principles of veracity, autonomy and beneficence at the individual level isn't going to be halted by the short-term gains of meeting targets based on population derived indicators. Our challenge is to conduct interactions with individuals where the risk-benefit equations are openly discussed and how we enable individuals to enjoy the freedom that self-management and self-adjusted dosing can provide: in summary, how to facilitate the autonomy derived from a good understanding of long term illnesses. Ironically, it will be patients who will push for this as the digital information era creates the need for better partnerships.[17–19] We are making progress even though we watch the clock and count the points.

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Identifying unmet health needs in older people:

comprehensive screening is not the answer

The case for routine comprehensive screening for unmet health needs in the older population has collapsed. A very large randomised controlled trial in the UK has demonstrated that there are little or no benefits to quality of life or health outcomes from population screening,[1] endorsing the deletion of the obligation to offer annual screening from the contract for general practice in Britain. The evidence of benefit from such whole population screening had always been thin, and the UK's '75 and over checks' had stalled long before they disappeared quietly from the new GP contract, suggesting that a mechanistic approach to needs assessment without a robust evidence base makes both bad science and bad policy.[2]

In contrast, the editorial[3] accompanying the paper by Fletcher *et al*[1] concluded that people over 75 should be offered 'preventative home visits' and argued that 'the common core is the multidimensional geriatric assessment, which helps to identify and manage the multiple problems and risks of older people'. The belief that screening could prevent functional impairment in older people has had an enduring appeal to researchers, clinicians, and older people, since the original study by Williamson.[4] The accumulating evidence against the value of whole population screening is not going to extinguish this enthusiasm for intervention, and nor should it, since there is some evidence that needs assessment of older people followed by active management may improve survival and function.[3] Efforts to improve the health of an ageing population should logically focus on a two-stage process, with case finding leading to highly selective comprehensive geriatric assessment, as advocated by GPs over a decade ago.[5]

Two problems remain. The first is that specialists in medicine for older people came out of the MRC trial performing no better than GPs, when implementing comprehensive assessment. The second is that we do not know how best to organise this two-step process in primary care, where most of this work will need to be done.[6] This is a risky situation, given the tendency for policy and practice in the NHS to evolve separately from the scientific basis for interventions, and there is a danger that innovation will ignore the imperatives of clinical practice.

Once again England is pioneering a nationwide programme of targeted assessments of need in selected sub-populations of older people, and runs the risk of pushing policy well ahead of the evidence, just as it did with the 75 and over checks. Standard 2 of the National Service Framework for Older People[7] introduced the Single Assessment Process, which aimed to promote person-centred care by ensuring that a standardised assessment process was in place across all areas and agencies to enable a full evaluation of older people's needs. The idea of a single assessment is appealing because as recently as 2002, only 10% of primary care trusts and social services departments in England shared case files and only 4% had information systems that were compatible.[8] This highlighted the importance of standardised assessments to allow sharing of information, to reduce duplication, and to provide enough detail to profile individuals fully.

Although the Single Assessment Process has provision for a brief 'contact assessment' that might be completed by a GP or practice nurse at the case-finding step of a two-stage process, the main emphasis is on the 'overview assessment', covering a range of health and social topics. The resulting information is then used to fill in a standardised summary that runs to seven pages and includes over 200 items of information. The information can be collected over a number of occasions, and not all of the summary is necessarily completed. Nevertheless, busy professionals may struggle with the volume of work needed to complete the Single Assessment Process, which also reduces their time to listen to and explore issues with individuals. The sheer length of the Single Assessment Process may also restrict its usefulness in practice, producing resistance to change among practitioners, and making the older individual feel less able to talk about their primary concerns. Some of the moves to consider self-assessment as outlined in the recent consultative paper on social care[9] may suggest a move to reduce the burden on professional time. However, in its current form the Single Assessment Process may simply reinforce the current culture of ticking boxes,[10] collecting volumes of information of dubious relevance to most older people, and adding even more bureaucracy to an NHS that is already overstretched.

It is not surprising that implementation of the Single Assessment Process is proving difficult. Three years after the publication of the National Service Framework for Older People a Department of Health milestone report (26 April 2004) implied that there was still a lot of work to do around Single Assessment Process development and was offering support to achieve this, specifically:

> *'The 2003 Single Assessment Process progress reports from local health and social care systems suggest considerable variation in the state of readiness to implement the new system. A range of support is being provided by the Department of Health to help localities achieve implementation, and plan for further developments after April 2004.'*

Nothing that we have encountered in our work with social and health services in different localities makes us think that the situation with Single Assessment Process has changed enormously since then.

The risks to general practice are that we will lose sight of the case-finding step, and become lost in the complexities of the overview assessment. We need to return to first principles and reclaim a clinical role in health maintenance in an ageing population. Unmet needs among community-dwelling older people encountered in primary care may be fewer than expected and cluster in particular domains[11] suggesting that what is required is a focused, brief assessment that identifies common unmet needs[12] rather than the comprehensive but time consuming multidimensional approach. Although some older people may value systematic assessment[13] this is likely to be most cost-effective if it is targeted on the common unmet needs. A brief assessment would also reduce the amount of irrelevant information collected, allowing the health professional more time for an adequate consultation and patient-centred care. This needs to take into account the individual circumstances of the older patient in two ways. First by emphasising the 'person-disease management approach'[14] that requires tailoring of clinical responses, and that is a strength of general practice; and second by promoting goal-oriented medical practice, which allows the older patient to state what outcomes matter most to them.[15] Such person-centred care may be compromised by excessive and time-consuming assessments of unproven value. Instead, it is worth exploring other options including the use of very short measures that may identify many of the commonest unmet needs in primary care.

Case finding carried out in this way can lead to more complex medical interventions directed at the co-morbidities that are so strongly associated with disablement. The fact that we do not know how best to do this means that there is ample scope for experimentation and innovation in general practice, using the growing evidence base about clinical interventions in a pragmatic way.[16] The imposition of the 75 and over checks in the 1990 general practice contract almost killed innovation in the primary care of older people in the community. Avoiding the pitfalls of the Single Assessment Process may be one way to revive our tradition of research and development.

Competing interests

Steve Iliffe and Martin Orrell have been funded by the Department of Health to develop a brief instrument to identify unmet needs in older people, and Steve Iliffe is currently funded by the Department of Health to explore the potential of promoting health and social wellbeing for older people using expert system technologies. Martin Orrell was involved in developing the Camberwell Assessment of Need for the Elderly (CANE) (www.thecane.co.uk), one of the tools originally considered for the Single Assessment Process

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