Primary Health Care Research & Development 2010; **11**: 61–71
doi:10.1017/S1463423609990314

RESEARCH

'We need to talk': communication between primary care trusts and other health and social care agencies following the introduction of the Single Assessment Process for older people in England

Michele Abendstern[1], **Jane Hughes**[1], **Paul Clarkson**[1], **Caroline Sutcliffe**[1], **Keith Wilson**[2] and **David Challis**[1]

[1]Personal Social Services Research Unit (PSSRU), University of Manchester, Manchester, UK
[2]Primary and Community Care, SISA, University of Sheffield and Director of Whole System Strategies, Sheffield, UK

Aims: The article seeks to provide evidence of developments in relation to the extent and type of information sharing between primary care trusts (PCTs) and other settings involved in the assessment and provision of services for older people with health and social care needs following the introduction of the Single Assessment Process (SAP) in England. **Background:** Poor communication between health and social care agencies with regard to individual service users has been an issue of concern internationally for many years. The SAP was introduced in 2001 in order to address some of the shortcomings in health and social care assessments of older people evident in the research and policy literature. An important element of this new procedure was the development of systems and practices to improve information sharing between agencies and settings. **Methods:** The data were derived from a national cross sectional postal survey of SAP lead officers, responsible for implementation of the policy in geographical localities. Questions reflected the policy guidance issued by government. Data were analyzed using SPSS 14. **Findings:** A response rate of 82% was achieved. Agreements regarding the transfer of information were more developed between PCTs and local authorities than with other agencies and settings. Some key elements of the SAP, as defined by the guidance, were not found to be in routine use. Traditional methods of information sharing were far more in evidence than were electronic approaches. Nonetheless, the SAP appears to offer a useful framework for improving inter-agency communication, an issue of perennial concern.

Key words: information sharing; Single Assessment Process

Received 5 March 2009; accepted 25 October 2009; first published online 16 December 2009

Introduction

There is a growing body of evidence, from the UK and overseas, to suggest that improved communication and information sharing between health and social care agencies and professionals results in greater efficiency, speedier assessments and the more effective organization of service provision for service users (Kane, 1990; Kendig *et al*., 1992; Challis, 1994; Challis *et al*., 2002a; 2002b; Hinchcliffe *et al*., 1995; Banerjee *et al*., 1996; Hardy *et al*., 1996; Otis and Butler, 1997; Social Services Inspectorate, 1997; Sheard and Cox, 1998; Byles,

Correspondence to: Michele Abendstern, Faculty of Medical and Human Sciences, Personal Social Services Research Unit, University of Manchester, Oxford Road, Manchester, M13 9PL, UK. Email: Michele.Abendstern@manchester.ac.uk

2000; Rummery and Glendinning, 2000; Brown *et al*., 2003; Howe and Kung, 2003). In England research to date, however, suggests shortcomings in this area with individual professionals and agencies often carrying out serial assessments with little sharing of information (Petch, 1996; Moriarty and Webb, 2000; Challis *et al*., 2002b; Chevannes, 2002; McNally *et al*., 2003; Weiner *et al*., 2003). The Single Assessment Process (SAP), introduced in England in 2001 (Department of Health, 2001), was intended to overcome these weaknesses by, amongst other things, reducing duplication in the assessments of older people through the development of information sharing protocols and agreements. The main objectives of the SAP were to introduce a more standardized assessment process across agencies, to raise the standards of assessment, to assess older people's needs in the round and to provide a timely response. Four types of assessment were introduced: contact, overview, specialist and comprehensive, the latter comprising a combination of an overview and one or more specialist assessments. A core principle of the SAP was that of inter-agency and multi-professional assessment, where appropriate, by means of improved information sharing and communication practices. This article examines the nature and extent to which this had occurred, two years after the official implementation date of April 2004, between primary care trusts (PCTs), one of the key agencies involved in the SAP, and the other major settings in which health and social care assessments for older people take place. These include acute hospital trusts; old age mental health services; authorities in local government providing social care (referred to subsequently as local authorities (LAs)); housing; and intermediate care services.

PCTs are responsible for all primary and community healthcare services and include pharmacists, dentists, opticians, general practitioners (GPs), health visitors and district nurses. As the SAP guidance singled out GPs as having a distinct role to play in the assessment of older people and asked PCTs 'to actively seek' their involvement in its implementation (Department of Health, 2002a), the relationship between them and other combined PCT constituents is considered separately. Housing services, which like social care, are provided by local government, are also considered separately as their role in the delivery of health and social care has increasingly been recognized in government policies including the SAP (Department of Health, 2002a). PCTs are required to communicate and collaborate with all of these agencies and settings if the SAP is to fulfill its potential (Department of Health, 2002a; 2003a).

Aims

Using data derived from a national survey of SAP lead officers in England, this article has three aims. First, it seeks to provide evidence of how far the process of implementation of the SAP has been achieved in relation to information sharing between PCTs and other settings. Second, to establish the methods by which SAP information is shared within the primary care sector, between GPs and others, and between this sector and the other agencies noted above. Third, to identify the types of SAP data held electronically in different settings, and the extent to which shared information technology (IT) systems were in operation. In order to set the SAP in a broader context, these data are preceded by a brief description of the development of information sharing between health and social care sectors in England since the 1990s.

The promotion of information sharing

Prior to the development of PCTs in 2000 and briefly, before that primary care groups, (Department of Health, 1999), information sharing between primary health and social care services was largely conducted through GP practices (Glendinning and Rummery, 2003). The autonomy with which GPs operated during this period, as a result of their original National Health Service (NHS) contract (Pater, 1981), however, gave rise to a fragmented system reliant on individual commitment (Glendinning *et al*., 1998). As in earlier studies (Goldberg *et al*., 1968) some evidence of both enhanced communication and shared understanding of roles, responsibilities and organizational structures between the two sectors was found as a result of locating social services care managers within GP practices during the

1990s (Challis *et al*., 2002b; Glendinning and Rummery, 2003). However, such arrangements were also said to create unequal relationships between the professionals involved, were unpopular with social services care managers, and did not become mainstream practice (Hardy *et al*., 1996; Hodgson, 1998; Brown *et al*., 2003; Lymbery, 2005). Major reforms to the NHS, including the introduction of PCTs following the publication of *The NHS Plan* (Cm 4818-I, 2000), made collaboration between primary health and social care mandatory. PCTs were charged with commissioning and providing responsive and efficient services to be delivered through effective partnerships with LAs (Department of Health, 2006).

The National Service Framework for Older People (NSFOP) (Department of Health, 2001) again emphasized the importance of information sharing as part of an integrated health and social care service for older people including those with mental health difficulties. The SAP, an important element of this framework, included the development of sets of arrangements between agencies and settings to assist those involved in the assessment of older people with health and social care needs to share information appropriately (Department of Health, 2002a). The 'requirements' set out by the SAP implementation guidance for April 2004 included the need for agreement regarding: a set of shared values, which would underpin joint approaches to assessments; the terminology to be used in assessments; assessment approaches to be used, including the tools and scales; joint working arrangements; and the implementation of a joint staff development strategy. It also specified the use of a summary record as the main information sharing tool (Department of Health, 2002a; 2003a; 2004). The significance of information sharing to good assessment practice is reflected in the SAP guidance, which stated that 'the key to consistency lies not so much in the assessment process itself but in how assessment information is stored and shared' (Department of Health, 2004: 1).

Additionally, the growth in the range of services and the complexity of service provision in both community and acute hospital trusts has accentuated the importance of the good communication of assessment and care planning information across these settings. The development of intermediate care provides an example of this. This service area, which spans health and social care and can be provided in a variety of settings, was first introduced in England under the auspices of the NHS Plan (Cm 4818-I, 2000). It resulted from the need to provide rehabilitative services for older people on discharge from hospital and as a means of avoiding hospital admission (Steiner, 2001; Steiner *et al*., 2001). The importance of having good communication systems in place between acute hospitals and community services, in the form of discharge planning arrangements for older people, has been recognized for some time (Bull, 1994; Nazarko, 1997; Social Services Inspectorate, 1998) and was reiterated in the NSFOP and subsequent guidance (Department of Health, 2001; 2003b). In relation to people with mental health difficulties, who are likely to come into contact with a range of health and social care services, the NSFOP specifically noted the need for these agencies to have 'systems in place to communicate with one another, share information (and) understand how and when to refer older people on to appropriate services' (Department of Health, 2001: 92). Finally, GPs were highlighted as having a vital role to play in the SAP, given their regular contact with many older people (Department of Health, 2002a). Emphasis on the development of information systems that can be accessed by each of these professional groups, particularly where complex needs are identified, has continued to be seen in recent government policy initiatives and updates (Cm 6499, 2005; Cm 6737, 2006; Department of Health, 2006).

Information sharing methods

Methods of information sharing supported by government vary from the use of shared electronic systems at one end of the scale to user held records at the other (Department of Health, 2002a). The potential of IT to enhance information sharing is clearly considerable (Reeves and Freeth, 2003). However, the development of such technology is both complex and costly and remains a work in progress with sophisticated computer systems often installed but underutilized (Warburton, 1999; Cameron and Lart, 2003; McNally *et al*., 2003). The rationale for the introduction of IT systems in different settings has also impacted on their ability to be used

as information sharing tools. Within general practice, for example, computer systems are in common usage (Watkins *et al*., 1999; Morris *et al*., 2003), as the result of the 1990 contract, introduced under the auspices of the Family Health Services Authorities (Department of Health, 1989). However, these systems were introduced on an individual basis, vary considerably and have traditionally been used to aid patient registration and GP remuneration rather than to share information to enhance clinical management. The NHS IT Strategy, Connecting for Health (National Audit Office, 2006), a major milestone in the development of a shared record system between health and social care agencies, has proved difficult to implement within general practice, as a result of the plethora of systems in operation. A compromise was reached in 2006 whereby GPs were permitted to continue to use their existing systems and to migrate to a common system if and when they chose (NHS, Connecting for Health, 2006). The introduction of the NHS Care Record Service (Department of Health, 2002b), which seeks to both store and make available 'relevant parts of a patient's clinical record…to whoever needs it to care for the patient' (National Audit Office, 2006: 1), has also been a significant development on the road to shared IT systems. When fully operational it is designed to provide information on health and social care needs and interventions, and be available to social care as well as health care professionals (Department of Health, 2004b).

Whilst recognizing the potential of IT, the SAP guidance, noted that it was 'not an end in itself' but should be regarded as an aid to 'the collection, storage and sharing of assessment and care planning information' (Department of Health, 2004: 3). The use of person held records as a means of 'making information available to the right people at the right time' (Department of Health, 2004: 4) has therefore also been encouraged and was reported to be popular with service users/patients (Department of Health, 2004). The SAP implementation guidance stated that by 2004 localities should be collecting, storing and sharing information as effectively as possible and, subject to consent, using the current summary record, or local variant as the main method of transmitting information between settings (Department of Health, 2003a).

Method

The data used in this research form part of a wider study to investigate the implementation of the SAP in England (Challis *et al*., 2007). Ethical approval for the study was gained from the University of Manchester and from the Association of Directors of Social Services. As the focus of the study was at an organizational rather than individual level, ethical approval was not required from the NHS. Early drafts of the questionnaire were reviewed through discussions with health and social care managers and via contributions from academics in the field of health and social care for older people in order to ground the questions in the context of current practice. The final questionnaire (Abendstern *et al*., 2007) was sent to directors of all 149 English LAs, between October 2005 and May 2006 with a request to forward these to SAP lead officers in their locality. Telephone calls and a second mailing were made to non-responders. Questions were framed around the requirements cited by the Department of Health (2003a) in its implementation guidance to localities. Respondents were asked to state: whether formal agreements with a range of agencies were in place across their locality and to which elements of the SAP they applied; the methods used to share information between agencies; whether a SAP electronic form was available and, if so, which elements of the SAP were held in this format. In relation to information sharing methods, respondents were provided with a list of options to identify. They were also asked to indicate, which method of communication usually applied to each set of combinations of agencies or settings by completing a grid. More than one entry was consequently possible for each combination. Other than for GPs, the data described here is described at the agency rather than individual professional level. Data were entered and analyzed on SPSS Version 14 and are of a descriptive nature.

Findings

The survey had an 82% ($n = 122$) response rate across England. Overall, 70% of respondents were based in LAs with a further 22% in PCTs. One-third of respondents ($n = 40$) occupied jointly funded posts of whom just over half were

based in LAs and over one-third in PCTs. Of the remaining six respondents, three were based in acute NHS trusts, one in a care trust, one in a health informatics service and one did not specify a location.

Inter-agency agreements and the use of the current summary record

Table 1 demonstrates the extent to which agreements to ensure the smooth flow of SAP information between stakeholders across agency boundaries were in place at the time of the survey between PCTs and others. It shows that, approximately two years after such arrangements were due to be in place, the predominant form of linkage was between PCTs and LAs (70%). PCTs across the country had established fewer protocols with acute hospital trusts (43%), mental health trusts (41%) or GPs (24%).

In relation to the current summary record, PCTs appeared again to share information to a greater extent with LAs than with other health care agencies. Table 2 shows that the current summary record was reported to be routinely shared between PCTs and LAs by two-fifths of respondents, the largest single group. The sharing of this document between PCTs and acute hospital trusts was reported to occur by just below a quarter of respondents (24%) whilst mental health trusts and GPs were found to share the current summary record with PCTs by 20% and 15% of respondents, respectively.

Additionally, it is worth noting that the current summary record was reported to be in use less than other core elements of SAP documentation. Over half of the respondents (56%) reported that this document was not in use at all in their localities. This was in marked contrast to other elements of the SAP, in particular the contact and overview assessments, which by the time of the survey were reported to be more widely used. Other study data, not specific to particular agencies, demonstrated that the contact assessment was in use across the whole of a locality in 43% and in part of a locality in 53% of the country. The corresponding figures for the overview assessment were 28% and 61%, respectively.

Methods of information sharing between PCTs and others

The range of information sharing methods used between PCTs and others is summarized in Table 3. Most respondents supplied information on this topic although not all provided data on

Table 1 Agreements between PCTs and other stakeholders

	Yes		Partly (ie, only one trust or under; development)		No	
	Number	%	Number	%	Number	%
PCT and LA ($n = 119$)	83	70	30	25	6	5
PCT and acute/foundation NHS trust ($n = 119$)	51	43	31	26	37	31
PCT and mental health trust ($n = 93$)	38	41	31	33	24	26
PCT and GP ($n = 117$)	28	24	32	27	57	49

PCT = primary care trust; LA = local authority; NHS = National Health Service; GP = general practitioner.

Table 2 Current summary record shared between PCTs and other agencies

	Yes		Under development		No	
	Number	%	Number	%	Number	%
PCT and LA ($n = 119$)	48	40	35	29	36	31
PCT and acute/foundation NHS trust ($n = 119$)	28	24	36	30	55	46
PCT and mental health trust ($n = 91$)	18	20	30	33	43	47
PCT and GP ($n = 119$)	18	15	36	30	65	55

PCT = primary care trust; LA = local authority; GP = general practitioner.

https://doi.org/10.1017/S1463423609990314 Published online by Cambridge University Press

Table 3 Methods of information sharing between PCTs and other agencies

	GP		LA		Intermediate care		Old age mental health service		Acute/hospital NHS trust		Housing	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Shared electronic	9	8	19	17	20	17	6	8	10	9	2	2
Shared paper	12	10	22	19	20	17	13	11	12	10	4	4
Separate electronic	7	6	6	5	3	3	2	2	2	2	0	0
Separate paper/meeting	29	25	28	24	23	20	40	32	37	32	36	31
Person held record	15	13	23	20	20	17	17	14	16	14	6	5
No identified system	43	37	17	15	29	25	37	32	38	33	67	58

PCT = primary care trust; LA = local authority; GP = general practitioner.

every combination of settings. Overall, the findings demonstrate that separate rather than shared systems were the norm and that paper or face-to-face methods were the most frequently used. Shared electronic systems were reported to be used by only a small number of respondents. Fifty eight percent of respondents identified no particular system of information sharing as being in existence between PCTs and housing services. This was only the case with 15% of respondents in relation to information sharing between PCTs and LAs.

PCTs were reported to share information with LAs via separate paper systems or meetings between staff in almost a quarter of localities (24%) and via person-held records in one-fifth. Shared paper systems between PCTs and LAs were found in 19%, and shared electronic systems in 17%, of responding localities. In relation to how information was shared between PCTs and intermediate care services, the most commonly reported method was a separate paper system or meetings between staff. Person-held records, shared electronic and shared paper systems were all reported to be a usual method of information sharing between these two settings by 17% of respondents. Separate paper systems or meetings were by far the most commonly reported means of information sharing between PCTs and each of the four remaining settings considered (25% for GPs, 31% for housing services, 32% for both old age mental health services and acute/foundation NHS hospital trusts).

Electronic information collection tools

Agencies involved in the implementation of the SAP were advised by the Department of Health to make interim arrangements regarding IT systems to gather, store, retrieve and share information, in anticipation of the national roll out of the NHS Care Records Service (Department of Health, 2004). Table 3 suggests that, at the time of the survey, shared electronic systems were used in only a small minority of localities and by a minority of agencies. Where this method was identified to be in use, it was mostly with regard to information sharing by PCTs with LAs (17%) and intermediate care settings (17%) and least with GPs (8%) and housing (2%). The use of electronic tools within agencies was more evident with two-thirds (66%) of respondents indicating that such a tool was in operation in their locality. Table 4 shows the breakdown of this figure by agency. Almost half (47%) of professionals aligned to PCTs (in this context, community nurses and GPs) were found to utilize a SAP electronic form whilst 13 (16%) were using the NHS care record system. Almost every respondent (93%) who reported the use of an electronic form noted it to be used by LAs.

The current summary record was reported to be held electronically by 15% of PCTs (Table 5). The percentage of GPs to hold this document electronically was on a par with the housing department, at just three percent. In comparison, 30% of LAs, 19% of intermediate care services, 11% of acute hospital trusts, and nine percent of old age mental health services held this document in an electronic format.

Overall, Table 5 shows that LAs held all elements of SAP data electronically in more of the country than did other settings. Primary care settings, held the contact and overview assessments in an electronic form in 36% and 33% of

https://doi.org/10.1017/S1463423609990314 Published online by Cambridge University Press

Table 4 Single Assessment Process electronic form in use ($n = 81$)

	Number	%
LA IT system	75	93
Community nurse IT system	27	33
GP IT system	11	14
Local NHS IT system for acute hospital	15	18
NHS care records service/connecting for health	13	16

LA = local authority; IT = information technology; GP = general practitioner; NHS = National Health Service.

localities, respectively. The contact and overview assessments were the only elements of the SAP to be reported to be held electronically by more than a quarter of respondents for any setting, other than LAs. GPs held the least assessment information electronically compared with other agencies except for the contact assessment, which was held electronically by 10% of GPs compared to six percent of housing departments.

Conclusion and discussion

The findings of this research, whilst specific to the SAP, are relevant to the wider and perennial concern of policy makers and practitioners about how to improve the quality of health and social care services, reflected here in relation to the ways information is shared. The paper provides evidence, which will be useful to managers charged with this task.

The high response rate to this survey offers a reasonable degree of confidence regarding generalizability of the findings. However, the fact that the majority of respondents were SAP lead officers mainly employed by LAs (71%) might have biased the data in favour of LAs as a result of information being more available or known to respondents. Nevertheless, the findings are a useful source of information providing baseline data two years after the implementation of the SAP in England and prior to the national roll out of the National Health Service IT programme, 'NHS Connecting for Health' (National Audit Office, 2006). Inevitably, implementation is a lengthy process and it is acknowledged that evaluation after two years will represent only early evidence of process change (Wildavsky, 1979). The data provide information about *who* does *what* and *how*. An evaluation of the appropriateness of these results in relation to good practice is beyond the scope of this article. What is demonstrated here are the complexities involved in information sharing at a number of levels and that there are many varied ways of sharing information in practice, both traditional and emergent.

The findings presented here demonstrate both similarities and differences with other recent studies. First, in relation to SAP implementation, they suggest that PCTs are making good progress in relation to sharing information with LAs but have more work to do with GPs and with other health care settings. This supports the stronger history of collaborative practice found between community nurses and social care staff in LAs, compared with such practice between the latter and GPs and also between community nurses and GPs prior to the introduction of PCTs (Glendinning and Rummery, 2003). However, given the importance of good hospital discharge care planning to the wellbeing of older people, and the development of rehabilitative services at home following hospitalization under the banner of intermediate care, the limited engagement of GPs is a finding of some concern. In relation to the development of electronic systems for storing SAP information, it would appear that PCTs are behind LAs but ahead of other settings. This concurs with a survey of old age psychiatrists in England conducted in 2004 (Tucker *et al*., 2007), which found the use of electronic record systems to be 'the exception rather than the rule' within this setting (2007: 214).

Second, regarding the methods of information sharing described by the study, for all of the settings considered it would seem that: traditional methods of information sharing remained the most popular; the current summary record was in limited use; shared IT systems were still embryonic;

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Table 5 Elements of the Single Assessment Process held electronically by agency ($n = 110$)

	Primary care other than GP		GP		LA		Intermediate care		Old age mental health service		Acute/hospital NHS trust		Housing	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Current Summary record	17	15	3	3	33	30	21	19	10	9	12	11	3	3
Contact	40	36	11	10	95	86	47	43	24	22	28	26	7	6
Overview	36	33	3	3	83	75	43	39	22	20	22	20	3	3
Comprehensive	11	10	0	0	26	24	12	11	10	9	8	7	0	0
Standardized scores	9	8	0	0	9	8	6	6	2	2	6	6	1	1
Care plan	14	13	1	1	67	61	23	21	18	16	8	7	1	1
Other	1	1	1	1	12	11	4	4	2	2	2	2	1	1

GP = general practitioner; LA = local authority; NHS = National Health Service.

and person held records were used by only a minority of agencies. Again, there are similarities here with other studies. One such, which reported on an area incorporating 14 LAs, 30 PCTs and 20 acute hospital trusts (Association of Directors of Social Services and Department of Health, 2004) noted that: most areas used paper based systems; electronic systems were in the early stages of development; no links to the NHS record systems were available and no area was using documentation, which fully met the Department of Health requirements of the current summary record. Unlike the present study, however, person held records, were found to be used in the majority of localities. More recently, a national survey of LAs, found that although the majority used an IT system to support the SAP, in only 13% of cases was this a shared health and social care system (Department of Health, 2007), a finding not dissimilar to the present study.

Given the government's target date of 2010 for the full roll out of the National Care Records System (Department of Health, 2002b), the fact that only a minority of respondents stated that their IT systems were linked to this is perhaps not surprising. However, the apparent preference for more traditional information sharing methods might be justified by professionals on other grounds. The quality of the information shared and the system by which it is transferred are, after all, distinct entities. Although electronic information transfer has been heralded as a significant development in the manner of communication between agencies and professionals and has the potential to improve the *amount* of information shared, it might not support an improvement in the *quality* of what is transferred. The latter requires a shared understanding between professionals of the purpose of assessment and, as a consequence, the reason for providing particular information. Where professionals have already developed a level of trust and shared understanding there might be reluctance to let go of the personal interaction, which nurtured this. Thus, if electronic methods of information sharing were to replace all face-to-face discussion between professionals, positive and individualized outcomes for service users may be compromised. The means of improving the quality of assessment information collected and shared between professionals and agencies remains a contested area, both linked

https://doi.org/10.1017/S1463423609990314 Published online by Cambridge University Press

and additional to issues surrounding the electronic transfer of information.

The Department of Health has noted that the success of the SAP will be limited if 'professionals do not share information, in situations where it is both legitimate and appropriate for them to do so' (Department of Health, 2004: 5). Within this statement lies a recognition of the need for a differentiated approach, appropriate to the needs of the individual. Where multidisciplinary assessment is required due to the complexity of need, for example, both the extent and nature of information sharing required to bring about good quality assessment and service provision will be of a different nature than where a straightforward request for a single service is made. Consequently, in order for information sharing to lead to more effective and efficient practice it must be fit for purpose.

Finally, the data suggest that the government target of implementing the SAP by 2004 has not been achieved. A multiplicity of reasons will have contributed to this, two of the most important of which are the tension at a local level in the implementation of national policy (Sabatier, 1986) and, second, cultural resistance (Heap, 1989). Evidence of the influence of both of these issues is reflected in this study. The guidance disseminated to localities by central government, for example, stressed the importance of the current summary record. However, it would appear that other elements of the SAP, in particular the contact and overview assessment tools, were given higher priority by locality managers charged with implementing the SAP. In terms of cultural resistance, the limited use of person held records at this time suggests a slow response to what amounts to a cultural rather than a process change, person held records representing a more participative approach and a radical change for at least some community based agencies.

How, then, might information sharing between all agencies and professional involved in the implementation of the SAP be improved? Protocols and agreements are a vital part of this project. However, these must be sensitive to the needs of the individual, giving rise to a possible conflict with standardization, whilst deep rooted aspects of occupational culture and tradition must also be challenged if real change for the better is to take place (Payne *et al*., 2002; Glendinning and Rummery, 2003; Marriott *et al*., 2005; Powell *et al*., 2007). The personalization agenda in both health and social care (Cm 6737, 2006; Department of Health, 2008) increases the necessity for inter-agency and inter-professional understanding and harmonization of communication systems. Tools, which enable and support this process, such as those developed as part of the SAP have an important role to play achieving this outcome. The policy focus on raising the quality of health and social care services (Cm 7432, 2008) provides another incentive for managers and practitioners to improve information collection and exchange. This research demonstrates that infrastructure supporting the introduction of the SAP provides a framework, which is capable of supporting this end and it may be surmised that this could be transferred to the goals of the Common Assessment Framework (Department of Health, 2009). It may, however, not be enough in and of itself, to achieve it.

Acknowledgements

PSSRU receives funding from the Department of Health who supported this study. We are most grateful to the local authority and PCT staff who participated in the research. Responsibilities for the views expressed in this paper are the authors alone.

References

Abendstern, M., Hughes, J., Clarkson, P., Sutcliffe, S. and **Challis, D.** 2007: *A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England. Stage ll – Impact of the SAP from the Perspective of Multiple Stakeholders. Volume 4 – The National Survey of SAP Lead Officers.* Personal Social Services Research Unit, University of Manchester, Discussion Paper M167. Manchester: Personal Social Services Research Unit.

Association of Directors of Social Services West Midlands Older People's Network and Department of Health. 2004: *The SAP and Cross Boundary Working*. ADSS West Midlands Older People's Network and Department of Health, Health and Social Care Change Agent Team.

Banerjee, S., Shamash, K., Macdonald, J.D. and **Mann, A.H.** 1996: Randomised controlled trial of effect of intervention by psycho-geriatric team on depression in frail elderly people at home. *British Medical Journal* 313, 1058–61.

Brown, L., Tucker, C. and **Domokos, T.** 2003: Evaluating the impact of integrated health and social care teams on older people living in the community. *Health and Social Care in the Community* 11, 85–94.

Bull, M. 1994: Patients' and professionals' perceptions of quality in discharge planning. *Journal of Nursing Care Quality* 8, 47–61.

Byles, J.E. 2000: A thorough going over: evidence for health assessments for older persons. *Australian and New Zealand Journal of Public Health* 24, 117–23.

Cameron, A. and **Lart, R.** 2003: Factors promoting and obstacles hindering joint working: a systematic review of the research evidence. *Journal of Integrated Care* 11, 9–17.

Challis, D. 1994: Case management: a review of UK development and issues. In Titterton, M., editor, *Caring for People in the Community: the New Welfare*. London, UK: Jessica Kingsley, 91–112, Ch 7.

Challis, D., von Abendorff, R., Brown, P., Chesterman, J. and **Hughes, J.** 2002a: Care management, dementia care, and specialist mental health services: an evaluation. *International Journal of Geriatric Psychiatry* 17, 315–25.

Challis, D., Chesterman, J., Luckett, R., Stewart, K. and **Chessum, R.** 2002b: *Care Management in Social and Primary Health Care: The Gateshead Community Care Scheme*. Aldershot, Hampshire, UK: Ashgate.

Challis, D., Clarkson, P., Hughes, J., Abendstern, M., and **Sutcliffe, C.** 2007: *A Systematic Evaluation of the Development and Impact of the Single Assessment Process in England. Stage ll – Impact of the SAP from the Perspective of Multiple Stakeholders. Volume 6 – Final Overview Report*. Personal Social Services Research Unit, University of Manchester, Discussion Paper M167. Manchester: Personal Social Services Research Unit.

Chevannes, M. 2002: Social construction of the managerialism of needs assessment by health and social care professionals. *Health and Social Care in the Community* 10, 168–78.

Cm 4818-I. 2000: *The NHS Plan. A Plan for Investment, a Plan for Reform*. London, UK: The Stationery Office.

Cm 6499. 2005: *Independence, Well-being and Choice: a Vision for the Future of Social Care for Adults in England*. London, UK: The Stationery Office.

Cm 6737. 2006: *Our Health, Our Care, Our Say: a New Direction for Community Services*. London, UK: The Stationery Office.

Cm 7432. 2008: *High Quality Care for All. NHS Next Stage Review Final Report*. London, UK: The Stationery Office.

Department of Health. 1989: *Terms of Service for Doctors in General Practice*. London, UK: HMSO.

Department of Health. 1999: *Primary Care Trusts: Establishing Better Services*. London, UK: NHS Executive.

Department of Health. 2001: *National Service Framework for Older People*. London, UK: Department of Health.

Department of Health. 2002a: *Guidance on the Single Assessment Process for Older People*, HSC 2002/001: LAC(2002)1. London, UK: Department of Health.

Department of Health. 2002b: *Connecting for Health*. London, UK: Department of Health.

Department of Health. 2003a: *Guidance on the Single Assessment Process for Older People: Implementation guidance for April 2004*. London, UK: Department of Health.

Department of Health. 2003b: *The Community Care (Delayed Discharges, etc.) Act*, HSC 2003/009: LAC (2003)21. London, UK: Department of Health.

Department of Health. 2004: *Single Assessment Process for Older People: Information sharing*. London, UK: Department of Health.

Department of Health. 2006: PCT and SHA Roles and Functions electronic only. Retrieved 3 April from 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4134649

Department of Health. 2007: *National Electronic Social Care Record Survey Report – 2006/07*, NHS Connecting for Health and the Association of Directors of Adult Social Care. London, UK: Department of Health.

Department of Health. 2008: *Transforming Social Care*, LAC (DH) 2008-1. London, UK: Department of Health.

Department of Health. 2009: *Common Assessment Framework for Adults: Consultation on Proposals to Improve Information Sharing Around Multi-disciplinary Assessment and Care Planning*. London, UK: Department of Health.

Glendinning, C. and **Rummery, R.** 2003: Collaboration between primary health and social care: from policy to practice in developing services for older people. In Leathard, A., editor, *Interprofessional Collaboration: From Policy to Practice in Health and Social Care*. London, UK: Psychology Press, 186–99, Ch 13.

Glendinning, C., Rummery, K. and **Clarke, R.** 1998: From collaboration to commissioning: developing relationships between primary health and social services. *British Medical Journal* 317, 122–25.

Goldberg, E.M., Neill, J., Speak, B.M. and **Faulkner, H.** 1968: Social Work in General Practice. *Lancet* 7567, 552–55.

Hardy, B., Leedham, I. and **Wistow, G.** 1996: Care management co-location in GP practices. Effects upon assessment and care management arrangements for older people. In Bland, R., editor, *Developing Services for Older People and their Families. Research highlights in Social Work 29*. London, UK: Jessica Kingsley, 161–78, Ch 10.

Heap, J. 1989: *The Management of Innovation and Design*. London, UK: Cassell.

Hinchcliffe, A.C., Hyman, I.L., Blizard, B. and **Livingston, G.** 1995: Behavioural complications in dementia – can they be treated. *International Journal of Geriatric Psychiatry* 10, 839–47.

Hodgson, C.R. 1998: It's all good practice: linking primary care and social services in Greenwich. *Journal of Interprofessional Care* 12, 89–91.

Howe, A.L. and **Kung, F.** 2003: Does assessment make a difference for people with dementia? The effectiveness of the Aged Care Assessment Teams in Australia. *International Journal of Geriatric Psychiatry* 18, 205–10.

Kane, R.A. 1990: Assessing the elderly client. In Monk, A., editor, *Handbook of Gerontological Services*. New York, USA: Columbia University Press, 55–89, Ch 3.

Kendig, H., McVicar, G., Reynolds, A. and **O'Brien, A.** 1992: *Victorian Linkages Evaluation*. Canberra, Australia: Department of Health, Housing and Community Services.

Lymbery, M. 2005: *Social Work with Older People: Context, Policy and Practice*. London, UK: Sage.

Marriott, A., Reid, G., Jones, K., de Villiers, R. and **Kennedy, C.** 2005: Interdisciplinary working in intermediate care: generic working or the key to a person centred approach?. In Beech, R., and Roe, B., editors, *Intermediated and Continuing Care: Policy and Practice*. London, UK: Blackwell, 78–94, Ch 6.

McNally, D., Cornes, M. and **Clough, R.** 2003: Implementing the Single Assessment Process: driving change or expecting the impossible? *Journal of Integrated Care* 11, 18–29.

Moriarty, J. and **Webb, S.** 2000: *Part of Their Lives. Community Care for Older People with Dementia*. Bristol: The Policy Press.

Morris, L., Dumville, J., Campbell, L. and **Sullivan, F.** 2003: A survey of computer use in Scottish primary care: general practitioners are no longer technophobic but other primary care staff need better computer access. *Informatics in Primary Care* 11, 5–11.

National Audit Office. 2006: *The National Programme for IT in the NHS. Summary*. The Stationery Office, London, UK: Department of Health.

NHS, Connecting for Health. 2006: *GP Systems of Choice Scheme*. London, UK: Department of Health.

Nazarko, L. 1997: Improving hospital discharge arrangements for older people. *Nursing Standard* 11, 44–47.

Otis, N. and **Butler, A.,** editors. 1997: *Assessment of Older People: a Review of Recent International Literature*. Bundoora, Victoria, Australia: Lincoln Gerontology Centre, La Trobe University.

Pater, J. 1981: *The Making of the National Health Service*. London, UK: King Edward's Hospital Fund for London.

Payne, S., Kerr, C., Hawker, S., Hardy, M. and **Powell, J.** 2002: The communication of information about older people between health and social care practitioners. *Age and Ageing* 3, 107–17.

Petch, A. 1996: New concepts, old responses: assessment and care management pilot projects in Scotland. In Phillips, J. and Penhale, B., editors, *Reviewing Care Management for Older People*. London, UK: Jessica Kingsley.

Powell, J., Robison, J., Roberts, H. and **Thomas, G.** 2007: The single assessment process in primary care: older people's accounts of the process. *British Journal of Social Work* 37, 1043–58.

Reeves, S. and **Freeth, D.** 2003: New Forms of Technology, New Forms of Collaboration? In Leathard, A., editor, *Interprofessional Collaboration: From Policy to Practice in Health and Social Care*. Hove, England: Brunner-Routledge, 79–91, Ch 6.

Rummery, K. and **Glendinning, C.** 2000: *Primary Care and Social Services: Developing New Partnerships for Older People*. Oxford, UK: Radcliffe Medical Press.

Sabatier, P. 1986: What can we learn from implementation research? In Kaufmann, F.X., Majone, G., and Ostrom, V., editors, *Guidance, Control and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project*. Berlin, Germany: de Gruyter.

Sheard, D. and **Cox, S.** 1998: *Teams, Multi-disciplinary and Interprofessional Working and Dementia*. Stirling Dementia Services Development Centre, Stirling, UK: University of Stirling.

Social Services Inspectorate. 1997: *The Cornerstone of Care: an Inspection of Care Planning for Older People*. London, UK: Department of Health.

Social Services Inspectorate. 1998: *Getting Better? Inspection of Hospital Discharge (Care Management) Arrangements for Older People*. London, UK: Social Services Inspectorate.

Steiner, A. 2001: Intermediate care: more than 'a nursing thing'. *Age and Ageing* 30, 433–35.

Steiner, A., Walsh, B., Pickering, R., Wiles, R. and **Ward, J.** 2001: Therapeutic nursing or unblocking beds? A randomised controlled trial of a post-acute intermediate care unit. *British Medical Journal* 24, 453–60.

Tucker, S., Baldwin, R., Hughes, J., Benbow, S., Barker, A., Burns, A. and **Challis, D.** 2007: Old age mental health services in England: implementing the National Service Framework for Older People. *International Journal of Geriatric Psychiatry* 22, 211–17.

Warburton, R. 1999: *Meeting the Challenge: Improving Management Information for the Effective Commissioning of Social Care Services for Older People*. London, UK: Department of Health.

Watkins, C., Harvey, I., Langley, C., Faulkner, A. and **Gray, S.** 1999: General practitioners' use of computers during the consultation. *British Journal of General Practice* 49, 381–83.

Weiner, K., Hughes, J., Challis, D. and **Pedersen, I.** 2003: Integrating health and social care at the micro level: health care professionals as care managers for older people. *Social Policy and Administration* 37, 498–515.

Wildavsky, A. 1979: *The Art and Craft of Policy Analysis*. Basingstoke, Hampshire, UK: Macmillan Press.