



## **A – Z Introductory Guide to Health and Social Care in Scotland**

### **Single Shared Assessment**

#### **Brief Description**

Single Shared Assessment is a streamlined, person-centred assessment that aims to provide users of health and social care services faster access to the services they need by co-ordinating access to services via one lead professional.

#### **What it aims to do**

Single Shared Assessment is intended to provide:

- a faster track to services and a faster journey along the tracks;
- a single point of entry to community care services;
- a holistic, structured approach to the assessment;
- less bureaucracy, duplication and delay;
- information shared between professionals and agencies appropriately; and outcomes accepted by fellow professionals.

The Single Shared Assessment should seek information once, through a lead professional who co-ordinates documents and shares appropriate information, co-ordinates all contributions, and produces a single summary assessment of need. The assessment should actively involve people who use services and their carers and should seek to provide results acceptable to them and to all agencies that are involved.

#### **The National Picture**

Faster access to services is one of four Key National Outcomes agreed by the Health and Community Care Ministerial Steering Group in February 2004. Single Shared Assessment is central to delivering that outcome. To support the outcomes, local partnerships are required to set their own Local Improvement Targets (LITs), some of which cover Single Shared Assessment. LITs should include:

- waiting time for assessment;
- time taken for assessment to be completed;
- time taken for first part of care package to be delivered;
- increasing numbers of carers' assessments; and
- user/carer satisfaction with Single Shared Assessment

[There is a separate entry on Local Improvement Targets in this A-Z Guide to Health and Social Care, and you can find out more on the Joint Future website.]

## **Key Developments**

Single Shared Assessment for older people was introduced from April 2003, and extended to all community care groups from April 2004. Every area has an assessment tool and is working towards a common data set for older people. SSA is also the catalyst for the information sharing arrangements in place in every area. Electronic assessment and information sharing should be in place across Scotland by March 2006.

The Executive has defined what counts as a Single Shared Assessment (Circular CCD 7/2004, available online via the Joint Future website) and is now collecting information on the number of assessments and the waiting times from referral to first service delivery.

An integral part of the SSA is the Indicator of Relative Need (SSA-IoRN), which draws information from the SSA to place individuals in bands of relative levels of need. The SSA- IoRN supports professionals and managers in decisions about the use of resources and the planning of services. All areas should be using SSA-IoRN by March 2006.

## **Where can I find out more?**

Single Shared Assessment is an integral part of Joint Future. Visit the Joint Future website for more information and contact details for the policy team that leads on this area of work:

<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Introduction>