcliffe, 2008; Christiansen & Roberts, 2005; Clarkson & Challis 2004; Cornes & Clough, 2004; Dickinson, 2006; Eccles, 2008; Powell, Robison, Roberts & Thomas, 2006). There was evidence of improved communication between staff and patients as a result of shared assessment. In one study which focused on a model of assessment, called 'Easycare', the framing of the questions prompted staff to spend more time communicating with patients and relatives (Wilson & Clegg, 2005). Reporting slightly more mixed findings, Challis et al (2008) cited improved identification of need, especially relating to cognitive functioning and mobility, but continued poor diagnosis of depression via SAP. These authors also identified that user satisfaction was higher among new entrants to services than longer term service users, shaped by the effectiveness of assessment. The requirement to obtain consent to share information heightened the awareness of patients as partners in the process, including the sharing of paperwork with clients (Cameron, 2006). Focusing on older people's views, Powell et al (2006) aimed to locate assessment within the broader context of their lives, which confirmed the importance of the assessor spending time with the older person.

In Wales the UA was found to promote more consistent application of eligibility criteria, making the links between eligibility and risks to independence explicit. This led to more transparency for individuals requiring services (Seddon et al., 2008). UA also resulted in assessment tools that facilitated a person-centred approach and a greater emphasis on presenting information in the person's own words, although further training was required (Seddon et al., 2008).

Discussion

The implementation of shared inter-agency assessment emerged from research, policy and practice highlighting the problematic nature of the continuing division between health and social care. Reviewing papers from each UK country, we found convergence in relation to identified key policy objectives, which in addition to improving partnership, included improving effectiveness, efficiency, consistency and quality of assessment, and improved user and carer involvement.

There are differences between this and previous literature reviews (Abendstern et al., 2008; McCormack et al., 2007). The earlier reviews included wider issues around challenges to joint working and assessment in general, whereas this review selected literature on the basis that it addressed shared assessment specifically. It also included the most recent evidence available on shared assessment from the four countries within the UK. Thirdly, this study identified benefits as well as challenges. The context of endless (and not always meaningful) change in community care policy and practice meant that staff and managers were often and justifiably resistant to change (Eccles, 2008; Ridout & Mayers, 2006). Yet, as approaches to shared assessment are currently under review or being implemented across the UK, it is imperative that evidence is available to inform continued developments in this area.

A limitation of this literature review was that the search itself was limited to just a few databases, given the limited time available to inform developments with interagency assessment standards in Scotland. It is conceivable that other relevant studies might have been located with continued searching. There were limits to the evidence available on shared assessment. Although a variety of perspectives were sought through qualitative research methods in many of the studies, these were usually limited to frontline practitioners and managers and service users and carers. Less attention was paid to other stakeholders including information managers, senior managers and policymakers, whose perspectives could helpfully inform the evidence base.

While we have highlighted the narrow range of stakeholder perspectives as a limitation, it is also the case that the views of those who were included; namely, users, family carers and staff, should retain central place. Interestingly, the challenges emphasised most by these groups predate shared assessment. Resolving the tension between standardisation and flexibility was a key issue in the literature. While evidence suggested that flexibility, local ownership and 'fit' with local assessment processes supported implementation, lack of a standard

approach led to concern about capacity to develop tools, inconsistent data gathering and a tendency to focus on tools at the expense of practice. One study concluded that it is questionable whether any instrument can be developed to meet all the ideal requirements (Richardson et al., 2005). Reflecting on the policy requirement that assessment should be person-centred, there was a widespread view that tools should open up communication between service users, carers and professionals. Although a secondary concern was that, as far as possible, consistency should be promoted for its potential to yield data for other requirements, such as service planning, the literature overall reflected a tendency for efforts to be focused on processes, tools and data. While culture was also an important theme, there was overall less attention paid to assessment as a social process. There was evidence that organisational requirements to focus on standardisation and data had resulted in staff viewing shared assessment as an overly cumbersome process, with limited understanding evident that the level of assessment should be commensurate with need.

A further key challenge for staff conducting holistic assessments, which predates shared assessment (Parry-Jones & Soulsby, 2001) is the balancing of the identified need of an individual with organisational requirements for rationing. In England the FACS eligibility criteria (2002) have resulted in sustained reductions in the number of older people receiving support and consequently poorer quality of life for many (CSCI, 2007). People have been 'lost to the system' due to being deemed ineligible, with subsequent cost implications for the individuals, family carers and services (CSCI, 2009). Scotland has recently introduced FACS criteria in response to the Sutherland review (Scottish Government, 2009). While FACS criteria may support greater standardisation, they might lead to people not receiving the support they need.

While evidence of benefits of shared inter-agency assessment at this stage is relatively limited, some have emerged, including two which relate directly to the policy objectives: improved service user and carer involvement and communication, and improved partnership and joined-up working. It was noticeable that despite the considerable challenges involved, several studies found continuing staff commitment to joint working, including shared information and assessment. However, more effort needs to be invested in identifying outcomes of shared assessment for service users and family carers.

Overall, while there is insufficient evidence at this stage to conclude firmly on whether the efforts involved in implementing shared assessment are worthwhile, this examination of the literature from across the UK has moved beyond highlighting some of the persistent barriers, to identifying where efforts have had positive results, with relevance both to shared inter-agency assessment and wider joint working.

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Table 1: Shared assessment policy and practice in the four countries of the UK

	Scotland	England	Wales	Northern Ireland
	Single Shared Assessment (SSA)	Single Assessment Process (SAP)	Unified Assessment (UA)	Single Assessment Tool (NISAT)
Policy drivers referred to	A Joint Future (2000)	NHS Plan (2000) National Service Framework (NSF) (OP) (2001)	NSF (OP) (2001)	People First: Community Care in NI (1990) NSF (OP) (2001)
Year of Implementation	April 2002 for OP 2003 for all adults	April 2004 for OP followed by all adults	April 2005 for OP April 2006 for all adults	From Feb 2009 over 18 months
Eligibility criteria	Fair Access to Care Services (FACS) criteria introduced 2009	FACS sit alongside SAP	FACS incorporated in UA guidance	Determined locally, with some L.A.s using FACS
Level of discretion re tools	Minimum standards produced by government; flexibility re local application	Local discretion re tools, based on 8 domains, in some cases 'off the shelf' tools	Local discretion re tools, based on 12 domains	Produced and validated by Ulster Uni – based on 10 domains