

Implementing the Single Assessment Process for older people in England: lessons from the literature

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Abstract

With the introduction of the Single Assessment Process (SAP) in England, in 2004, the government aimed to address the shortcomings in the assessment of older people with health and social care needs. The SAP promoted a person-centred approach, multi-professional working and the standardisation of assessment practice. By reviewing the literature on assessment from the mid-1980s to the present, this article identifies issues that may help or hinder effective implementation of the SAP. In addressing assessment from the viewpoint of different stakeholders, potential tensions between different policy aims are exposed. It is suggested that achieving the aims of the SAP will be a complex process, with historically contentious issues in assessment practice remaining relevant to the implementation of this policy.

Keywords: Comprehensive assessment, multi-disciplinary assessment, older people, Single Assessment Process

Introduction

The assessment of the needs of older people is an issue of international concern (Otis & Butler, 1997; Carpenter, 1998; Byles, 2000; Kane & Kane, 2000; Jorg *et al.*, 2002; Campbell & Ikegami, 2003; Howe & Kung, 2003; Challis *et al.*, 2004). In England recent attempts to improve assessment practice are enshrined in the Single Assessment Process (SAP) (Department of Health, 2001, 2002a), a government policy designed to address some of the concerns about the quality of assessments for older people raised by reports and research subsequent to the community care reforms of the early 1990s. A number of reports have identified variability in both the content and quality of the information collected in assessments; poor categorisation of needs and problems; lack of clarity regarding the purpose of assessment; a lack of differentiation of assessment according to need; and a shortfall in appropriate health care inputs to the assessment process (Department of Health, 1993 a, b, 1996; Audit Commission,

1997; Social Services Inspectorate, 1999). At the same time research also highlighted uncertainties over the scope of assessment and how it was conducted, with marked variability in both the form (the way in which assessments were conducted and which staff were involved in them) and the content (what information was sought about needs) of assessments by UK social services departments, leading to inconsistency in practice (Caldock, 1993, 1994a, b; Lewis *et al.*, 1995; Stewart *et al.*, 1999; Parry-Jones & Soulsby, 2001).

The SAP represents a recent attempt by central government in England to address such weaknesses. Its underlying principle is to provide a framework for assessment making it more integrated between different settings and between different professional groups. The policy aimed to: place the individual at the heart of the assessment process; raise the standards of assessment; develop a more standardised practice, and reduce duplication by developing greater multi-disciplinary and multi-agency communication and understanding

(Department of Health, 2001, 2002a). The nature of assessment and what are conceived to be its different purposes such as need identification, effective information collection via the promotion of inter-professional practice, and strategic service development may, however, be viewed in different ways by the different stakeholders involved, as outlined in Box 1. This makes it likely that implementation of the SAP will be a complex and difficult process.

The aim of this article is therefore to explore, via a literature review, how the different stakeholders in the assessment process conceptualise and understand assessment. The review is structured around the three major stakeholder groups - older people and their carers, the different professional groups involved, and policy makers – and focuses on key themes

reflecting the aims and intentions of the SAP. At the service user level, the notion of person-centred care, including user participation, and the concept of ‘need’ considered through the prism of different professional cultures, are discussed. At the professional level, collaboration between different professional groups and different professional views of standardisation are considered. Finally, at the policy level, the promotion of efficiency and the structures required to support inter-agency and professional assessment practices described in the literature are outlined. By these means the complexities, potential obstacles to effective implementation, and tensions between different policy aims of the SAP are drawn out. By raising awareness of past practices and experiences it indicates that lessons may be learned which can support the effective implementation of the SAP.

Box 1 Purposes of assessment from the viewpoint of various stakeholders

<p>Service users:</p> <ul style="list-style-type: none"> • Information on services, options for care • Ideally empowers older people to have control over decision making process • Early screening for medical disorders • Comprehensive appraisal of functional capacity, disability, psychosocial needs, environmental situation, vulnerability and carer’s needs • Diagnosis by clinicians of specific disorders • Eligibility for services, especially social care • Information and advice <p>Professionals:</p> <ul style="list-style-type: none"> • Informs care planning, enabling identified needs to be matched to services • Determines eligibility for services • Prioritises access to services • Informs allocation of resources • Provides information on unmet needs • Provides information for planning new services • Provision of data for performance monitoring and quality assurance <p>Policy makers:</p> <ul style="list-style-type: none"> • Application of eligibility criteria • Targeting of service in response to identified need • Aggregation of information to monitor performance • Information to plan new service • Cost containment by regulating access to services
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Sources: Lawton (1986); Terri & Lewinsohn (1986); Payne (1989); Kane (1990); Leutz *et al.*, (1993); Philp & Dunleavy (1994); Hughes (1995); Otis & Butler (1997); Kane & Kane (2000).

Parameters of the review

The review had the specific purpose of highlighting issues relevant to SAP implementation. The areas of enquiry were therefore chosen *a priori* to reflect both the key attributes of the SAP as described in the Department of Health Guidance (Department of Health, 2002a) and as a means of identifying any distinct views of assessment held by the various stakeholders involved. A broad strategy for literature searching and for locating relevant studies was adopted. Literature concerned with issues pertinent only at a local level was excluded. To provide acceptable scientific quality for evidence, only peer reviewed articles were included amongst the published papers.

The literature search was undertaken on refereed journals, books and government documents from immediately before the community care reforms of the early 1990s to the present. This period was chosen because of the important developments occurring at that time, which have a bearing on the present conduct of assessment in England. Both UK and non-UK sources were considered so as to highlight important issues arising from developments in assessment processes in other countries. The US and Australia, for example, have operated more formal standardised or integrated assessment procedures than the UK. The literature from these countries was therefore drawn upon to throw light on the potential impact of similar attributes within the SAP, thus highlighting some of the potential obstacles to its effective implementation.

Searches were undertaken on a range of electronic databases (Social Science Citation Index, Medline, PsycInfo, Cinahl, Sociological Abstracts, EconLit) with key search terms refined during this process to include: 'the assessment of care needs', 'community-based assessments' and 'assessments of older people for health or

social care services'. Grey literature was accessed via specific databases (Caredata), research organisations (The Joseph Rowntree Foundation, The National Institute for Social Work) and the internet. The literature reviewed is broad in scope, with some studies referring to issues related to assessment only tangentially, for example in relation to the integration of health and social care. This is indicative of the fact that assessment is a fundamental part of the wider health and social care system.

Assessment at the service user level

Assessment at this level is characterised by the way assessments impinge on the older person who has approached or been referred to health or social care agencies. It is the most frequently debated aspect of assessment. Here, the SAP aims to promote assessments that enhance 'person-centred care', leading to care delivery that upholds the values, wishes and preferences of older people and involves them as active partners in the process of assessment and service planning (Department of Health, 2001, 2002a).

A person-centred approach to assessment is not new. Such an approach was advocated in the policy guidance *Caring for People: Community Care in the Next Decade and Beyond* (Cm 849, 1989) in the form of 'needs-led' assessments. However, the literature suggests that this concept was at times misunderstood by social care professionals who regarded 'need' largely in terms of those needs expressed by the service user (Bradshaw, 1972), whereby the latter's definitions of their needs were privileged over both professional opinion and service availability (Parry-Jones & Soulsby, 2001). Case law legitimised the view that 'need' could be considered in the light of available local authority resources (*R. v. Gloucestershire County Council, ex parte Barry* [1997] 2 WLR 459), resulting in some disaffection by local authority assessors who were concerned that their

traditional advocacy role was becoming compromised by their requirement to act as gate-keepers of scarce resources (Caldock, 1993; Richards, 1994; Twigg & Atkin, 1994; Nolan & Caldock, 1996). The literature suggests that the tension between wishing to provide services on the basis of user-defined need and having to take account of agency eligibility criteria in framing decisions about need remains a real conflict for practitioners (Parry-Jones & Soulsby, 2001; Preston-Shoot, 2003).

Much of the literature on this topic draws a sharp distinction between assessment seen from a professional viewpoint, where the assessor is deemed as an expert in identifying users' needs, and that from the user's viewpoint, where the older person's preferences and wishes become paramount. Several studies have suggested that despite an expressed commitment to listening to and taking account of the perspective of the service user, professionals were unable to do this when these perspectives differed from their own (Ellis, 1993; Barnes & Wistow, 1994; Glenister, 1994; Clark, 1996; Myers & McDonald, 1996). Professionals in these studies tended to operate what Smale and Tuson (1993) termed a 'questioning' or one-way model of assessment whereby the professional is regarded as the expert and the service user as the passive recipient of care. In contrast, an 'exchange' model of assessment is advocated whereby the service user is recognised as the expert in their own lives and the professional and service user are considered to have "equally valid perceptions of the problems and can contribute to their solution or perpetration" (Smale & Tuson, 1993, p.7; see also Lloyd, 2000; Preston-Shoot, 2003). Such an approach can be seen to rest upon a rights-based conception of community care, in which the service user's experience is used as the basis for entitlements to particular services (Oliver, 1996) as well as reflecting the underlying concept of the 'patient as

expert' recognised in relation to particular disease groups (Lloyd, 2000).

Although signalled explicitly in Standard Two of the English National Service Framework for Older People (Department of Health, 2001) as being central to the SAP, it would seem that person-centred care has been largely regarded as a value that acknowledges the rights of older people to determine their own ends rather than a concrete practice involving the use of particular skills (McCormack, 2003). The involvement of older people as active partners in the assessment process, considered fundamental to a person-centred approach within the SAP (Department of Health, 2001), is one means of operationalising this concept. Here the literature suggests the need to balance a responsibility to protect the most vulnerable people in society (Stevenson, 1996) with the recognition of the desire and right of older people to participate in the assessment process. The literature suggests that only lip-service has been paid to the concept of user participation by professionals (Croft & Beresford, 1992; Cahill, 1998) with participation often regarded as an end in itself rather than an important linkage to other goals (Qureshi, 1999). There is also evidence in the literature suggesting that older people have often been perceived as uninterested in active involvement (Beisecker, 1988; Waterworth & Luker, 1990; Barnes & Prior, 1995; Jewell, 1996). However, this view has been challenged by others (Myers & Macdonald, 1996; Eales *et al.*, 2001; Roberts, 2002; Chapman *et al.*, 2003; Clark *et al.*, 2004), who have suggested that the apparent acquiescence and passivity of older people in the assessment process found in some studies may be the result of factors such as feelings of powerlessness and ignorance in the face of complex and confusing systems (Hardy *et al.*, 1999); asymmetry of power between practitioners and service users (Meethan & Thompson, 1993, McWilliams *et al.*, 2001; Carr, 2004); disillusionment based on

previous negative experience (Croft & Beresford, 1992); and older people's views being subordinated to those of family members or professionals (Roberts, 2002).

Safeguarding a person-centred approach to assessment will require an understanding, by those implementing the SAP, of the relationship between 'rights' and 'needs' as defined by service users and professionals. This will necessitate more precise definitions as to the purposes of assessment on each side of the 'exchange'. Whilst it has become popular to support the concept of participation as representing a move towards an 'exchange' model of assessment, it is also important to identify limits and consider those who, for reasons of frailty and ill health, may not be in a position to take control of, or even participate in, the assessment process. Concurrently, the potential difficulties involved in limit setting in terms of who makes these decisions and how they are scrutinised must be considered. The Mental Capacity Act (2005) provides an example of how this issue is being addressed by legislators. The literature suggests that people with cognitive impairment have until recently been viewed as lacking the mental capacity to take part meaningfully in discussions about their quality of life and have consequently been excluded from negotiations about their care needs (Albert, 1997). A number of published studies have challenged this standpoint (Mozley *et al.*, 1999; Barnett, 2000; Wells & Dawson, 2000; Wilkinson, 2001) whilst the Mental Capacity Act (2005) has enshrined in law the notion of the "presumption of capacity" and a requirement to provide appropriate support to enable people to participate in decision making processes about their care (DCA, 2007, para. 1.2). The purpose of assessment from a person-centred perspective, including greater participation of older people in the assessment process, may therefore conflict with the role of assessment as a professional decision-making tool used in conjunction with

criteria relevant to the aims of health and social care agencies.

Assessment at the professional level

Assessment from the professional viewpoint raises further debate concerning how and in what form information is generated. Variations in both the extent and nature of information elicited by professionals during assessments have continued to raise concerns, despite initiatives aiming to standardise assessment content and ensure the coverage of a broad range of domains (Carpenter, 1998; Martin *et al.*, 1999; Stewart *et al.*, 1999; Parry-Jones & Soulsby, 2001). Two aims of the SAP are particularly pertinent in attempting to overcome these difficulties (i) the reduction of duplication of information gathered by different professional assessors, itself an aim dependent on more effective collaboration between them and (ii) the standardisation of practice across the country, an aim intended to ensure that assessments cover a broad range of domains so promoting consistency between agencies and within and between localities (Department of Health, 2002a).

Professional collaboration

A major obstacle to sustained, effective collaboration between professional groups, highlighted by the literature, is a lack of shared vision regarding both the purpose of assessment and how it should be undertaken. This issue can in part be summarised in terms of the 'clinical/social divide', and whilst there is evidence that this divide is neither as static nor clear-cut as is sometimes suggested, with community nursing in particular spanning the divide (Worth, 2001), the literature does indicate that professionals continue to lean towards either one model or the other, depending on their professional orientation (Dalley, 1991; Worth, 2001; Royal College of Nursing Scotland, 2003). Although debate before the community care reforms signalled the need for community care assessments to operate

in consort with both primary and secondary health care (Browning, 1992), the distrust that existed between the sectors meant that this largely failed to materialise (Hunter, 1994; Wistow, 1994); a consequence being that UK community care assessments tended to neglect specialist health care information (Challis, 1999). By contrast, in Australia, the development of Geriatric Assessment Teams following the 1986 Nursing Homes and Hostels Review (Department of Community Services, 1986) formalised multi-disciplinary assessment practice, including primary and secondary health and social care (Kendig *et al.*, 1992; Challis *et al.*, 1995). The Australian experience demonstrates how structural reform to assessment at a national level could lead to greater integration at the professional level. However in England, by giving the lead responsibility for the coordination of community care assessments to local authorities (Cm 849, 1989; Department of Health, 1990), the community care reforms failed to bridge the divide between health and social care and, in particular, neglected the contributions of secondary health care professionals. Such large scale reform, and particularly the manner in which it was implemented locally, has obvious relevance to a national policy such as the SAP. Despite efforts to reduce duplication, by promoting collaborative practice in assessments (Department of Health, 2002a), the literature testifies to potential difficulties at a local level, including the distrust of professionals over the motives of such activity (Dalley, 1991).

Standardisation

Standardisation of the process and content of assessment is a fundamental aim of the SAP as a means of promoting its operation in a similar and consistent way across the country and between professional groups. By this process it aims to achieve both 'territorial justice' (Davies, 1968; Department of Health, 2002b) and the

ability to aggregate assessment information in order to inform performance management and service development (Kane & Kane, 2000).

As detailed above, the literature suggests that the purpose of assessment is viewed diversely by different professional groups involved in assessing older people. With regard to standardisation, a distinction can again be drawn between the medical profession, where standardised tools and scales have long been in routine use (Burns *et al.*, 2003) and social work, where such tools have been less widely acknowledged and little used (Abendstern *et al.*, 2006). Where they have been employed by the latter, evidence suggests that their value was compromised by local adjustments being made to them (Glasby, 2004). These difficulties may be due to a level of circumspection regarding standardisation within some professions, notably social work and nursing, where an open-ended assessment model (the antithesis of a standardised approach) has been seen as an important characteristic of their professional role (Qureshi, 1999; Worth, 2001). Standardisation has been regarded by these groups as leading to a mechanistic and bureaucratic process, denying individuals their 'voice' and pre-judging users' and carers' priorities (Nolan & Caldock, 1996). In the absence of standardisation, however, there is evidence in the literature of judgemental assessment practice (Ellis, 1993), based on individual 'practice style' (Ozcan, 1998) and variation according to the professional identity of the assessor rather than the needs of the service user (Runciman, 1989). The result has sometimes been a degree of variation in assessment information that is over and above that expected from the variations in the circumstances of older people in a particular locality (Stewart *et al.*, 1999).

Such professional differences to the approach and view of the purpose of assessment may continue to raise issues for

the implementation of the SAP. The guidance does acknowledge these potential difficulties regarding differing professional views, noting that standardisation should “support existing good practice [and be] useful to those practitioners responsible for its day-to-day operation” (Department of Health, 2002a, Annex A). The guidance is not prescriptive regarding how standardisation of assessment content and practice should be achieved. Whilst it lists the domains that comprise the SAP, it comments that not all domains will always be required to be completed. The Guidance also endorses the development of local tools and emphasises the importance of local implementation processes relevant to existing local good practice. A tension is evident here between support for local implementation initiatives which are sensitive to local circumstances and a desire to promote a standardised national approach to the implementation of the SAP.

The existence of the SAP as a government policy is acknowledgement of the inefficiencies of previous assessment practice, both in terms of duplication and its consequent costs to public agencies (see Gershon, 2004), and in the less than optimum outputs from the resulting mix of services – an issue arising when the “scale and depth” of assessment is not proportionate to need (Department of Health, 2002a, p.1). Notions of efficiency and cost effectiveness have underpinned previous policies, particularly the community care reforms of the 1990s. However, as noted above, a tension is evident in the literature in that efficiency has been considered by some professionals as an undesirable aim, being linked purely with cost minimisation, and perceived as in direct conflict with a person-centred approach (Qureshi & Nicholas, 2001; Martin *et al.*, 2004).

Promoting efficiency

The identification of the likely difficulties in promoting efficiency through the SAP is assisted by examining policies that have articulated similar goals in relation to the practice of assessment. An analogous policy, raising similar issues concerning the promotion of efficiency, is that of the implementation of care management in the early 1990s. Care management is important in this respect because, in its assessment phase, it aimed towards a differentiation of assessment according to need and a coordinated approach to assessment, aspects similar in important respects to those of the SAP.

Studies undertaken during the time of the introduction of care management in the UK found it was often a predominantly administrative process, at times involving the use of generic assessment tools, and failing to target those most in need (Challis, 1992, 2004; Lewis *et al.*, 1995; Stewart *et al.*, 1999). One aim of care management was to overcome some of these problems in relation to assessment. Intensive care management studies, carried out in a number of settings in the late 1980s and early 1990s (Challis & Davies, 1986; Davies & Challis, 1986), showed gains for very vulnerable older people, in particular in relation to improvements in their wellbeing and reductions in carer stress, with these gains largely being achieved at a lower or similar cost than normally expended (Challis & Davies, 1986; Knapp *et al.*, 1992; Challis, 1993; Challis *et al.*, 1998). Key elements of this model were “a differentiated response to need; appropriate targeting; devolution of budgets; continuity of involvement of care manager with service user and appropriate links with specialist health care expertise” (Challis, 2004, p.233). These features, however, were not translated into mainstream practice following the introduction of care management across social services authorities in the UK which bore little

relation to the intensive care management studies, thereby meaning that potential benefits of the policy may not have been realised. The SAP, similarly, advocates changes to assessment based on previous research evidence (Department of Health, 2001). However, experience derived from the introduction of the care management arrangements suggest that the benefits in the assessment process may be slow to materialise unless local implementation is allied more precisely to the factors underpinning gains in efficiency. Such debate has consequences for the SAP, which advocates differentiation in assessment as one means of promoting efficiency, in particular for the policy's implementation locally. A further important element of assessment viewed from this level is the establishment of structural support to enable more effective professional collaboration to take place.

Structural support for collaborative practice

Studies have demonstrated that more effective outcomes for older people arise from formal mechanisms which integrate the assessment approaches of different professionals (Hunter *et al.*, 1993; Challis *et al.*, 2004; Clarkson *et al.*, 2006). Donald and Bown (2003), for example, found that a multidisciplinary assessment panel, incorporating a geriatrician, care manager, community psychiatric nurse, district nurse, physiotherapist and occupational therapist, for those being considered for admission to long-term care, ensured a more appropriate and consistent categorisation of care for older people, compared with recommendations made by care managers alone. Challis and colleagues (2004) found that integrating the assessments of care managers and specialist clinicians, through a reporting process between them, resulted in improvements in medical information passed to and used by care managers in their work. This, in turn, resulted in less deterioration in older people's physical

functioning, less contact with nursing homes and emergency services and cost savings, particularly to the NHS.

Translating the potential benefits of such collaborative studies into policy development or mainstream practice has proved difficult. For example, in hospital discharge, Marks (1994) commented on the consistency of research findings, going back over twenty years, documenting the breakdown of discharge procedures, despite government guidance and a number of schemes at the local level. One of the lessons from implementing collaborative schemes in this area is the value of coordinating the diverse functions and assessments of different professionals. In the UK examples of such a strategy in this area include a dedicated discharge co-ordinator (Houghton *et al.*, 1996), a liaison nurse (Peters *et al.*, 1997) and the full involvement of the hospital multidisciplinary team (Bull & Roberts, 2001).

These findings provide valuable evidence for those implementing the SAP in relation to developing operational structures, procedures and guidelines which integrate the assessment processes of key professionals at particular key episodes in an older person's care. The literature suggests that developing appropriate structures is important for systematic implementation. This involves moving away from 'force of circumstance', when professionals are obliged to collaborate through shared tasks (Dalley, 1991), which, although potentially leading to greater professional understanding, is vulnerable to an over reliance on individual commitment to the process (Sheard & Cox, 1998). The role of information technology to enhance multidisciplinary assessment practice is also an important aspect of operational structure implicit in the SAP guidance (Department of Health, 2002a). Information technology offers an "electronic bridge to overcome the temporal-spatial difficulties associated with

traditional forms of collaboration” (Reeves & Freeth, 2003, p.89) and may supersede the goal of co-location aimed for in recent years. Installation alone, however, will not guarantee success (Department of Health, 1995; Warburton, 1999; Cameron & Lart, 2003; McNally *et al.*, 2003). It is a necessary but not sufficient condition. Structural divisions will need to be addressed further for such collaboration to bear fruit (Warburton, 1999; McNally *et al.*, 2003; Reeves & Freeth, 2003).

Conclusions

A review of assessment across health and social care testifies to the considerable complexities involved in delivering a ‘joined up’, standardised and participatory assessment process for older people. It also demonstrates that critical issues relevant to the implementation of the SAP are not new but have been considered by commentators from a variety of backgrounds over a substantial time period. Several issues stand out and are summarised in Box 2 as constituting the principal lessons from this review. Implementing the SAP in the medium to long-term is likely to be a complex process involving challenges for all concerned. The changes envisaged will tend to be filtered through interpretations

and implementation of policy at the local level (Lipsky, 1980). Throughout this process, long standing and deeply embedded professional practices, traditions, beliefs and structures will need to be addressed; a key issue here being the differing professional values and roles of those involved in the assessment of older people.

Without a shared understanding across professional groups there is a danger that professionals will continue not to accept the assessments made by others, so duplicating information collection and therefore jeopardising the efficacy of the shared tools and systems envisaged as part of the SAP. Joint working protocols and training programmes may offer a means of addressing this. However, Barr (2003) has suggested they need to be carefully designed if they are not to compound stereotyping and negative attitudes held by professionals. The development of information technology offers the potential for a new style of collaborative practice with the capability to develop strong networks without the need for co-location (Reeves & Freeth, 2003), but its design will require thought if it is to strengthen rather than undermine a joint approach to assessment required by the SAP.

Box 2: Summary messages from the literature

- **On person-centred care:** Professionals are committed in theory but find it hard to give up control in practice. Approaches to involving older people in their assessments need to reflect the heterogeneity of older people.
- **On standardisation:** Hostility from some professional quarters remains a reality. The purpose of standardisation needs to be clarified for all professionals alongside valuing professional judgement.
- **On multi-disciplinary working:** Structures are needed to support the necessary ‘meeting of minds’ for integrated approaches to assessment to work more effectively.
- **On efficiency:** Still perceived with suspicion by professionals as a purely cost cutting exercise rather than being aimed at improving outcomes. Assessment efficiency involves both savings of time and expense involved in avoiding duplication and a more optimum mix of services resulting from the assessment.

A single collaborative approach, involving multiple agencies but co-ordinated by the social services care manager was an original intention behind the community care reforms (Department of Health, 1990; McNally *et al.*, 2003). The evidence is, however, of such a pivotal approach not being fully established and, instead, multiple separate assessments, often with little sharing of information, being undertaken. If such a collaborative model of care management, as envisaged by the reforms of the mid-1990s, has not fully emerged across localities, it seems likely too that an integrated assessment practice, as proposed by the SAP, will be similarly difficult to realise. One reason for this may be the inherent complexity of a policy which seeks to change professionals' behaviour rather than merely the pattern of resource allocation and distribution (Wildavsky, 1979). For local agencies to more effectively realise the aims of the SAP will require changes in the practices of professionals, which in turn will require local management to implement structures offering incentives for professionals to change the way they operate. However, one difficulty with the introduction of the SAP is its lack of prescription as to which agency should take on a co-ordinating role, which is likely to result in further uncertainty and even duplication. External prescription may therefore be required to direct agencies as to their respective responsibilities for coordinating the different 'stages' of assessment (Department of Health, 2002a). In the long term, judging the impact of the SAP and whether it has achieved its aims will require knowledge of the manner of its implementation, which, in turn, will need to take account of the debates considered above.

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