JOINT PERFORMANCE INFORMATION AND ASSESSMENT FRAMEWORK
JPIAF 6
SINGLE SHARED ASSESSMENT IN COMMUNITY CARE AND CARERS' ASSESSMENTS

1. This appendix defines the Performance Indicators for single shared assessment and carers' assessments required for JPIAF 6.

2. Three Performance Indicators (PIs) are proposed for collection from 1st January 2005. The first full reporting year will be 2005-06. The three PIs are set out in detail in Tables 1 to 3. They cover:

JPIAF6 – PI 1 Number of persons with completed community care assessments by agency of lead assessor, type of assessment, and service user group

JPIAF6 – PI 2 Number of persons with completed community care assessments by time interval from first identification date to first service start, and service user group.

JPIAF6 – PI 3 Number of carers with completed carers' assessments by age group of carer, service user group of cared for person, and type of assessment.

3. The Performance Indicator definitions are not intended to direct or limit the practice of SSA at a local level, nor to standardise practice nationally. They are concerned with the requirements of counting and measuring progress in single shared assessment and are necessary for purposes of consistent, reliable, national performance reporting.

4. The quality of the information collected for these Performance Indicators will be monitored. As JPIAF 6 develops over time, different PIs may be developed for consultation.

Table 1 COUNTING SINGLE SHARED ASSESSMENTS

JPIAF6 – PI 1: Number of persons with completed assessments in the reporting period, by agency of lead assessor, type of assessment, and service user group

	1	2	3	4	5	6	7	8
Lead Assessor	Social Work		Health	Housing	Joint Agency	Voluntary Organisation		**Total**
Assessment type	Single Agency	SSA	SSA	SSA	SSA	Single Agency	SSA	Single agency and SSAs
a) Older people aged 65+ without dementia								
b) Older people aged 65+ with dementia								
c) People aged 18-64 with mental health problems								
d) People aged 18-64 with physical disabilities								
e) People aged 18-64 with learning disabilities								
f) People aged 18-64 with drug/ alcohol abuse problems								
g) Other and service user group not known – aged 18-64								
TOTAL								

5. This table records:
- the number of persons in each service user group who had a completed assessment of their community care needs during the reporting period, whether by a single shared assessment or a single agency community care assessment;
- the number of persons with assessments undertaken in each agency by lead assessors.

6. The following rules apply to Table 1. Terms marked in ***bold italics*** are given more detailed definitions below.

(1) Table 1 records an entry for each person for whom all the following conditions are satisfied –
- The person has been the subject of a ***community care assessment*** within the reporting period.

- Either the person was a ***new community care service user*** when the assessment was initiated or the person was an existing community care service user who was assessed for needs under a different ***service user group*** from that applying formerly.
- The community care assessment was ***completed*** and the completion date fell within the reporting period, regardless of when the assessment started.
- The community care assessment was neither solely a ***self-assessment*** nor solely a ***screening*** assessment.

(2) A person should only be counted once for purposes of Table 1. If a person has received more than one completed ***community care assessment*** within the reporting period, the ***lead assessor*** and ***service user group*** details should be those applying at the first such assessment.

(3) When the lead agency is Social Work or a Voluntary Organisation, the community care assessment may be either a ***single shared assessment*** or a ***single agency assessment***. An assessment carried out by Health or Housing will only qualify as a community care assessment if it is shared with Social Work, so will always be a single shared assessment.

(4) In a couple or a family, each person who is regarded as a client in their own right should be counted separately if they have a separate assessment in the reporting period.

7. Definitions required for Table 1 are as follows –

- **Agency**
- **Lead Agency**
- **Lead Assessor**
- **Community Care Assessments**
- **Screening**
- **Self Assessments**
- **Reviews and Re-assessments**
- **Single Shared Assessments**
- **Single Agency Assessments**
- **Completed Assessments**
- **Service User and New Service User**
- **Service User Group**
- **Service User Age**
- **Number of Persons with a Completed Assessment**

7.1 Agency

Agency is a functional description: local authority social work, health, local authority housing, and voluntary organisations (as a whole) are all different agencies. Joint teams and jointly managed staff are treated in Table 1 as a separate agency type – '**joint agency**'.

7.2 Lead agency

The **lead agency** for single shared assessments is the agency employing the lead assessor. The lead agency for single agency assessments is the agency undertaking them and will usually be social work, though a single agency assessment may sometimes be undertaken by a voluntary organisation on behalf of social work. (See '***single agency assessments***'.)

7.3 Lead assessor

The **lead assessor** is the professional who co-ordinates all contributions to the assessment and the care plan and ensures that appropriate information is shared.

For the purpose of recording who is the lead assessor, this should be the lead assessor at the time of completion of the assessment.

7.4 Community Care Assessments

Under Section 12A of the Social Work (Scotland) Act local authorities have a duty to make an assessment of the needs of any adult who they believe may require community care services, as defined by the Section 5A of the Act, and to request and take into account information from health and housing authorities as to services that are likely to be made available by the health or housing authority where there may need to be provision of these services to the person. Such assessments are known as **community care assessments**. As well as seeking a contribution to assessments, local authorities can delegate their duty to assess need to others and this is the basis for widening the range of professional staff who may undertake Single Shared Assessments in social work, health and housing.

A **Community Care Assessment** comprises a series of actions, undertaken jointly as far as possible with the person being assessed, which includes identifying the extent and nature of their needs, the extent to which these may be met by community care services or support, informing the person and/or carer of the conclusion, and, where appropriate, devising a care plan and arranging services.

This definition covers all community care assessments, including assessments by local authority occupational therapists of people who require equipment or adaptation services. For the purposes of Table 1, screening activity that does not lead to further assessment, and ***self-assessments***, are not included within this definition of assessment. ***Scheduled and unscheduled reviews*** and re-assessments of need are also not included for purposes of Table 1 except where a re-assessment of community care need takes place under a different ***service user group*** to that applying previously.

Any assessment of community care needs (which meets the definitions above) originating in Health or Housing, and shared appropriately with Social Work, is deemed to be a Community Care Assessment for the purpose of this Performance Indicator.

7.5 Screening

Screening is the initial phase of contact following an inquiry or request for help when basic data about the person are gathered (name, address, etc.) along with sufficient information about the purpose of the contact to determine an appropriate response. It is also the stage at

which callers who have come inappropriately to an agency will be filtered out and / or redirected. Possible outcomes include: no further action, redirection to another agency, information or advice provided or basic service arranged, emergency or holding action or service, recommendation for a further assessment of need. **Assessment** is any aspect of further assessment of need beyond the screening phase.

7.6 Self Assessments

Self-assessments are assessments that are made by the person with community care needs that do not involve staff. They may result in services being provided through direct access on the basis of eligibility, without further assessment of needs. Self-assessments that are completed without any additional assessment input from staff are excluded from JPIAF6-PI1.

7.7 Reviews and Re-assessments

JPIAF6-PI1 excludes both scheduled and unscheduled reviews and re-assessments:

- **Reviews or scheduled / planned reviews** are an examination of an existing community care client's needs and services (the care plan where it exists) at or by a predetermined date.

- **Unscheduled or unplanned reviews** are re-assessments in response to a change of circumstances.

7.8 Single Shared Assessments

The Guidance on Single Shared Assessment of Community Care Needs (Circular No: CCD 8/2001) is issued under the Social Work (Scotland) Act 1968 (s. 5A and 12A).

Single Shared Assessments are those Community Care Assessments that require input and co-ordination across agencies (or from a joint team) and where the assessment information has been shared between the appropriate staff in the agencies, by whatever method, in order to complete the assessment and/or secure services as a result.

For the purpose of JPIAF 6, SSA is defined as a **sub-set of community care assessment.** It is the identification of community care needs in conjunction with health and/or housing/housing support needs and the sharing of information across agencies in order to assess and meet needs that defines SSAs in community care.

An assessment only counts as a Single Shared Assessment if there is an *actual* sharing between Social Work (or a voluntary organisation) and either Health or Housing. Use of a common assessment form does not in itself constitute a Single Shared Assessment for purposes of Table 1. **It must be stressed that an assessment should only be shared where there is a clear purpose for such sharing**. It is not sufficient to share information as a "precaution", without there being a clear reason why staff in other agencies need to know the information being shared.

If an assessment is shared between Social Work and a voluntary organisation, but not with either Health or Housing, it is a Single Agency Assessment for counting purposes.

7.9 Single Agency Assessments

Single agency assessments are ***community care assessments*** that involve only social work or a voluntary agency undertaking community care assessments on behalf of social work (e.g. the voluntary agencies which are commissioned to provide assessment and services to people with sensory impairment).

Single agency assessments under health or housing legislation are **not** included in JPIAF 6.

See Annex A for a flow chart for deciding whether an assessment ought to be counted as a single shared assessment or a single agency assessment.

7.10 Completed assessments

A **completed assessment** is one where all the components of the assessment of needs have been undertaken and the assessment form has been signed off. Include completed assessments which did not lead to the provision of services, or where clients made their own care arrangements. Where an assessment is ended prematurely (e.g. because the service user has moved or died), it does not constitute a completed assessment.

A financial assessment is not included within the definition of assessment of needs; therefore a client's financial assessment need not have been finished for the purpose of this categorisation.

7.11 Service User and New Service User

A **service user** is any person known to an agency that is undergoing an assessment of their need for community care services, or waiting for such an assessment to begin; or who is in receipt of community care services or waiting to receive such services as a result of an assessment of need.

A **new service user** is someone who is not awaiting or undergoing assessment or in receipt of services in the period immediately before the event or contact that triggered the assessment. This does not mean that the person has never been assessed or received services. 'New service user' does not include persons who receive information or advice or a basic service as a result of screening but without further assessment.

For purposes of Table 1, however, an existing service user who receives a new assessment under a new service user group (see below) is included in Table 1 as if they were a new service user. For example, an older person who has already been receiving home care but who is given a new assessment on account of the onset of dementia would be included in the Table.

Persons who are being assessed and/or provided with services outwith their home area should be included as service users or new service users, as appropriate, in the area providing for them only if their home area is not paying for assessments done or services provided. Where the ***home area*** is paying, that area would count them as service users. **'Home area'** is the person's area of ordinary residence.

7.12 Service User Group (See Annex B for details of each category)

The **service user group** under which a person is recorded should be the group that best reflects their areas of need. For example, people with acquired brain injury could be included under the physical disability, learning disability or mental health category according to which best describes their needs.

People should be recorded in Table 1 under **one group only**. If a person is assessed for community care needs under more than one heading within the same reporting period, then for Table 1 they should be recorded under the group that applies at the first such assessment.

People with HIV/AIDS should be included in the "other" category. People with housing support needs (under 'Supporting People') should be recorded only if they also have community care needs, in which case they will be recorded under one of the specified service user group categories.

7.13 Service User and Carer Age

For purpose of assigning people to age groups, service user's age and carer's age should be age at the time of completion of the assessment.

7.14 Number of persons with a completed assessment

This is the number of persons for whom at least one assessment has been completed in the current reporting period, regardless of when the initial contact was made by the person with an agency which led to this assessment being undertaken. **This applies to counting people who have a community care assessment or SSA and to carers who have a carer's assessment.**

For purposes of Table 1, persons should be counted only once in the reporting period and under one service user group category. The service user group category should be the one which best describes the person's needs. Where more than one assessment has been completed in the reporting period, only the first assessment should be considered for reporting purposes. Those who have a re-assessment as a result of scheduled or unscheduled reviews are not counted.

Table 2: **TIME INTERVALS FOR COMMUNITY CARE ASSESSMENTS**

JPIAF6 – PI 2: Number of persons with completed community care assessments by time interval from first identification date to first service start, and service user group.

	1	2	3	4	5	6	7	8	9
	Up to 3 days	**4 to 6 days**	**7 to 27 days**	**28 to 55 days**	**Over 56 days**	**Total with service**	Average (median)	No service provided	**GRAND TOTAL (6+8)**
a) Older people aged 65+ without dementia									
b) Older people aged 65+ with dementia									
c) People aged 18-64 with mental health problems									
d) People aged 18-64 with physical disabilities									
e) People aged 18-64 with learning disabilities									
f) People aged 18-64 with drug/ alcohol abuse problems									
g) Other and service user group not known aged - 18-64									
TOTAL PERSONS									

8. This table records:

- the number of people in each service user group who have had a completed community care assessment involving staff (i.e. excluding self-assessment) in the reporting period;
- for those of the above who have had a service in or before the reporting period, the time from first contact with an agency, in relation to the needs which become subject of a community care assessment, to the start of the first service to the service user;
- the total number of those who did not receive a service in or before the reporting period.

9. The following rules apply to Table 2. Terms marked in ***bold italics*** are given more detailed definitions below, where they have not been defined already for Table 1.

(1) Table 2 records an entry for each person for whom an entry has been recorded in Table 1. For each row in Table 2, column 9 should be the same as the total for the equivalent row in Table 1.

(2) If a person receives more than one completed community care assessment within the same reporting period, the ***first identification date*** and ***first service start date*** should be those relating to the first completed assessment.

(3) The ***assessment completion date*** must fall within the reporting period, but the ***first identification date*** may fall before the start of the reporting period.

(4) In the case of an ***interim or emergency service***, the ***first service start date*** may fall before the ***assessment completion*** date, but it may not fall before the ***first identification date***.

(5) A person should be counted in columns 1 to 5 only if the first service start date falls within (or before) the reporting period. If the first service start date falls after the reporting period (or if no community care service is provided), the person should be counted in column 8.

(6) The average calculated for column 7 should be the median time interval (to the nearest day) for persons counted in column 6.

10. Where relevant, the definitions applying to Table 1 apply to Table 2. Further definitions required for Table 2 are as follows –

- **First Identification Date**
- **First Service Date**
- **Interim / Emergency Response**

10.1 First identification

The **first identification date** is the date on which a person is first identified by Social Work, Health or Housing as requiring a ***community care assessment*** (as previously defined). When the lead agency is Social Work, first identification date is the date of the referral that initiated this assessment. When the lead agency is Health, it is the date on which a person, who may already be receiving an NHS service, is first identified as requiring an assessment of community care needs. The same would apply to Housing.

10.2 First service

This is the **first service response** (as distinct from assessment response) to those client needs which are the subject of assessment. The **first service date** is the start date of the service to the service user or the date of provision for one-off services.

By definition the provision will occur after the date of contact; that is, it cannot refer back to a previous round of assessment and services, but it may take place prior to, concurrent with or after the current assessment. The first service may be one that is part of the care plan, or may be an interim or emergency response to a client's needs. "Professional support" can be included as a first service response only if it is a discrete service response by professional staff and goes beyond the support normally provided as part of the assessment of needs. For this purpose it needs to be "face to face", and provide direct support to the individual. Activities that are part of the assessment are not a first service response, nor is the provision of leaflets of any kind. Direct payments count as a provision of service, as does interim or emergency response.

10.3 Interim / emergency response

These are services provided in response to the urgent or severe nature of a service user's needs. Generally they will be provided either while further assessment is being carried out, and prior to the preparation of a care plan, or while a care plan is in existence but the service user is waiting for a planned service to become available (e.g. community services provided while a service user is waiting for a place in a residential setting).

Table 3: CARERS' ASSESSMENT
JPIAF6 – PI 3: Number of carers with completed carers' assessments by age group of carer, service user group of cared for person, and type of assessment.

	1	2	3	4
	Older Carers Aged 65+	**Adult Carers aged 18-64**	**Young Carers Under 18**	**Total Carers**
Carers of Children with a disability				
Assessed jointly				
Assessed separately				
Total				
Carers of older people aged 65+ without dementia				
Assessed jointly				
Assessed separately				
Total				
Carers of older people aged 65+ with dementia				
Assessed jointly				
Assessed separately				
Total				
Carers of adults 18-64 with mental health problems				
Assessed jointly				
Assessed separately				
Total				
Carers of adults 18-64 with physical disabilities				
Assessed jointly				
Assessed separately				
Total				
Carers of adults 18-64 with learning disabilities				
Assessed jointly				
Assessed separately				
Total				
Carers of adults 18-64 with drug / alcohol abuse problems				
Assessed jointly				
Assessed separately				
Total				
Carers of other adults 18-64 with community care needs				
Assessed jointly				
Assessed separately				
Total				
GRAND TOTAL				

11. This table records:

- the number of carers in all age groups who have a carer's assessment;
- the number of carers of persons in each service user group who have a carer's assessment; and
- the number of carers whose needs are assessed jointly with those of the cared-for person or separately in each group.

12. The Performance Indicator will include a calculation of the rate per 1,000 relevant population for each carer group. For consistency, this calculation will be carried out centrally by the Scottish Executive.

13. The following rules apply to Table 3. Terms marked in bold italic are given more detailed definitions below, where they have not been defined already for Tables 1 and 2.

(1) Table 3 contains an entry for each ***carer*** for whom a ***carer's assessment*** has been completed within the reporting period.

(2) A ***carer*** should only be counted once for purposes of Table 3. If a person has received more than one ***carer's assessment*** within the reporting period, the details used for the table (including carer age) should be those applying at the completion of the first such assessment.

(3) A person may be counted for both Table 1 and Table 3 if they have received both a ***community care assessment*** and a ***carer's assessment*** within the same reporting period.

(4) Table 3 covers ***carers' assessments*** undertaken by Children's Services as well as those undertaken by Community Care.

14. Where relevant, the definitions applying to Table 1 and Table 2 apply to Table 3. Further definitions required for Table 3 are as follows –

- **Carers and Entitlement to Carers' Assessments**
- **Carers' Assessments**
- **Completed Carers' Assessments**
- **Carers Assessed Jointly and Carers Assessed Separately**
- **Numbers of Carers Assessed**

14.1 Carers and entitlement to Carers Assessments

A **carer** is defined under Section 12AA of the Social Work (Scotland) Act 1968 and Section 24 of the Children (Scotland) Act 1995 as a person who provides … "*a substantial amount of care on a regular basis*" either for a person over 18 years of age or for a child with a disability, or affected by a disability, where it appears to the local authority that the cared for person or child is someone for whom the authority must or may have to provide community care or children's services . A carer, as described, may be a child.

Such carers are entitled … "*to request a local authority to make an assessment"*... **the carer's assessment...** "*of the carer's ability to provide or continue to provide such care"* ...for the cared-for person or child.

Carers may or may not be living with the person for whom they are caring. Other terms often used are "unpaid carers" and "informal carers". The definition excludes care provided by paid workers or volunteers.

"Substantial and regular care" is not defined. It is a matter of professional practice to identify, in conjunction with the carer, the impact of the caring role on the individual carer and their family, in light of the carer's age, general health, employment status, interests,

perceptions of the impact of their caring role and other factors discussed in the guidance on carer's assessment. Key factors relevant in deciding the impact of the caring role on the carer are the sustainability of the caring role and the extent of risk to the sustainability of that role.

14.2 Carers' Assessments

A **carer's assessment** is intended to:

- establish what level of care the carer is willing and able to provide, and to determine whether their caring role is sustainable;
- determine what resources the carer needs to support them in the caring role and to maintain their own health and wellbeing, and to decide how these resources can best be provided;
- identify the care provided by a carer and the carer's views so that they can be taken into account before the local authority decides what package of care to provide to the cared-for person.

It is not sufficient for a carer's assessment that the carer should be asked for their views on the cared for person's needs. The carer's needs must be assessed in their own right.

The outcome of assessment is an agreed statement of needs, together with a statement of how these needs are to be met; this may include:

- new or changed services provided to the cared-for person, which may include respite care or short breaks;
- new or changed direct payments to the cared-for person
- direct support to the carer through information, advice or access to other resources.

14.3 Completed Carers' Assessments

A carer's assessment is completed when all factors have been considered that affect the carers' capacity and willingness to provide care, and the full range of carers' needs has been recorded, either on the care plan of the cared-for person, or separately on a carers' assessment form, or on any locally agreed recording tool.

14.4 Carers assessed jointly and Carers assessed separately

Carers may be assessed separately, or they may be assessed as part of the overall assessment of the needs of the person they care for. The Scottish Executive guidance (CCD 2/2003) states:

Local authorities will need to decide whether to assess the carer in conjunction with an assessment of the cared-for person, or in a separate assessment. They should decide this on the basis of the individual circumstances, and the wishes of the carer and the cared-for person. In all cases, the carer and cared-for person must be given the opportunity to discuss their needs and views without the other person being present. (para 6.10.1)

and carers should be given *"a permanent record of the final assessment in an accessible format"* (para 6.14)

A **separate Carers' assessment** is one where either:

- the cared-for person is not being assessed at the same time; that is, there is no overlap between the start and end dates for the Carers' and cared-for person's assessment;

or

- the cared-for person is being assessed at the same time but the assessor has at least one meeting with the carer to discuss their needs without the cared-for person being present,

and

- the carer receives a separate statement of the outcome of their assessment.

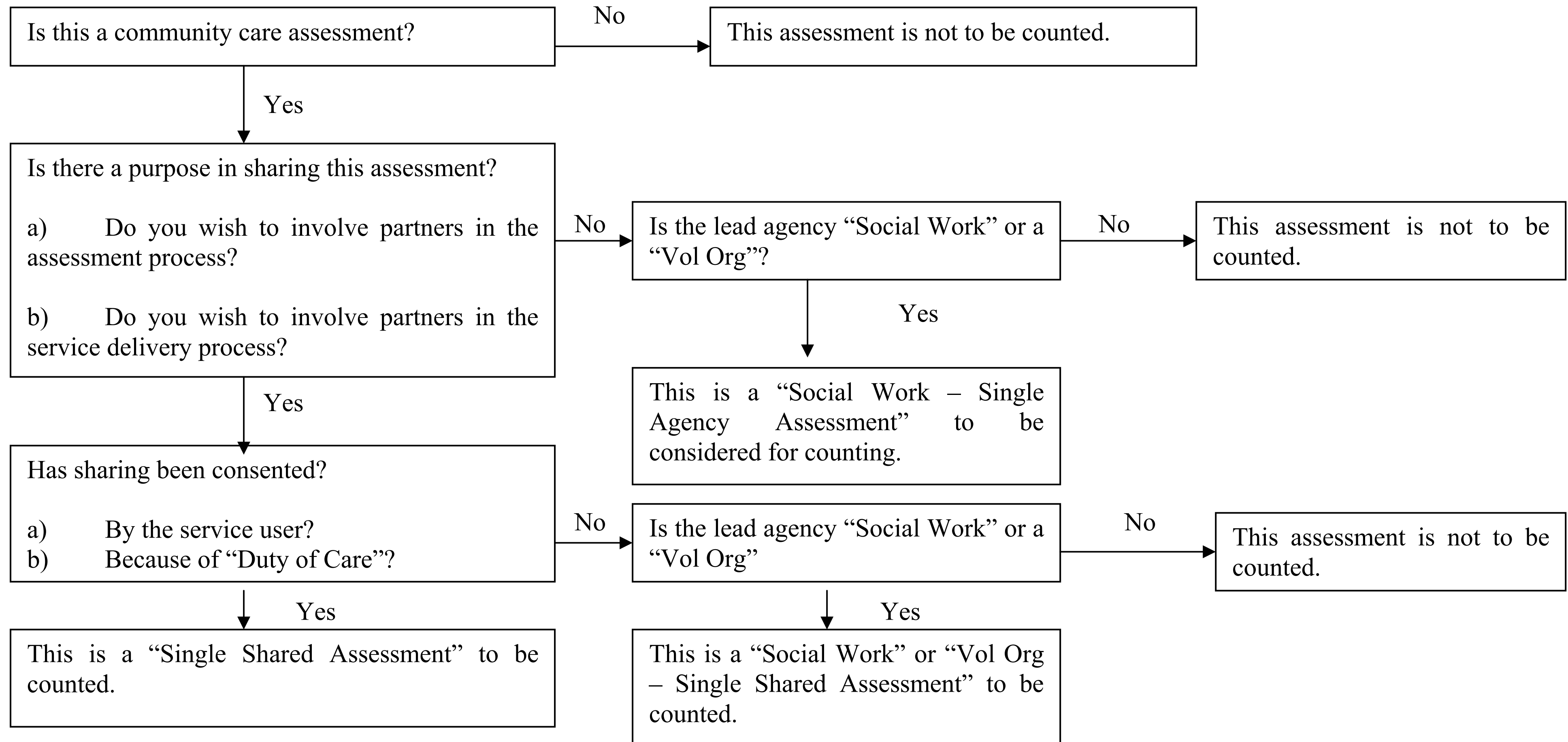
14.5 Numbers of Carers Assessed

The numbers of carers assessed is the number of carers whose assessment is completed in the reporting period, irrespective of when the contact was made that led to the assessment process. Carers should be counted only once in the reporting period.

ANNEX A

JPIAF 6

Definition of Single Shared Assessment & Social Work or Vol Org – Single Agency Assessment



APPENDIX 1

ANNEX B

SERVICE USER GROUP CATEGORIES

	Service User Group	Definitions and subgroups
a)	Elderly people aged 65+ without dementia	**All people aged 65+ without dementia.**
b)	Elderly people aged 65+ with dementia	**All people aged 65+ with dementia**. **Dementia** is a global deterioration of intellectual functioning. Normally a progressive condition resulting in cognitive impairment ranging from some memory loss and confusion to complete dependence on others for all aspects of personal care. Normally, dementia will be medically diagnosed.
c)	People aged 18-64 with mental health problems	**People aged 18-64 with mental health problems (other than dementia)**. Mental health problems are characterised by one or more symptoms including: disturbance of mood (e.g. depression, anxiety), delusions, hallucinations, disorder of thought, sustained or repeated irrational behaviour. Include: persons assessed as having mental health problems whether or not the symptoms are being controlled by medical treatment. Exclude: alcohol or drug related problems where these categories best reflect areas of need and record under f.
		People aged 18-64 with dementia. (see definition of dementia above)
d)	People aged 18-64 with physical disabilities	**People aged 18-64 with a visual impairment.** Blindness or partial sightedness (unless problems resolved by spectacles or contact lenses).
		People aged 18-64 with a hearing impairment. Profound or partial deafness and other difficulties in hearing (unless problems resolved by a hearing aid).
		People aged 18-64 with other physical disability or chronic illness. Physical disabilities have many causes in chronic illness, accidents, and impaired function of the nervous system, which, in particular physical or social environments, result in long term difficulties in mobility, hand function, personal care, other physical activities, communication, and participation. Include: severe epilepsy; limb loss; severe arthritis; diseases of the circulatory system (including heart disease); diseases of the central nervous system (e.g. strokes, multiple sclerosis, cerebral palsy, spina bifida and paraplegia).
e)	People aged 18-64 with learning disabilities	**People aged 18-64 with learning disabilities.** A significant, lifelong condition which has three facets: • significant impairment of intellectual functioning resulting in a reduced ability to understand new or complex information; and • significant impairment of adaptive/social functioning resulting in a reduced ability to cope independently; and • which started before adulthood (before the age of 18) with a lasting effect on the individual's development.
f)	People aged 18-64 with drug/ alcohol abuse problems	**People aged 18-64 with alcohol-related problems**. Any person who experiences social, psychological, physical, or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her use of alcohol.
		People aged 18-64 with drugs-related problems. Any person who experiences social, psychological, physical or legal problems related to intoxication and/ or regular excessive consumption and/or dependence as a consequence of his/her use of drugs or chemical substances.
g)	Other and service user group not known – 18-64	People with AIDS/HIV, vulnerable people who are homeless or people whose service user group is not known. Excludes: people in multiple service user groups and with acquired brain injury: code these to the service user group representing the most significant needs.