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Can the shift from needs-led to outcomes-focused assessment in health and social care deliver on policy priorities?

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Introductory summary

Assessment, planning and review are at the heart of the provision of services and support in health and social care in the community, providing key means through which professionals interact with people using their services. These interactions provide opportunities for relationship building, with evidence that involving the person in identifying their priorities and required support can itself improve outcomes. At the same time, professionals use assessment to assess eligibility for support, and assessment has also increasingly become a mechanism for data gathering, to inform a range of requirements at local and national level including planning, commissioning, inspection and performance management. Despite attempts to move assessment from being service-led to person-centred, meeting such a broad range of objectives and requirements can create tensions at the front line, influencing both how interactions are conducted, and the resulting decisions. More recently, there has been an increasing emphasis on outcomes for individuals using health and social care services, including a shift from needs-led to outcomes-focused assessment. This paper will consider both a recent review of literature about shared health and social care assessment, and emerging evidence from implementation of outcomes-focused assessment in the UK, before considering whether and how the recent shift towards outcomes might resolve longstanding tensions around assessment.

Keywords: needs-led assessment, outcomes-focused assessment, eligibility, person-centred practice, partnership working

Introduction and policy context

The role of assessment in health and social care in the community has been an area of concern over the past twenty years. Before the current system of community care was established by the NHS and Community Care Act (DH, 1990), assessment procedures were service-led, involving slotting people into a limited range of inflexible and traditional services, with limited attempts made to respond to the individual needs of people requiring support. Crude criteria such as age or impairment could be used as the basis for allocating services to individuals (Petch, 2008). Wide-ranging community care reforms were signalled by The White Paper

Caring for People (DH, 1989) which emphasised that the primary objective was “to make proper assessment of need and good case management the cornerstone of high quality care” (DH, 1989, p.5). Following the White Paper, the 1990 Act introduced the requirement for a community care assessment focused on identifying the needs of the individual and determining the appropriate response. Needs-led assessment was heralded as the means by which users of services would receive personalised, tailored care co-ordinated by a care manager acting as a broker on their behalf:

There was ... the need for a cultural shift amongst those conducting assessments, a switch from the tradition of ‘this person

requires a day centre' to 'this person has a need for support and activity during the day'. (Petch, 2008, p.47)

The extent of the implementation challenge was summarised by the Audit Commission's (1992) report *Community Care: Managing the Cascade of Change*. This cascade of change included the purchaser-provider split, development of needs-led assessment tools and eligibility criteria and decisions about who would be care managers. As well as the shift from service-led to needs-led approaches, there was also emphasis in policy on partnership working. Reflecting the challenges associated with the divide between health and social care in the UK, the vision of a one door approach to community service delivery underpinned the changes. However, the 1990 Act was also part of a wider programme for introducing 'government by the market' (Hudson & Henwood, 2002), presenting further challenges for partnership working. Further, social services were given the lead role in conducting assessments of the needs of individuals, in collaboration with other professionals. However, the different funding arrangements for health and social care services meant that service users and carers could still be subject to both assessment and care management and the nursing process (McNally *et al.*, 2003).

With regard to the quality assessments required to deliver on the user-centred aspects, evidence from research soon suggested that the way in which assessment and care management systems were implemented may have restricted the use and development of the interpersonal skills required (Means *et al.*, 2008). From the outset, local authorities tended towards an administrative approach, with care managers spending increasing amounts of time on administrative tasks at the expense of spending time with service users and the balance shifting away from therapeutic intervention (Lewis & Glennerster, 1996). A further concern was the balancing of the

identified need of an individual with organisational requirements for rationing (Parry-Jones & Soulsby, 2001).

Shared assessment

With the arrival of a New Labour government in 1997, there was a renewed emphasis on partnership working, not least between health and social care. From around 2000, with continuing recognition that community care assessment was not delivering on policy objectives, there was increased emphasis on shared inter-agency assessment. The key policy drivers in the UK varied by country. In Scotland the broad aims of collaboration were set out in the report *A Joint Future* (Scottish Executive, 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. Northern Ireland has developed shared assessment more recently, with the development of the Northern Ireland Shared Assessment Tool (McCormack *et al.*, 2008). There was renewed emphasis in all relevant policy documents of the importance of involving the assessed service user in decision-making as well as continued concern about individuals being subject to multiple assessments, with corresponding inefficiencies. There was a further concern to introduce a broader range of assessors than social workers.

With regard to decision making about allocation of services and support to individuals, the Fair Access to Care Services (FACS) Guidelines (DH, 2003) were developed in England and introduced there alongside the Single Assessment Process (SAP). The FACS criteria are 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 were integrated within the Unified Assessment (UA) guidance in Wales (Welsh Assembly, 2002). Scotland recently introduced new mandatory eligibility criteria for local authorities in relation to services for older people, prompted by the Sutherland Review (Scottish Government, 2008a). Northern Ireland also operated eligibility criteria, but these were determined at the local level.

Shared assessment: key findings from literature review

Before going on to discuss outcomes-focused approaches to assessment, brief consideration will be given to a recent literature review of shared assessment in the UK, undertaken by the author and a colleague with the aim of informing continued development of assessment in Scotland. Although not a systematic literature review, key databases were included in the effort to identify relevant literature and an account of the methods is available (Miller & Cameron, forthcoming). The review confirmed that introduction of shared assessment brought with it a further cascade of change for health and social care in the community, including requirements to develop new tools and information sharing protocols and processes, to find ways of sharing information between different IT systems and training of a range of professional staff in assessment and care management. Thematic analysis of the literature identified some evidence of benefits emerging from shared assessment, particularly around user and carer involvement as well as examples of efficiencies. However, a range of challenges also emerged from the review. Two of the three predominant themes will be discussed briefly here, because of their resonance with previous concerns about health and social care assessment.

The first dominant theme identified was the challenge of resolving the tension between standardisation and flexibility in developing assessment tools. Reflecting 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 it was a secondary concern 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 and tools. Organisational requirements to focus on standardisation and data had resulted in staff viewing shared assessment as an overly cumbersome process.

The second key and continuing challenge for staff which emerged from the review is the balancing of the identified need of an individual with organisational requirements for rationing. The requirement made of practitioners to balance user-defined need against fixed agency eligibility criteria in framing decisions about support and services was highlighted as representing an issue of real conflict for practitioners (Abendstern *et al.*, 2008). The requirement for staff to focus on needs in assessment as a means of establishing eligibility encourages staff to focus on what the person or carer is unable to do, to focus on their problems and deficits and commensurate risks, in order to establish a sufficiently high band to be able to access services. The lack of attention to outcomes, goal-setting and involvement of the person in assessment is inconsistent with person-centred, personalised and preventive services. Indeed, evidence has shown that while FACS criteria may support greater standardisation, they are likely to lead to people not receiving the support they need with subsequent cost implications for the individuals, family carers and services (CSCI, 2009).

Richards (1994) asserts, with reference to community care guidance, that effective implementation of a needs-led approach depends on creating a clear separation between the tasks of needs assessment and care management. Therefore practitioners must distinguish between the assessment of need and the consideration of the service response to avoid predetermination of the outcome of an assessment. She comments that:

to identify need appropriately, practitioners must have an unimpeded view, free from the distorting effect of service considerations. (Richards, 1994, p.5)

One way to facilitate this process is the separation of needs assessment and subsequent decision-making about eligibility. This depends on the concept of need operationalised independently of the agencies' policies and guidelines (Richards, 1994). If the distinction between service-driven and needs-led is not clarified by such a separation, the consequence will be a definition of need in terms of eligibility criteria for specific service interventions. An alternative approach is the adoption of outcomes-based working, which can revitalise person-centred aspects to assessment, as well as the potential for greater overall efficiency.

Outcomes in policy and research

Outcomes have become a policy theme in health and social care in the latter half of the last decade. In England the DH (2006) outlined seven national outcomes for service delivery in *Our Health, Our Care, Our Say*: improved health and wellbeing, making a positive contribution, economic wellbeing, freedom from discrimination, improved quality of life, choice and control and personal dignity. The Joint Future Agenda has been the overall policy driver for joint working between health, social care and housing in Scotland, acknowledging the

need to move from process and structures to increased emphasis on outcomes. Four national outcomes for service users and carers were to serve as the objective for partnership activity, as set out in *Better Outcomes for Older People* (Scottish Executive, 2004). The four high level outcomes were as follows: supporting more people at home, assisting people to lead independent lives, ensuring people receive an improved quality of care and better involvement of and support for carers. More recently there has been the development of an outcomes-focused performance framework (Gooday & Stewart, 2009), with increasing emphasis on outcomes in standards for assessment (Scottish Government, 2008b). In Wales, there is an emphasis on outcomes in the guidance for unified assessment (Welsh Assembly, 2002).

In parallel with the policy emphasis on outcomes, service user and carer outcomes have been a feature in research and practice both south and (more recently) north of the border. Longstanding work on personal outcomes by the Social Policy Research Unit (SPRU) at York University has been particularly influential in social care practice in the UK over the past ten years (see Qureshi, 2001; Glendinning *et al.*, 2006). With this approach, outcomes are understood as follows:

The impacts or end results of services on a person's life. Outcomes-focused services therefore aim to achieve the aspirations, goals and priorities identified by service users. (Glendinning *et al.*, 2006, p.2)

In this model there are three broad sets of outcomes (Nicholas *et al.*, 2003): maintenance – with a focus on quality of life and *maintaining* health and well-being; change – with a focus on short term removal of barriers to quality of life or *improving* health and well-being; process – with a focus on the *way that services are delivered*,

or how the person feels they have been treated. Consistent with the policy intentions behind health and social care assessment over the past twenty years, early evidence from SPRU suggested that an outcome-focused model supports: a person-centred approach, effective partnership working and best value, including the requirement for greater efficiency (Nicholas *et al.*, 2003).

More recently in Scotland, the Talking Points: Personal Outcomes Approach, has developed from Department of Health funded research at the University of Glasgow, for which the researchers used an adapted version of the SPRU outcomes to evaluate services provided in partnership by health and social care (Petch *et al.*, 2007). The Talking Points approach has subsequently been developed by the researchers working with the Joint Improvement Team (JIT) of the Scottish Government and representatives from community care organisations across Scotland since 2006. Talking Points is currently being implemented in over 40 partnerships and provider organisations. Similar to the approach adapted by SPRU, Talking Points seeks to maximise outcomes for users of community care services and their unpaid carers as follows:

- By focusing on outcomes in interactions with people using services and their unpaid carers, including finding out from individuals what is most important to them in life and identifying how everyone can work together to achieve the best outcomes possible for that person. The information gathered can be recorded in outcomes-focused support plans. The circumstances of the person can be revisited at review, including checking out whether outcomes are being achieved.
- By using information on service user and carer outcomes captured during these interactions to complement other routine locality-based data sources, to

support service improvement and the planning and commissioning of services and performance management.

A range of resources have been developed by the JIT and partner organisations to support implementation. More information and issues of direct relevance to practice and culture change are covered in the Key Messages Document and the Implementation Guidance. These resources are freely available from the JIT website: <http://www.jitscotland.org.uk/action-areas/user-and-carer-involvement/>.

Outcomes in assessment: key findings from implementation

In this section, consideration will be given to early evidence from England and emerging evidence from Scotland and Wales on the potential benefits of outcomes-based approaches to assessment. To take the early work from England first, one of the key challenges is the investment required to support the change in culture. Although some staff may easily adopt an outcomes perspective, for many others opportunities for training, discussion and practice are important facilitators in achieving the culture change required (Qureshi & Nicholas, 2001). With regard to benefits, early research by SPRU undertaken with older people suggested that, once professionals have a clear understanding of the concept of outcomes, then the identification of agreed intended outcomes during assessment helps to focus intervention on the desired aims of services and the aims and preferences of users. It also provides a clear basis for planning and briefing providers (Qureshi, 2001). Slightly later work by SPRU confirmed that practitioners participating in projects reported a number of specific benefits from this approach which contributed to person-centred practice:

- assessment process more focused;

- gave attention to aspirations and not just problems;
 - highlighted the user's and carer's sense of priorities;
 - greater recognition for carers;
 - made care plans more creative;
 - clearer guidance for providers about the purpose of help and individual preferences;
 - clarified differences in perspectives which could assist negotiation;
 - feedback about the impact of services helped in fine-tuning care packages.
- (Ball *et al.*, 2004, p.15)

In Wales, although outcomes-focused elements have been incorporated into the Unified Assessment, a range of professional, technical and operational issues are as yet unresolved and requirements for further investment in staff development programmes have been identified (Seddon *et al.*, 2010). Innovative work is underway in some areas, including a range of outcomes-focused and relationship-centred pilots in Swansea, with positive early feedback from staff, providers and service users (Andrews *et al.*, 2009). This work has incorporated the 'Senses Framework', emphasising the inter-dependence between service users, carers and staff and the creation of 'enriched environments' of support (Nolan *et al.*, 2006), within which service users, carers and frontline staff can all achieve a sense of:

- Security – to feel safe within relationships;
- Belonging – to feel 'part of things';
- Continuity – to experience links and consistency;
- Purpose – to have a personally valuable goal or goals;
- Achievement – to make progress towards a desired goal or goals;
- Significance – to feel that 'you' matter.

In Scotland, the focus on personal outcomes has been promoted by the Joint

Improvement Team, with its focus on supporting partnership working. Therefore, Talking Points has been promoted to both health and social care staff, and more recently to other providers. In some localities, the approach has been taken up by different agencies at different stages. Mirroring early work involving SPRU and North Lincolnshire social services, researchers in Scotland worked closely with staff in early implementer sites from 2007 to develop shared understanding of outcomes in practice. As was the case with SPRU and North Lincolnshire, the local authority staff in one area, North Lanarkshire, had already decided to focus on outcomes prior to involvement with the researchers.

In order to assess progress and barriers to implementing an outcomes approach in North Lanarkshire, the author jointly conducted focus groups with staff, frontline managers and senior managers in 2008. This exercise confirmed that a shift in the culture of social work in North Lanarkshire was evident. The focus on outcomes was viewed positively by staff at all levels for both restoring the values and principles of professional practice, which were described as having been diminished through care management and bureaucracy. The focus on outcomes was also viewed as providing a sense of clarity and purpose to practice and also as improving partnership working with service users. There was an additional concern in the managers' group to ensure that a methodology should be developed locally to measure and evidence outcomes, and to counterbalance existing performance indicators with user and carer outcomes. Otherwise, there was a risk that the outcomes approach would not endure (Miller & Johnston, 2008).

More broadly, early implementers of the Talking Points approach have recently reported on their outcomes-based activities. Themes which emerge repeatedly include the role of outcomes in supporting person-centred and enabling approaches to

assessment and planning with individuals. Another theme, consistent with policy objectives for community care assessment, is the potential for outcomes to support partnership working through providing a common language and concepts. Table 1 below is based on learning from practice in Scotland and was produced to support

understanding of the potential of the personal outcomes approach to progress some of the policy priorities which have not been fully realised through previous service-led approaches to assessment in health and social care.

Table 1 Service-led and outcomes-focused approaches compared

Service-led	Outcomes-focused
Tools encourage information gathering through standardised question and answer approaches to assessment, support planning and review	Semi-structured conversations with individuals in assessment, support planning and review
'Tick box' approach to assessment	Analytical skills involved in assessment
The person's views may be included in decision-making	The person's views/preferences are central to decision-making
The person is viewed as a client, service user or patient	The person is a citizen with rights and responsibilities
Where needs link to strict eligibility criteria, the assessor is required to maximise individual difficulties to access services	Involves consideration of difficulties, limitations and aspirations or goals. The priority is to identify what to work towards
If the person is deemed eligible, identified needs are matched to a limited range of block-provided services, resulting in service-driven approaches	Identifying outcomes involves considering a range of solutions/strategies including the role of the person, family supports and community-based resources
Where needs are tied to eligibility criteria, preventive work with people with low level needs may be excluded	Outcomes allow preventive work to take place while services and resources are prioritised for those most in need
Focusing exclusively on deficits and difficulties, and how needs are to be met, results in a focus on tasks and in services which do things <i>to</i> people	By focusing on strengths, capacities and goals, while mindful of limitations, the role of the person is maximised. Services do things <i>with</i> people
Matching needs/deficits to services tends to result in static service delivery	Outcomes may change in the person's life journey and so should be revisited
Where outcomes are identified, these tend to be professional or organisational outcomes e.g. improved nutrition, or avoid delayed discharge	Outcomes are what matter to the person, though often consistent with professional and organisational outcomes e.g. being able to get out and about
Starting from what services are currently available restricts communication and limits options	Starting from the person's priorities supports enabling relationships, creates clarity and identifies goals at an early stage. Being listened to, involved and respected supports better outcomes

Source: Miller, E. *et al.* (2009) *Philosophy and Principles Underpinning a Personal Outcomes Approach*.

This table highlights some of the lessons from outcomes-focused practice in Scotland, and the potential for outcomes to deliver on long sought after policy objectives in community care assessment, although not without caveats. Some of the emerging benefits from the outcomes approach were also amongst the expectations from needs-led assessment following the 1990 Act, and subsequently from shared assessment. The review of shared assessment highlighted how competing priorities impeded realisation of the benefits of shared assessment. Similar risks to delivering on policy intentions to improve person-centredness and fulfil the enabling potential of assessment in health and social care have also emerged in relation to outcomes-based assessment north and south of the border.

First, there is the challenge of merging an outcomes focus with existing needs-led approaches. Glendinning *et al.*, (2006) particularly highlight the Single Assessment Process (Single Shared Assessment in Scotland, Unified Assessment in Wales) as continuing to be service-led and prescriptive. They found that assessments often emphasized dependency or overlooked psychological and emotional needs and did not challenge low expectations of services or the limited range of help older people think it is legitimate to request. Although evidence from Scotland has shown that staff want to move from a perceived bureaucratic model to spend more time with people, it can still be a challenge to shift from a deficit or dependency approach to one which is not service-led (Jarvis, 2010) and deficit-based models of assessment still predominate over outcomes-based elements within assessment processes.

Secondly, as identified in the literature review, rigid imposition of FACS eligibility criteria presents a significant risk to outcomes-focused assessment and may result in further inefficiencies. The Institute of Public Care (2009) recently concluded

that developing outcomes-based eligibility criteria need not necessarily call for a major haul of the eligibility system but rather its refinement and improved application. They identified three hurdles that require to be overcome:

- By tightly linking needs with resources the eligibility process discourages other forms of help being brought into the package;
- Eligibility tests discourage a preventative approach because if people do not cross the threshold at the time of assessment they are not eligible for resources even though the acquisition of help now may prevent poor outcomes later;
- By making the eligibility threshold increasingly hard to cross it encourages people to hold onto resources once obtained and hence provides no incentives for improvement either by the service user or the provider.
(IPC, 2009, p.23)

In practice, some early implementers of the outcomes approach in Scotland have identified the eligibility criteria as the key challenge to progress, and work is underway in two areas to try to identify ways of implementing the criteria so that they are consistent with the outcomes focus, and the associated emphasis on a more enabling approach to practice.

Thirdly, it has been noted how tension emerges around outcomes-based interactions for evaluations, where these are very firmly focused on evidencing the value of the service, or where the performance management agenda overrides value-based practice in the organisation. As already identified, evaluation was the focus for the research on outcomes of partnership working which informed the development of Talking Points (Petch *et al.*, 2007) and it is feasible to use Talking Points this way. In practice, however, evidence from Scotland

has shown that tensions can emerge in some evaluation exercises. One of the advantages of a personal outcomes approach is that it is not service-led, which means that the role of the person and other supports in their lives and communities are part of the picture, which supports more enabling relationships. Analysis of qualitative information gathered through use of Talking Points can develop understanding of how individuals, either supported by the organisation or independently, have worked towards achieving their outcomes. Where the evaluation exercise is very service-led, this may mean that practitioners are required to focus on the impact of the service only, with no attention paid to the role the person or informal supports have played in achieving their outcomes (Cook & Miller, 2010). Similarly, performance management should support rather than undermine outcomes for individuals. There are examples from implementation of Talking Points whereby outcomes-based information has been collated and discussed with staff at feedback sessions, in line with Seddon's (2010) assertion that the most important learning occurs at the front line where staff and service users interact, rather than a reliance on targets and bureaucratic performance management systems built on relationships of mistrust.

A further challenge which is not so much about the assessment process itself, but is very relevant to the outcomes of assessment, emerges from a contracting culture emphasis on task and time, with the plethora of providers which have entered the market in community care following the 1990 Act. Considerable effort has been invested in developing outcomes-focused contracting, which was a feature of early work by SPRU in England (Qureshi, 2001) and more recent development work is underway in Wales (Andrews *et al.*, 2009) and in Scotland.

Discussion

Reviewing the history of health and social care assessment over the past twenty years confirms that key challenges endure, despite policy objectives to improve partnership working and the quality of assessment as well as user and carer involvement. These objectives were emphasised in the 1990 NHS and Community Care Act, which heralded the new focus on needs in assessment. Some years later, given the continuing difficulties in achieving these objectives, shared assessment was promoted and implemented at various points across the UK. The recent review of literature on shared assessment identified that some benefits were evident. However, despite the enormity of efforts involved in developing and implementing shared assessment across three of the four countries of the UK¹, assessment in practice has not as yet significantly realised these objectives. The review also found continuing concerns amongst staff around the amount of time spent on form-filling and requirements to balance needs assessment with gate-keeping.

Recent evidence from implementing outcomes-focused approaches to assessment in Scotland, England and Wales has demonstrated shared concerns amongst practitioners to progress from previous bureaucratic processes and their impact on person-centred practice. There is also evidence to suggest that the personalisation agenda in England, with its emphasis on putting people first through a focus on the process of providing of Individual Budgets, is adding to rather than reducing the amount of time spent on form filling and bureaucracy (Samuel, 2010). Meanwhile, outcomes-focused assessment has been identified as restoring relationship-based approaches to practice, ensuring that the priorities of service users and carers are considered as part of the planning process, rather than being determined solely by agency priorities (Nicholas & Qureshi,

2004; Andrews *et al.*, 2009; Miller *et al.*, 2009). The enabling potential of focusing on outcomes has also been highlighted, as the focus moves from being about matching needs to services to identifying what matters to the person and working out what role each person will have in achieving that outcome (Miller *et al.*, 2009). Recent studies highlight the emphasis that service users place on the nature and quality of the relationship and the importance of positive human qualities in workers (Beresford *et al.*, 2005, 2006; Nolan *et al.*, 2006; Andrews *et al.*, 2009). The importance of relationships is not an add-on to efficient practice. Rather, good relationships skills and successful alliances are related to better outcomes (Horvath & Symonds, 1991; Howe, 1998).

However, achieving outcomes-focused assessment in practice has been found to be more challenging than anticipated (Qureshi & Nicholas, 2001; Andrews *et al.*, 2009; Miller *et al.*, 2009). This is partly due to the challenge for practitioners who have had to work within service-led cultures but also because wider systems need to adapt. Shifting to outcomes-focused assessment does therefore require a further 'cascade of change', although the change is more about re-orientation than restructuring. Relationship-centred approaches would also suggest that the well-being of frontline staff and carers need to be taken into account in the achievement of good outcomes for service users (Nolan *et al.*, 2006).

A further continuing challenge is the competing requirements made of assessment, including person-centred aspects which require flexibility and qualitative elements, as compared to information requirements for service improvements and more managerialist concerns such as centrally directed performance management systems, which tend towards standardised and quantitative approaches. One study in the review of shared assessment concluded that it is questionable whether any instrument can be

developed to meet all the ideal requirements (Richardson *et al.*, 2005). It is a question therefore, of balancing and prioritising these demands.

There are very promising signs that outcomes-focused assessment can progress policy objectives for assessment in health and social care, where previous efforts have faltered. It is becoming increasingly clear at the time of writing that funding levels for health and social care are facing serious constraint, while demographic trends suggest that demand is unlikely to diminish. Ensuring that service users and carers are involved in decision-making and that the right support is made available to those who need it, as opposed to the often prescriptive and service-led solutions currently on offer, can both deliver on person-centred objectives whilst also resulting in more efficient and effective use of resources. However, some of the longstanding barriers to achieving these objectives also need to be reviewed, which would include re-prioritisation of the many drivers influencing assessment practice, so that they support rather than impede delivery of outcomes for people.

Footnote

¹ The new Northern Ireland Shared Assessment Tool is still being implemented at the time of writing.

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