SCOTTISH EXECUTIVE

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Joint Future Managers
LHCC Managers
Older People Service Managers

Dear Colleague

SINGLE SHARED ASSESSMENT INDICATOR OF RELATIVE NEED (SSA-IoRN)

Introduction

1. This Circular introduces new operational guidance on implementing the Single Shared Assessment Indicator of Relative Need (SSA-IoRN), formerly known as the Resource Use Measure (RUM). It aims to support extending implementation of the SSA-IoRN from the 5 initial sites to the whole of Scotland. The content of the guidance has been heavily influenced by the experience of these 5 sites.

Context

2. As this guidance demonstrates, the purpose of the SSA-IoRN has changed significantly since the early thinking around entitlement to free care. Its function has shifted to supporting professionals and managers in decisions about the use of resources and the planning of services. And being an integral part of the single shared assessment brings it into the heart of the person centred agenda. The SSA-IoRN can therefore contribute to delivering Joint Future's wider goals of better and faster access to services.

3. This guidance also reflects the greater integration of elements of Joint Future, in particular Single Shared Assessment (SSA), the Indicator of Relative Need, e-Care and Data Standards. Single Shared Assessment is the pivotal feature: the other elements should integrate around it. The SSA-IoRN, for example, is a standardised process that emerges directly from the SSA. The change of name reflects the changing purpose of the tool. The "Resource Use Measure" was conceived to determine entitlement to free care. As it developed the purpose changed from a measure of resource use to a standardised measure of relative need. The new title more accurately reflects its use. We advised interested parties of the change on 1 April 2004. These changes have been strongly influenced by the initial 5 sites and welcomed by stakeholders across Scotland.

The Guidance

4. There will be two key elements to the operational guidance:

(1) practitioner/user handbook available in a ring-binder folder aimed at frontline practitioners with the basic details regarding SSA-IoRN as a process and the benefits to practitioners. The practitioners handbook will be distributed across partnership areas to be made available to frontline practitioners for the roll-out plans.

(2) CD ROM with full operational guidance for roll-out plans aimed at a strategic level for managers, planners and trainers who will be implementing the SSA-IoRN. There are 10 CD ROMS available for each partnership area. These will be distributed to LHCC and Joint Future Managers, SSA Leads and Older People Service Managers. The full pack will also be available on the Joint Future website (**http://www.scotland.gov.uk/about/HD/CCD2/00017673/Home.aspx)** and will be updated as required by the Joint Future Unit.

Implementation

5.. The Scottish Executive will continue to provide support to partnership areas with the implementation process. Between January-March 2004 the majority of partnership areas had briefings to provide an update on the SSA-IoRN implementation process, with the remaining briefings being arranged during April-May. Partnership areas are currently confirming their plans for the roll-out and implementation of SSA-IoRN, which will be indicated in their Extended Local Partnership Agreements due at the end of April 2004. Work will continue over the next 3 months to push forward the Joint Future Agenda through the more integrated approach above and we will provide further information in support of these arrangements on the JFU website.

Review of Early Implementation

6. A short term review of early implementation within the 5 sites will be published in May. It will be available through the Scottish Executive Publications website (www.scotland.gov.uk/publications/recent.aspx). Copies of the report will be sent to the 5 participating sites.

Action

7. Local authorities and their partners should now be well placed to develop and progress their plans for the implementation of SSA-IoRN over the period 1 April 2004-31 March 2006.

Enquiries

8. Enquiries about this circular should be addressed in the first instance to Brenda Kerr, Joint Future Unit, Scottish Executive Health Department, Community Care Division 2, 3rd Floor East Rear, St Andrew's House, Edinburgh EH1 3DG (telephone 0131-244 3744). Professional issues should be referred to Winona Samet (winona.samet@scotland.gsi.gov.uk or telephone: 0131 244 5317) or Margaret-Anne Dale (Margaret-anne.dale@scotland.gsi.gov.uk or telephone: 0131 244 5331).

7. This circular is also available on Scottish Health on the Web (www.show.scot.nhs.uk/sehd/ccd.asp). Further copies are available by telephoning or e-mail. It will also be available on the JFU website where practical advice and updates are found.

Yours sincerely

Adam Rennie

ADAM RENNIE

SINGLE SHARED ASSESSMENT – INDICATOR OF RELATIVE NEED

OPERATIONAL GUIDANCE
USERS' HANDBOOK

Joint Future Agenda:
improving joint working, improving services,
improving lives

OPERATIONAL GUIDANCE
USERS' HANDBOOK

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SINGLE SHARED ASSESSMENT – INDICATOR OF RELATIVE NEED (SSA-IoRN) IMPLEMENTATION OPERATIONAL GUIDANCE

Renaming the Resource Use Measure (RUM) to Single Shared Assessment – Indicator of Relative Need

The Scottish Executive Joint Future Unit have agreed in consultation with representatives from the partnership areas to review the term Resource Use Measure (RUM) in order to more appropriately reflect the fact this is a standardised process which "falls out" of the **Single Shared Assessment** and provides an indicator of relative need.

In terms of the operational guidance for practitioners and managers which has been developed in partnership with our implementation sites, there are references to the RUM. A decision was made to retain the RUM identity for some material, however, in terms of future implementation and roll out plans from 1 April 2004 we will use the term **"Single Shared Assessment – Indicator of Relative Need"**.

This is a significant milestone in terms of the development and implementation process, which we believe has been driven by the front-line practitioners, who have had a "strong voice" with the Scottish Executive in terms of shaping social policy and implementation plans.

Introduction

The operational guidance has been produced to assist partnerships implement the SSA-IoRN across Scotland and will provide a useful reference/guide for both practitioners and managers. The *Users' Handbook* is aimed at practitioners, for use on a day-to-day basis, the *Resource Pack* provides more detailed information for reference purposes. This guidance will support the implementation process benefiting from the experience gained during the development and initial implementation phase of SSA-IoRN. It covers a range of issues on a broad basis from experience without being too prescriptive. We plan to issue the *Users' Handbook* in a ring binder file to allow it to be updated as implementation evolves. The *Resource Pack* will be on CD ROM only and each partnership area will receive 10 copies. The *Users' Handbook* and *Resource Pack* will also be available on the Scottish Executive Joint Future Unit (JFU) website from April/May 2004. Any updates to the guidance will be placed on the website only.

Background

Single Shared Assessment (SSA) for older people needs to be in place before the SSA-IoRN can be applied. The SSA is key to providing good quality information on the individual's needs which will enable the practitioner to respond to the specific SSA-IoRN questions.

The SSA-IoRN is a questionnaire comprising 12 questions that draw on the information a practitioner will already have gathered from an individual's assessment of need (SSA). The SSA-IoRN will place people over the age of 65 into groups according to their level of relative need. The development of the SSA-IoRN originated from the Minister for Health and Community Care's response to the Royal Commission on Long Term Care October 2000. Its development was undertaken within the framework of the Joint Future Agenda and is consistent with the principles underpinning joint resourcing, joint management and single shared assessment.

Development

The development process was an interactive process drawing on the expertise of front-line practitioners and managers. Development was undertaken in 2 phases: the first phase involved 4 partnership areas which increased to 9 testing 2 questionnaires. The data was subsequently analysed which resulted in one questionnaire being produced. The second phase involved 29 sites testing the new questionnaire. Following the development phase the Report on the Development of a Resource Use Measure for Scotland (circular CCD 9/2002) and recommendations was presented and accepted by Ministers in August 2002. Incremental implementation across Scotland started in January 2003 within 5 partnership areas; Orkney, Perth and Kinross, East Renfrewshire, South Lanarkshire and Glasgow.

Early Implementation

The 5 sites began implementing the SSA-IoRN within defined geographical patches in January 2003. Work has been ongoing and the SSA Team continue to support these sites. To support implementation a Learning Network was established in June 2003 to bring key people (practitioners, managers, IT representatives) from the early implementation sites together to share knowledge and address implementation issues. Members of the Learning Network have played an integral part in progressing implementation and have informed a number of issues such as the Direct Access paper, rewording of the guidance within the questionnaire, planning uses, Care Assessment Data Summary (previously known as RUM-ICADS), the training framework, the quality assurance framework and the early evaluation work.

Experience from the sites has indicated that some of the key components that will help partnerships implement the SSA-IoRN are:

- co-located/integrated teams
- meeting Joint Future Agenda aims/objectives
- good leadership
- good support frameworks both locally and nationally

Training

Partnerships will have a range of training plans to cover different areas including induction, specialist on the job training etc. A training framework based on the experience of the 5 partnership areas has been produced to guide implementation in other areas for the phased roll-out. This can be found within the Resource Pack available from the Joint Future Website http://www.scotland.gov.uk/about/HD/CCD2/00017673/Home.aspx. Copies of the SSA Team's Briefing and Guidance for Implementation and Process Summary are enclosed within this pack.

Quality Assurance (QA):

During early implementation a quality assurance exercise was undertaken within the 5 sites and a report detailing the results are published in the Resource Pack. It was agreed that partnerships would develop local protocols within a Quality Assurance Framework. A Quality Assurance Framework was subsequently developed in partnership with the Learning Network and is available in the Resource Pack.

Direct Access

During early implementation it became apparent that some partnership areas would not be applying the SSA-IoRN to every assessment of older people. Some areas were looking at direct access for certain services without the need for a full assessment. A scoping exercise and report was produced and is published within the Resource Pack.

Planning Uses

The use of SSA-IoRN as a planning tool will develop and evolve during the implementation process. The early implementation sites undertook a consultation exercise to consider initial experiences and potential uses of the SSA-IoRN. Examples from each of the early implementation sites can be found in the Resource Pack. The RUM-ICADS paper also outlined possible uses of the SSA-IoRN.

IT

During implementation close links have been maintained with eCare and SSA developments. IT and information sharing systems will continue to evolve and, with the help of Modernising Government Funding (MGF) more robust IT systems will be in place to help partnerships with SSA and SSA-IoRN. The SSA-IoRN has been incorporated into Carenap. Partnerships who are about to develop or developing their own IT systems should consider incorporating the SSA-IoRN. One partnership who have already done this is South Lanarkshire. They have incorporated SSA-IoRN into their SWiSplus (social work IT system) and are currently incorporating it into PIMs (Health IT system).

Review of Early Implementation

A review on the early implementation of SSA-IoRN within the 5 sites was undertaken by Craigforth Consultancy. The main aim of the work was to review the processes used to implement the SSA-IoRN, highlight what went well, any problems encountered and how the problems were dealt with. The Report and Research Findings are in the process of being published. Following which these will be available through the JFU website (address noted below).

Further Information

Further information on the Joint Future Agenda generally and/or SSA-IoRN can be obtained at http://www.scotland.gov.uk/about/HD/CCD2/00017673/Home.aspx.

RUM – RESOURCE USE MEASURE OVERVIEW REPORT

This was an article which was produced for the Nuffield Database of Good Practices "Community Care Works". They published this on their website during February 2004. This document outlines the development and early implementation of the RUM and for that reason we have referred to RUM instead of SSA-IoRN throughout.

The Joint Future Unit at the Scottish Executive is charged with the RUM development and implementation. The RUM Project Team with information specialists within the Information and Statistics Division (ISD) of the Common Service Agency (part of NHSScotland) provides us with a progress report on the development and implementation in the first 5 sites, as part of the phased roll out over 2004-06.

Introduction

This article is an overview of the development and early implementation of the Resource Use Measure (RUM). The article will describe some of the achievements made in gaining practitioner and management involvement and buy-in to the RUM process, and discusses some of the identified benefits that are expected to accrue from the RUM in the longer term. The RUM is currently in the early stages of a phased roll out across Scotland in line with the Next Steps Letter, February 2003 requiring RUMs to be completed for older people over 65 years following their Single Shared Assessment (SSA).

As understanding and knowledge of the benefits and application of RUM increases it is hoped that participation and involvement in this exciting and innovative development will extend across Scotland.

Key areas

- **Background/Development**
- **Joint Future Agenda**
- **Single Shared Assessment**
- **RUM – What is it?**
- **Development and early implementation phase**
- **Completion of the RUM**
- **SSA implementation process issues**
- **Wider context**
- **Ultimate aims and goals**
- **Review of early implementation**
- **RUM– operational guidance to support roll-out**
- **Quality Assurance**
- **Training**
- **Using RUM for planning**
- **Conclusion with snapshot of experiences**

Background/Development

RUM for older people had its origin in the recommendations of the Royal Commission on Long Term Care (October 2000). The response by the Scottish Executive to the report of the Royal Commission and the subsequent *Chief Nursing Officer's Report* published in January 2001, provided the authority for the initial development work. Originally, RUM was conceived as a possible measure of the level of resource use in relation to free nursing care.

However, during the course of the development phase, the initial work to create a robust measurement tool, the emphasis changed from a measure of resource use to a measure of relative need. The outcome is a RUM as a standardised process which "falls out" of the Single Shared Assessment of individual need, with minimal extra effort by the practitioner carrying out a SSA. The RUM provides a summary classification of overall relative need. The RUM will provide a standardised measure of need which practitioners/managers can use to support strategic planning, caseload management and, through time, to record comparisons and trends.

The development of the RUM was led by the Scottish Executive Joint Future Unit in partnership with information specialists within the Information and Statistics Division (ISD) of the Common Service Agency (part of NHS Scotland), and a range of practitioners and managers delivering older peoples services in Scotland.

Joint Future Agenda

The context for RUM is within the Joint Future Agenda which aims to improve people's lives, improve services and improve outcomes. At the heart of the Joint Future Agenda is the service user, who has a right to an assessment of their needs. The outcome of which may result in a range of "seamless services" across agencies which could allow them to remain at home in the community. Within the Social Work Scotland Act 1968 (as amended) by the Community Care and Health Scotland Act 2002, the responsibility for the assessments of need for community care services, lies with the local authority.

Single Shared Assessment

Circular CCD8/2001 on Single Shared Assessment (SSA) reinforced the definition of a SSA as "the subset of community care assessments which must be shared with one or more agency". All 32 partnership areas across Scotland have developed shared assessment frameworks. SSA is the first step for service users towards having their community care needs met. The service user will have a full needs assessment and care plan which will be provided following the SSA process. In terms of care management and review processes, there will be ongoing support provided to the service user.

RUM – What is it?

The RUM is a standard tool that classifies individuals into 9 groups according to their level of relative need. It comprises 12 questions covering 5 characteristics, i.e. activities of daily living, personal care, food and drink preparation, mental well-being and behaviour and bowel management (Section 4). The RUM draws on the information a practitioner will already have gathered from an individual's assessment of need. The practitioner will complete the RUM on completion of the SSA. By drawing on the good quality information on the individual's needs and characteristics identified in the SSA practitioners are readily able to respond to the specific RUM questions. We recommend that the RUM is applied by the lead practitioner following the assessment when sufficient information has been gathered to inform the individual's care plan. It is important to emphasise that the RUM is only applicable to older people over 65 years. The RUM is not a substitute for an assessment of individual need, and it should not influence the individual's care plan.

The 9 RUM groupings range from A (low need) to I (high need). The RUM group is assigned by practitioners scoring their response to the questions contained within the RUM. The RUM group should be re-calculated when there is a review of the SSA, or significant change in the situation requiring a re-assessment. This means the care pathways for the older person which are mapped through the assessment and review process, can also be tracked with a RUM scoring of relative need.

Development and Early Implementation Phase

During the development phase, 2 questionnaires were designed and tested with a range of questions relating to the assessment of need. A single final questionnaire was then developed, tested and subsequently refined into the RUM tool. The development phase lasted just over 2 years, and involved an interactive process with the direct experience of front-line practitioners and their managers, crucial to the final design.

The first phase involved initially 4 partnership areas increasing to 9, in the design and testing of the 2 pre-RUM questionnaires. The testing of the single prototype RUM questionnaire involved 29 teams from 24 partnership areas.

At the end of the completed development phase a detailed RUM project report was prepared and this, along with the recommendations, was presented to and accepted by Ministers in August 2002. The Circular CCD9/2002 confirmed the requirement of all partnership areas to use the Resource Use Measure (RUM) to inform the planning process.

Incremental implementation across Scotland commenced in January 2003 with 5 partnership areas: Orkney, Perth and Kinross, East Renfrewshire, South Lanarkshire and Glasgow.

In September 2003 follow up with the other partnership areas was undertaken in order to establish timescales and targets to achieve full implementation across Scotland in line with the Ministerial decision. Between January to March 2004, briefings are being undertaken with partnership areas to provide an update on the RUM implementation to facilitate roll out plans. It is anticipated full roll out will be achieved by 2006, with partnerships becoming directly involved over the next 2 years.

There is a major exercise to provide updated information from the current implementation process to inform partnerships of the benefits of the RUM. Inevitably there are many misconceptions and concerns about RUM, but it is anticipated that with proper information and understanding, these reservations can be alleviated. Effective communication is vital for this and with information being regularly updated on the JFU website, publication of information within the "Database of Good Practice" and input into a range of forums and networks underway, it is hoped that good progress can be made.

The 12 questions in the RUM tool cover the broad areas of relative need for example in terms of mobility, bowel management. Previously described in earlier paragraph how RUM is scored.

Completion of the RUM

The RUM tool is fundamentally a questionnaire covering the main areas from the assessment of need which results in groupings into relative need. The aim is to integrate the RUM fully within the SSA process. In time, this will be achieved through the development of appropriately integrated IT systems. The practitioner would complete an SSA and the RUM questions would be populated from this data. The ability to achieve this level of sophistication is the challenge ahead for the e-Care developments.

Across the 5 early implementation sites different SSA tools are in use and the RUM tool is both manually and electronically completed.

At present there are 2 main approaches to completing the RUM that can be described.

1. Practitioners fill in the RUM Questionnaire manually following the SSA being completed. This takes approximately 3-5 minutes, and is easily completed following the full needs assessment. The practitioner manually calculates the scores which are added to give the overall RUM grouping. This information is then attached to the SSA record and entered manually on to an Excel spreadsheet for overall comparisons and planning uses at the locality level.
2. SSA and RUM integrated through Carenap application. This has been developed with SEMA Schlumberger and piloted in the Western Isles. This will enable practitioners to complete SSA and RUM as a single sequential process. Similarly the SWiSplus development in South Lanarkshire also has the RUM questionnaire integrated within the SSA process. A range of questions require to be completed, or will move to default and a score of 1 allocated.

The future should be a SSA process with RUM integrated, resulting in a pre-populated RUM calculation. This is the ultimate aim, is beginning to take shape, but will not be available in the short term to assist implementation.

The Issues and Challenges of Implementation

The experience from the 5 implementation sites over the last 12 months has been invaluable. Practitioners and managers continue to be involved in the development and consolidation of the RUM tool. The Learning Network established in June 2003 brought together key people involved from the early implementation sites to share knowledge and address implementation issues. From the experience gained, it is clear that the Learning Network has been a major driving force consolidating SSA and RUM as an integrated process.

The issues which have been addressed at the Learning Network, supported by small task groups and consultation processes, have been wide ranging. Over the last 6 months an Action Plan to support the development and implementation schedule was developed identifying key objectives, targets and timescales for completion. The aim has been to document lessons from early use of the RUM and compile the guidance for operational implementation to assist with roll out plans from April 2004.

Practitioners and managers have continued to raise issues and offer solutions to resolve issues arising from the use of the RUM, with the objective of finalising operational guidance that is relevant and meaningful. The Learning Network has underlined the developing and evolving nature of the process, along with the commitment from the Scottish Executive to continue to listen to the experience from the front line.

SSA Implementation Issues

One major issue, raised consistently during the implementation process, is the direct relationship between the SSA process and the RUM tool. The practitioners and managers involved have confirmed the main concerns is to ensure the SSA process is right. Completion of the RUM tool is relatively straightforward if the SSA process is appropriate.

The issues around RUM implementation have been reflected in the experience of SSA implementation. The 5 early implementation sites have different approaches to SSA. Two partnership areas follow the Scottish Executive's definition of SSA in CCD8/2001 and RUMs are not completed for every older person referred for a needs assessment. Three partnership areas interpret the guidance more widely and use the SSA core documentation for all assessments. Consequently they are completing RUMs for every older person who has an assessment of need.

The guidance on SSA is not prescriptive as to a model and aims to facilitate local needs. The current consultation process on the Joint Performance Information and Assessment Framework (JPIAF) which aims at providing key performance measurements on assessment, has raised similar issues of consistency and standardised definitions for measuring performance. The JPIAF will define how to count SSAs but will not dictate how SSAs should be carried out.

In support of the RUM implementation an investigation was undertaken in terms of the implementation of Direct Access to Services by older people across Scotland. The findings confirmed that variation across partnership areas to RUM implementation was primarily a consequence of different approaches to SSA implementation. In the light of this variation it is as yet unclear how consistent comparable data at national level for comparison purposes can be assured.

Wider Context

Joint Future has moved from theory to delivery over the last year. The Joint Future Implementation and Advisory Group (JFIAG) has set out the expectations for delivery, enhanced by Mr Tom McCabe's (Deputy Minister for Health and Community Care) initiative to "re-invigorate Joint Future", that focuses in particular on moving from process and systems to outcomes for people who use services and their carers. Maintaining the momentum and delivering the results of Joint Future is essential. Achieving the full roll out of RUM, in tandem, to support that agenda is crucial. SSA is the centre of Joint Future. It needs to be effective in its own right; but it also has to dovetail with other key components such as joint resourcing and joint management to deliver speedier access to services and more effective results. Delivering on RUM across 32 partnerships in this complex environment is a challenge, but one that we intend to achieve.

Consequently the aim of the Scottish Executive through the direct work by the RUM Project Team within the Joint Future Unit is to support, encourage and facilitate this harmony. This will be achieved through the co-ordination of the key components of the wider agenda. The SSA and RUM Learning Networks will become a more integrated model, within the broader Joint Future Agenda.

The overall linkages between SSA, RUM, e-Care and Data Standards are also becoming clearer as a result of this work. The consultation process on the RUM-ICADS (Integrated Care Assessment Data Summary) has also highlighted the need for the effective inter-relationship across the major components, which influence and directly bear on the Joint Future Agenda.

RUM-ICADS aims to provide a national dataset which will facilitate local and national planning of services for Older People. The RUM grouping on its own strength does not provide the whole picture of needs. Therefore, the broader context has been set within the RUM-ICADS. Key components include gender, date of birth, carer involvement, service provided, geographical area which has an overall objective in terms of achieving a more standardised approach to data gathering. The e-Care developments for the next stage of the Modernising Government Funding (MGF3) bids requires a consistent data standards model integral to the system. The current work with the RUM-ICADS consultation process, the JPIAF consultation process, SSA experiences and RUM implementation are all informing this broader base.

Ultimate Aims and Goals

Through the development of a RUM-ICADS national dataset, which is informed by a service user's assessment of need and their relative needs grouping (RUM score) there will be an opportunity to map out across Scotland the full needs of older people who have a SSA. Ultimately this information should facilitate service delivery, service design, commissioning and re-development of services to ensure the balance of care is appropriately targeted at the needs of older people.

It is acknowledged RUM is not the only factor in this broader planning and strategic framework, however, it is a crucial and key component. Therefore, the Scottish Executive through requiring partnership areas to implement RUMs at locality level, are ensuring the benefits of the 3 years of development work is maximised.

The RUM Project Team are fully committed to this development and integrated approach. In order to raise the profile on the RUM, its potential, value and uses an approach to promote RUM is being adopted. Further information and details are available on the website (http://www.scotland.gov.uk/about/HD/CCD2/00017673/Home.aspx), or through direct contact with the team.

A national conference is being planned for early spring 2004 to promote the Joint Future Agenda, reviewing current progress and the way ahead. RUM is integral to this agenda, and it is hoped, by word of mouth, direct experience, increased awareness and direct evidence of the benefits of RUM will result in the broader participation and involvement of partnership areas within this very stimulating and encouraging piece of work.

Review of Early Implementation

We have commissioned a study of the experience of the 5 early implementation sites. This work commenced in October 2003 and the final report is due at the end of January 2004. This work will review the processes involved in the implementation of RUM, highlighting the areas of good practice, the problems encountered and how they were dealt with. An Executive Summary and full report of the research findings will be available through the Scottish Executive publications website (www.scotland.gov.uk/publications/recent.aspx).

RUM Operational Guidance to Support Roll Out

We will provide RUM operational guidance to support the roll out and assist implementation generally. The reference and guidance for practitioners and managers will be covering a broad range of issues. The framework to assist implementation will be available in a ringbinder file in order to update and review over the phased roll out 2004-06. The information will be gathered from the experiences of the 5 implementation sites.

Quality Assurance

The quality assurance process incorporated within the operational guidance was devised from the experiences during the implementation process. Local partnership areas will be developing their own QA arrangements across a range of areas. However, in order to ensure the validity and reliability of the RUM data, it is intended to develop a national QA process to monitor and validate the RUM tool throughout implementation and roll out.

The summary report from the QA experience of the 5 implementation sites is already available on the JFU website. This has the experience from the 5 sites detailed and key areas to be considered are reported.

Training

Throughout the process of the RUM roll out and implementation process there has been regular training provided and delivered from the joint Scottish Executive and ISD team. Within the Resource Pack the full briefing and training notes to facilitate roll out plans are included.

It is intended to provide training for local trainers to support the future roll out plans. The experience from 5 implementation sites has confirmed RUM training should be integral with SSA training and delivered at locality level by the partnership areas.

Using RUM for Planning

The uses of RUM as a Planning Tool Initial Scoping Paper, November 2003 was updated for the Learning Network in February 2004. Work is being progressed with each of the 5 implementation sites with the RUM Project Team and ISD to support the localities.

There has been work undertaken across all the areas and examples of using RUM for planning will be provided within the RUM operational guidance. Orkney have been using the RUM data to inform their Older People's Strategy, January 2004. Perth and Kinross have been developing work around direct access to services through the analysis of the RUM data. South Lanarkshire Council is considering the use of RUM data within local teams and practises and council/health partnerships particular interest in planning uses around hospital discharges.

All 5 implementation sites are interested in comparisons of RUM groupings in the community settings and care homes, age groupings and RUM scores, and level of carer input. This work has also been directly related to the RUM-ICADS developments, which will pilot the broader national dataset in the 5 partnership areas from April 2004.

Conclusion

The RUM is an important part of the wider implementation of Joint Future. It is new. It is different; and it has both its admirers and its critics. Its development has been successful due to a combination of commitment at the centre from the Executive and the high level of commitment and support locally from front line operational staff. We thank in particular the practitioners and managers from the early development phase and the current implementation phase for all the hard work. It is to their credit, despite other pressures, competing priorities and often the lack of IT systems (resulting in paper based approaches), that the RUM roll out has progressed. There are many challenges ahead, but we are determined to see RUM as part of the mainstream of community care in Scotland.

This is the view from the Joint Future Unit. What have the implementation sites to say.

Snapshot of Experiences

Perth & Kinross – comments

"The huge benefit to the development of RUM that the Learning Network has had. I am really impressed at the involvement of practitioners on the ground and the way that the Scottish Executive RUM Project Team have taken on board all the issues that they (the practitioners) have raised and actually set time aside and action planned how to address them. This gives staff a real feeling of 'being able to make a difference at a strategic level' as well as encouraging a feeling of ownership of new projects." – Iona Lancaster, January 2004.

Orkney – comments

"We were allowing for 5 minutes to complete a RUM but in practice it takes less than 3 minutes on paper. Doing it on the computer now will be much quicker as the calculations are automatic (and more accurate!).

"We knew that dependency levels at home were growing and care packages were costing more. It was such a relief to be able to evidence that the levels of need were actually commensurate with the needs of people in Care Homes.

"RUMS have helped us evidence the different dependency profiles in our care homes and following the next stage of the pilot we hope it can be used in planning staffing levels for new projects.

"The benefits to us in planning new services is that we can make comparisons between localities to evidence need, we can compare dependency levels with the age profile and we can now record change in dependency levels from our baseline to inform future plans." – Fiona Cowan, January 2004.

South Lanarkshire

"South Lanarkshire Council Partnership implemented RUM in one rural locality and are in the process of rolling out throughout the rest of the partnership area as an integral part of SSA. Social work and health staff were positive about the potential benefits, the score supporting what they knew intuitively especially when seeking and evidencing the need for high care packages. Because within SLC the RUM scoring is integrated into our electronic needs assessment recording system, the implementation went smoothly. Health staff are using the paper score until their own electronic system is ready, but as was anticipated the bulk of RUM scores at this stage are undertaken by Council staff.

For local managers and planners the Quality Assurance exercise highlighted areas within both our Single Shared Assessment processes and our interpretation of definitions that needed fine tuning. The unexpected benefit of RUM implementation was an opportunity to create clearer guidelines and definitions at an early stage. We also have found that staff, so long as the process is kept clear and simple at a time of significant demand on them from other directions, are more than able to embrace the RUM factor and have been keen to contribute both locally and through the RUM Learning Network to the creation of a more robust questionnaire and guidance."

East Renfrewshire

"The RUM Learning Network was a very positive experience involving frontline practitioners. There was a feeling of being actively involved in shaping policy and the RUM tool/voices being heard and comments being included. Informed and informing an inclusive process.

"We derived great benefit from the Scottish Executive's analysis about what we are doing in planning terms. This is a useful partnership for the team and the planning information from RUM will be used to inform local development." – Miriam Jackson, East Renfrewshire.

Glasgow South West

"Response from the team is mixed, and there is more work to be done to progress SSA and RUM integration through an IT solution. There are difficulties with implementation in a larger area and this needs to be recognised and supported. Practitioners need to see the relevance of RUM in terms of their own caseload, in order to take ownership of the process." – Willie Munro, Glasgow South West.

Glasgow North

"In the north of Glasgow it has taken longer to come to terms with SSA and RUM as an integrated process. This has been a long struggle for staff, however staff can now see benefits and are hoping it will have and impact on the services and resources for their clients. Staff are now quite confident using RUM with SSA." – Ian McAlpine, Glasgow North.

The benefits are real, the challenges are strong, but we are fully committed to achieving the Joint Future Unit objectives for improving the services users experience. It is hoped the overview will encourage other practitioners to become involved in this very challenging and stimulating agenda.

SINGLE SHARED ASSESSMENT INDICATOR OF RELATIVE NEED

Process Summary

- Single Shared Assessment – Indicator of Relative Need should only be completed for people aged over 65
- The Single Shared Assessment – Indicator of Relative Need is completed following a Single Shared Assessment
- Single Shared Assessment – Indicator of Relative Need is a questionnaire consisting of 12 multiple choice questions divided into the following sections:
  - Activities of Daily Living
  - Personal Care
  - Food/Drink Preparation
  - Mental Well-Being and Behaviour
  - Bowel Management
- Answer each question using the information contained within the SSA
- Add up the scores for each section
- Use the step-by-step instructions within the Single Shared Assessment – Indicator of Relative Need questionnaire to assign the Single Shared Assessment – Indicator of Relative Need grouping
- Single Shared Assessment – Indicator of Relative Need grouping to be passed on for local collection

SINGLE SHARED ASSESSMENT – INDICATOR OF RELATIVE NEED

BRIEFING AND GUIDANCE FOR IMPLEMENTATION

Introduction:

This guidance has been produced to assist the practitioners in implementing the SSA-IoRN. The guidance has been developed and shaped by the practitioners involved in the early implementation of the SSA-IoRN.

Details on the development of the SSA-IoRN can be found in the report titled *The Development of a Resource Use Measure for Scotland*, which was published by the Scottish Executive Health Department on 24 September 2002. This report can be accessed at the following web address – http://www.scotland.gov.uk/about/HD/CCD2/00017673/ Home.aspx.

The Joint Future Ministerial Steering Group agreed that the SSA-IoRN should be implemented incrementally during 2002-03 in the 5 local authority areas with their health partners. The next steps letter dated 28 February issued by the Scottish Executive confirmed this intention.

We are grateful to these authorities and their NHS partners for their willingness to lead the implementation nationally and to you for your part in using the SSA-IoRN as part of the single shared assessment process.

What is the SSA-IoRN?

The SSA-IoRN is a questionnaire comprising 12 questions that draw on the information a practitioner will already have gathered from an individual's assessment of need. It should be completed following (or as a component part of) a Single Shared Assessment (SSA).

The SSA-IoRN is a tool that has been developed by the Scottish Executive and the Information and Statistics Division (ISD) of the Common Service Agency (part of NHS Scotland) in collaboration with health and social work practitioners to provide a standardised means of grouping individuals according to their relative needs. Its purpose is to promote fair access and equitable distribution of resources for older people.

The SSA-IoRN and SSA

SSA for older people needs to be in place before the SSA-IoRN can be applied. Local authorities and their health partners have been working towards the Joint Future's SSA implementation timetable and have arrangements in place for older people from 1 April 2003.

As outlined above, the SSA-IoRN can only be completed following a needs assessment or SSA. The SSA will provide good quality information on the individual's needs which will allow the practitioners to respond to the specific SSA-IoRN questions. The SSA-IoRN will be best applied by the lead practitioner following the assessment when sufficient information has been gathered to inform the individual's care plan. If the SSA-IoRN is to be effective the SSA must be of a high standard. **It is important to emphasise that the SSA-IoRN is only applicable to older people, it is not a substitute for an assessment of individual need, nor should it influence the individual's care plan.**

Informing Service Users and Carers

In line with best practice for sharing information it is expected that the practitioner will inform the client and/or carer that the SSA-IoRN will be completed as part of the SSA process and share with them details of the group into which they fall.

How will it be introduced?

The work in early implementation has been staged to suit local circumstances and all of the 5 areas began using the SSA-IoRN by early April 2003. A report reviewing the early implementation and which highlights lessons learned will be published in April 2004.

The process for completing the SSA-IoRN will be linked to systems already in place in your area. Some will be using paper systems and others will be more advanced in developing ways of sharing information electronically. Where paper systems are in place the practitioner will calculate the SSA-IoRN score manually using the scoring card. Where electronic systems are well developed it may be possible to complete the SSA-IoRN electronically. Ultimately the aim is to have the SSA-IoRN incorporated into electronic systems that are being developed for SSA and that the SSA-IoRN score will fall out automatically.

Completing the SSA-IoRN:

It is essential that before you complete the questionnaire you read the guidance notes within it. Please answer all the questions.

The SSA-IoRN questionnaire consists of 12 questions covering the following areas:

Activities of Daily Living

Personal Care

Food and Drink Preparation

Mental Well-Being and Behaviour

Bowel Management

A score card is incorporated in the questionnaire to enable practitioners to assign a SSA-IoRN grouping for their client. Scores for the responses to the questions are listed in the right hand column except for Q11 – Mental Well-Being and Behaviour and Q12 – Bowel Management. Scores for Q11 and Q12 are as per the box ticked, e.g. if box 1 is ticked the client scores 1.

Practitioners should complete the front of the questionnaire consisting of client details, date of completion and the SSA-IoRN grouping for the client.

- **When responding to the questions, practitioners must ensure their client's mental health needs as well as their physical needs are taken into consideration.**
- **When responding to the questions, if unsure which option to select, always choose the higher category.**

Section 1 – Activities of Daily Living/Mobility: Q1-3

Q1 relates to a person's ability to obtain adequate nutrition, the question does not refer to a person's ability to cook/prepare meals (these aspects are covered in food/drink preparation). Think about the person's mental health needs and if they require prompting and encouragement to eat but require no physical help, select option D.

Q2 relates to a person's ability to transfer position. If a person is at risk or has a fear of falling and therefore requires observation, refer to the guidelines and select option D.

Q3 refers to transferring on/off the toilet, adjusting clothing and maintaining perineal hygiene. The question does not refer to continence and bowel function; these aspects are covered in Q12.

Score the responses to the questions and write the scores in the boxes relating to the questions.

Add the scores to Q1, 2 and 3 to calculate the ADL score. The ADL score is the most important score when allocating the SSA-IoRN grouping therefore it is important to ensure responses to the questions are accurate, in particular taking account of the client's mental health needs in respect of the questions in this section.

Section 2 – Personal Care: Q4-7

Relate to a person's ability to wash (hands and face, complete wash, wash hair) and dress.

If a person can only do one aspect of the task but not the other, e.g. can dress but not undress, refer to the guidelines and select option C.

If a person has difficulty performing tasks due to mental health or cognitive impairment, consider selecting option D.

Score the responses to Q4-7 and record on page 7 of the questionnaire.

Section 3 – Food and Drink Preparation: Q8-10

Relate to preparing food and drinks to obtain sufficient nutrition and hydration. Again, if a person has difficulty undertaking these tasks due to mental health or cognitive impairment refer to the guidelines and consider selecting option D.

Score the responses to Q8-10 and record the scores at the bottom of the page 7. **To calculate the personal care/food and drink preparation score, calculate the total score for Q4-10.**

Section 4 – Mental Well-Being and Behaviour: Q11

When responding to Q11 consider whether the person has exhibited any of the behaviours in the **previous 4 weeks only**. We acknowledge there may be a subjective judgement when assessing if the behaviours have occurred. If a behaviour presents itself but does not cause a problem to the person or others, it should still be recorded as having occurred.

Q11 D, E and F – if the initial response to the questions is "sometimes", then record as **"yes"**.

The scores for the questions are simply the value of the box ticked, either 1 or 2. Calculate the total score for **Q11 A-F** and record at the bottom of the page.

Section – 5 Bowel Management: Q12

Relates to assistance with bowel management and constipation.

No scoring is required for this question. The person is allocated to either a no/low bowel management group or a high bowel management group as detailed in the box on page 11.

Assigning Client to SSA-IoRN Grouping

The scoring of all responses is essential. Follow the guidance on page 12 of the questionnaire.

There are 2 stages involved:

Step 1 – allocate the ADL group, based on the ADL score on page 3.

Step 2 – go to the relevant box depending on the ADL group, e.g. medium ADL group, go to box 2.

The diagram on page 13 will assist when assigning the SSA-IoRN grouping.

Please remember…

Read the guidelines in the questionnaire to assist in responding to questions.

Answer all the questions.

If you have any queries, please refer to your local SSA trainer in the first instance.

Quality Assuring the Data

A Quality Assurance Framework has been developed in partnership with the early implementation areas. This will aim to ensure the effectiveness of the SSA-IoRN by ensuring that all teams are able to use the SSA-IoRN correctly, accurately and consistently.

Aim of QA Exercise

The main aim of the QA exercise is to support the implementation process. The QA programme will seek:

- **To identify problems early on**
- **To assess data quality at partnership level**
- **To help specify arrangements to ensure quality data in the longer term.**

The QA program is <u>not</u> designed to assess the performance of individual members of staff in completing the SSA-IoRN forms, but to identify problems with the interpretation of the SSA-IoRN questions and the arrangements for collation of data and completion of the SSA-IoRN.

Elements of QA Strategy

The quality and completeness of the data should be assessed using the following methods used during the initial SSA-IoRN implementation program:

- **Inter-rater checks – different scorers of same person**
- **Documentation checks – to ensure the responses within the SSA-IoRN are consistent with SSA documentation**
- **Feedback – ranked listings of clients by SSA-IoRN group to practitioners/teams and inter-rater results**
- **Calculation of SSA-IoRN Groups – ensure that scoring of the SSA-IoRN questionnaire is correct**
- **Completeness – Comparison of number of SSA-IoRNs against number of SSAs completed**

The inter-rater test is designed to pick up problems of differing interpretation of questions and between different staff members. The problems may relate to the availability of written case documentation to staff completing the SSA-IoRN. Issues may need to be resolved by further training and discussion.

Documentation checks will be carried out locally within each site to check how much of the information required to complete the SSA-IoRN is documented.

Feedback to practitioners should include:

- lists of anonymised client data in SSA-IoRN group order. This will allow staff to see if the order in which the SSA-IoRN places their clients reflects their own interpretation of the clients' level of need
- results of the inter-rater test
- results of documentation checks.

Completeness – checks will simply require a count, for each participating team, of the number of clients receiving an assessment within the relevant time period and a count of the number of SSA-IoRN forms completed within the same period.

A person should be identified within the local area as being the person responsible for carrying out QA.

Using the Data:

The main aims of the SSA-IoRN data collection are to support service delivery at the level of the individual practitioner and the local team. High quality information for planners, policy makers and managers in local authorities and the Scottish Executive should flow from a system that delivers for front line staff.

The linkage of SSA-IoRN data, both internally and externally to other related data gives the potential to describe patient/client pathways of care, the flows of patients/clients along those pathways, the impact of particular conditions and events on needs, and, ultimately a comprehensive picture of patient/client care services for the elderly and their relation to need.

The availability of such information allows comparisons of service levels between local teams and partnership areas to be made which take into account variations in client/patient circumstances, prior history and dependency and overlapping inputs from other agencies providing care. Such information would support:

- **The individual practitioner in managing their case load**
- **Local managers in prioritising and workload allocation.**
- **Council and NHS partnerships in planning and budgeting.**
- **Scottish Executive service monitoring and policy development, including information on access to services and equity of provision.**

Frequently Asked Questions (FAQs)

- **Question** – Can you define the care providers that will apply the SSA-IoRN in relation to private residential nursing homes?

- ***Response*** – Anyone over the age of 65 who has a single shared assessment (SSA) and/or review should automatically have a SSA-IoRN applied thereafter. Care providers will not be expected to apply the SSA-IoRN because it is unlikely they will be carrying out the SSA.

  However, the SSA-IoRN team will be working with the Care Commission on how the SSA-IoRN might be developed to inform staffing levels. The small pilot undertaken to test the applicability of the SSA-IoRN in care homes as part of Phase 2 development was inconclusive. Further work requires to be undertaken in collaboration with the Care Commission.

- **Question** – Can you expand on how you collected the data on recording "unmet" need via the practitioners applying SSA and the SSA-IoRN – in order to accurately collate this information?

- ***Response*** – During the development of the SSA-IoRN, part of the exercise was to gather information on unmet need. That is practitioners were asked to record the number of hours of unmet need per older person per week. This information was aggregated and assisted in the process of informing the SSA-IoRN groupings of relative need.

  In order to manage unmet need and plan services for older people systems will need to be in place for aggregating the SSA-IoRN scores locally and recording unmet need and for collecting data nationally. Work is underway with the first five implementation sites which will inform national information requirements.

- **Question** – How is the SSA-IoRN going to be analysed locally?

- ***Response*** – Health/LA statistics will be based on local information requirements and information sharing. Local teams need to agree what information is meaningful locally. It is important this is addressed during the early implementation phase. Planning information could be aggregated by teams/areas. A decision would need to be made at a local level how best to use the information.

- **Question** – What will be done nationally?

- ***Response*** – National information will provide a Scottish picture and there will be different need profiles in different areas. National data will allow comparison and possible information sharing/shared learning between areas.

- **Question** – Need to collect information on carers. What if need is met by carer – won't be reflected in resource requirement, but included in SSA-IoRN score?

- ***Response*** – Yes there is a need to collect information on carers and to what extent their needs are being assessed and met. This work is being taken forward through the Joint Performance Indicators Assessment Framework. The SSA-IoRN scoring and grouping process has been designed to take into account input from carers thereby reflecting the older person's relative need. The fact that a person's need is met by their carer will not alter their "relative need" grouping.

- **Question** – What if carer arrangements change?

- ***Response*** – Any change in the older person's needs and/or circumstances may trigger a re-assessment or review which could also involve a re-application of the SSA-IoRN. The care plan and care package will be determined by the person's needs assessment – not the SSA-IoRN.

- **Question** – How frequently should the data be analysed?

- ***Response*** – The assumption is that information would be analysed locally as and when needed. At a national level data would be collected regularly.

- **Question** – The introduction of SSA, free care and SSA-IoRN has an impact on resources. These policy developments highlight services are inadequate but it is the front-line staff that are faced with issues of stretched resources.

- ***Response*** – The team recognises the impact of new policies. Part of the Joint Future Agenda is to ensure localities work towards having joint budgets/management. In time the resources available will be more suited to the needs of the local population.

  The SSA-IoRN is a planning tool that could help to inform resource allocation.

- **Question** – How will the inter-rater test be of benefit to ensure equity of service provision?

- ***Response*** – The inter-rater test is not about ensuring equity of services. The test will be used as part of quality assuring that the data from the questionnaires are of good quality.

- **Question** – What is involved in the inter-rater test?

- ***Response*** – Two practitioners, who know the client well, will be asked to complete a SSA-IoRN questionnaire. This is to ensure there is compatibility in the response to the questions contained in the SSA-IoRN.

- **Question** – Once the SSA-IoRN questionnaire is completed; the SSA-IoRN grouping is to be used for planning purposes across teams to better target provision of services. Is the SSA-IoRN an eligibility tool?

- ***Response*** – The SSA-IoRN is not be used to determine eligibility for services.

- **Question** – Could you clarify the timescale for early implementation? Are we starting now?

- **Response** – The purpose of today's seminar (28 November 2002 at COSLA, Haymarket, Edinburgh) is to kick-off early implementation. Individual meetings will be arranged with the 5 sites to discuss implementation with a view to completion of the SSA-IoRN starting in January 2003. We recognise the need to work with local areas at their pace, taking into account what they can achieve.

- **Question** – Will the SE be providing additional resources for implementing the SSA-IoRN and training and admin/clerical support "for inputting" and managing data, etc.?

- ***Response*** – Joint Future Agenda is about better use of resources not more resources. Nonetheless, the Executive made available in 2001 settlement for amongst other things implementing the Joint Future Agenda – but its not specifically for SSA-IoRN or SSA. Partnerships will have their own plans for using it for joint future in their area. Developing electronic solution is the longer-term outlook. Funding is available under Modernising Government Fund to that end. At the end of the day, however, it will be up to local partnerships as to how they incorporate the SSA-IoRN into their systems whether it be manually or electronically.

- **Question** – More paperwork?

- ***Response*** – Only in the short term until electronic systems are developed. Long-term goal will be simple electronic solution.

- **Question** – When do you apply and reapply the SSA-IoRN?

- ***Response*** – The SSA-IoRN should be applied following the initial SSA/needs assessment and thereafter at review stage.

- **Question** – What happens when peoples' needs change after 6 weeks do you re apply the SSA-IoRN?

- ***Response*** – During the development of the SSA-IoRN, one of the pilot teams was an Early Supported Discharge Team and they applied the SSA-IoRN at 2 intervals, the first when the person was referred and discharged from hospital then a few weeks later when needs had changed. This was useful in those circumstances when someone had been in acute care, e.g. following a stroke. However, local circumstances will determine whether someone needs a re-assessment or review and therefore re-application of the SSA-IoRN. When someone goes in to care they are often reviewed at 6 weeks or 3 months and annually thereafter – so the SSA-IoRN would apply consistent with this, provided it is the practitioner/professional who is carrying out the SSA whether it is assessment or review process.

  The SSA-IoRN should be completed following every SSA for older people but there are some issues to tease out and learn from the first 5-implementation sites. Particularly as definitions for levels of and SSA differ across the country, e.g. a simple assessment in one authority might be a self assessment in another. This will have implications as to how information is collected for planning purposes.

- **Question** – SSA-IoRN to be completed for over 65s only. Women aged over 60 are OAPs and some clients are referred to Older People's teams who are under 65.

- ***Response*** – If a client is referred for an older people's needs assessment or for clients who are under 65 with advanced dementia then it would be okay to apply the SSA-IoRN. Practitioners are asked to use their judgements sensibly. The SSA team is comfortable with the application of the SSA-IoRN for those aged 60+ but not for clients aged under 60. SSA-IoRN is not designed for other care groups at this stage.

- **Question** – Question 6 within the questionnaire relates to a person's ability to give themselves a complete wash. What option should be selected if a client is unable to wash their feet, for some clients the ability to wash feet maybe more important than to others.

- ***Response*** – The guidelines will help answer this question, e.g. Select option 3 – the person is able to perform the task with difficulty or the person has difficulty with one aspect of the task.

- **Question** – What about clients who are in for example, a hospital setting, when assessed yet whose behaviour in such settings is different from that when at home?

- ***Response*** – If an assessment on the client is done then it should pick up that their behaviour can depend on the setting.

- **Question** – Can clients have a copy of the SSA-IoRN?

- ***Response*** – Yes, if clients receive a copy of the SSA.

CLIENT DETAILS ***(Please complete in BLOCK CAPITALS)***

Name: _____

Gender: M / F

Date of Birth: ____ / ____ / ____

Local Authority Reference Number: _____

NHS Reference Number: _____

Date of Completion: ____ / ____ / ____

SSA-IoRN Grouping: _____

SINGLE SHARED ASSESSMENT – INDICATOR OF RELATIVE NEED (SSA-IORN)

General guidelines for completion of the Single Shared Assessment – Indicator of Relative Need (SSA-IoRN) Questionnaire

- The "Client Details" box above is to allow you to enter appropriate identifiers for the person who is the subject of the SSA-IoRN questionnaire and score.
- Answer the questions based on your most recent assessment of the person's health and social care needs drawing on mental health as well as physical needs.
- If a person's needs fluctuate between two categories, select the higher of the two codes, e.g. if the person's needs fluctuate between options C and D for a particular question, select D.
- **Answer all questions.**

GUIDELINES FOR QUESTIONS 1-3

Activities of daily living are often affected by the individual's associated mental health needs. In responding to these questions please draw on the person's mental health needs as well as their physical needs. This may be most relevant to Option D, the response related to "requires encouragement, prompting and supervision".

Q1: When eating a meal, the person . . .

This question relates to a person's ability to obtain appropriate nutrition. This question does not concern the person's ability to cook or prepare meals.

Select **A**: if the person eats using ordinary utensils without help, prompting or supervision, even if the meal must be prepared by someone else.

Select **B**: if the person eats without help, prompting or supervision, but uses special or adapted utensils.

Select **C**: if the person requires food to be cut up or its consistency to be modified in order to eat.

Select **D**: if the person has difficulties eating a meal **because of frailty, disability or lack of awareness** and so requires prompting supervision and guidance.

Select **E**: if the person requires physical assistance from another person in bringing utensils to the mouth.

Select **F**: if, because of injury, disability or illness, the person must receive nutrition intravenously, by gastrostomy or by syringe.

Q2: When transferring from bed to a chair or wheelchair, the person . . .

This question relates to a person's ability to transfer from a position of lying down to a position of sitting in a nearby chair.

Select **A**: if the person is able to transfer independently and safely without the use of any equipment or adaptations, e.g. bedrail, specially adapted chair.

Select **B**: if the person is able to transfer independently but only with the use of equipment or adaptations, e.g. bedrail, specially adapted chair or chair specially selected (bought or supplied).

Select **C**: if the person requires physical assistance from one person, irrespective of whether equipment is required.

Select **D**: if the person requires encouragement, prompting or supervision, but does not require physical assistance; OR if the person uses any equipment or adaptation that requires one person to set it up or to supervise its use; OR if the person requires observation because of a risk or fear of falling; OR if the person has difficulties transferring **because of frailty, disability or lack of awareness**.

Select **E**: if the person requires the physical assistance of two people, irrespective of whether equipment is required.

Select **F**: if the person is confined to bed and/or does not sit in a chair because of illness, injury or physical disability.

Q3: When using the toilet or commode, the person . . .

This question relates to a person's ability to use the toilet/commode, that is to transfer on and off the toilet/commode, adjust clothing and maintain perineal hygiene. This question does not concern continence and bowel function (covered by question 12). **But it does cover how the person manages a catheter or colostomy.** It also does not concern a person's ability to get to the toilet/commode, only the ability to use it once they are there.

Select **A**: if the person is able to use the toilet or commode independently without the use of any equipment or adaptations, e.g. raised toilet seat, hand rails, etc.

Select **B**: if the person is able to use the toilet or commode independently, but only with the use of equipment or adaptations, e.g. raised toilet seat, hand rails. **This includes those persons who independently manage a catheter or colostomy.**

Select **C**: if the person requires minimal physical assistance from one person to use the toilet or commode, but performs the majority of the tasks himself/herself, e.g. if the person needs a small amount of assistance in transferring on and off the toilet, or in adjusting clothing.

Select **D**: if the person requires encouragement, prompting or supervision to use the toilet or commode because of a lack of motivation, fear of falling, confusion or memory loss, but does not require physical assistance; OR if the person uses any equipment or adaptation that requires one person either to set it up or to supervise its use; OR if the person has difficulties using the toilet **because of frailty, disability or lack of awareness**.

Select **E**: if the person requires assistance with all aspects of using the toilet.

Select **F**: if the person does not use the toilet or alternative receptacle because of physical disability or injury, or because he/she requires assistance to manage their catheter or colostomy.

Activities of Daily Living and Mobility

1. When eating a meal, the person **ADL Score**

- ❑ **A** Eats without assistance 1
- ❑ **B** Eats without assistance using equipment 1
- ❑ **C** Eats with help, e.g. cutting up or puréeing food 2
- ❑ **D** Eats with encouragement, prompting or supervision 2
- ❑ **E** Requires complete assistance 3
- ❑ **F** Receives nutrition by tube or infusion 3

2. When transferring from bed to a chair or wheelchair, the person **ADL Score**

- ❑ **A** Transfers independently 1
- ❑ **B** Transfers independently using equipment or adaptations 1
- ❑ **C** Needs the assistance of one person 2
- ❑ **D** Requires the encouragement, prompting or supervision of one person 2
- ❑ **E** Needs the assistance of more than one person (with or without equipment).....3
- ❑ **F** Does not transfer from bed to chair (e.g, confined to bed, etc.) 3

3. When using the toilet, the person **ADL Score**

- ❑ **A** Is independent 1
- ❑ **B** Is independent with catheter or colostomy and equipment or adaptations 1
- ❑ **C** Needs assistance 2
- ❑ **D** Requires encouragement, prompting or supervision 2
- ❑ **E** Requires complete assistance 3
- ❑ **F** Does not use the toilet 3

ADL Score

Q 1 – Eating	Score	
Q 2 – Transferring	Score	
Q 3 – Toileting	Score	
Total ADL Score (Q1 + Q2 + Q3)	Score	

GUIDELINES FOR QUESTIONS 4-7

Personal care tasks are often affected by the individual's associated mental health needs. In responding to these questions please draw on the person's mental health needs as well as their physical needs. This may be most relevant to Option D, the response related to "requires encouragement, prompting and supervision".

Q4: Is the person able to wash his/her face and hands?

This question relates to a person's ability to maintain good personal hygiene by washing his/her face and hands. It includes the ability to turn taps on and off, and adjust water temperature to avoid scalding. (See below for guidance on each option.)

Q5: Is the person able to give himself/herself a complete wash, bath or a shower?

This question relates to a person's ability to wash in a bath or shower (including getting into or out of the bath or shower) or give himself/herself a complete wash by other means. It includes the ability to turn taps on, adjust water temperature to avoid scalding, and turn taps off again to prevent flooding. (See below for guidance on each option.)

Q6: Is the person able to wash his/her own hair?

This question relates to a person's ability to wash his/her own hair, using soap or shampoo, irrespective of whether they do so in the shower/bath or over a sink. (See below for guidance on each option.)

Q7: Is the person able to dress/undress himself/herself?

This question relates to a person's ability to put on, take off, secure and unfasten all garments in a manner appropriate for the weather. It also includes, the ability to adjust and fasten garments following use of the toilet, and as appropriate, the ability to put on and take off any braces, artificial limbs or other surgical appliances. (See below for guidance on each option.)

For all questions 4-7:

Select **A**: if the person requires no help, prompting or supervision from another person to perform the task AND does not require equipment or adaptations to do so.

Select **B**: if the person requires no help, prompting or supervision from another person to perform the task, but uses equipment or adaptations to do so.

Select **C**: if the person *is able* to perform the task, but because of frailty, disability or recent injury, finds it difficult to do so, even when using equipment or adaptations; OR if the person has difficulty with one aspect of the task (e.g. putting on socks and shoes, getting into a bath), even if they have no difficulty with another aspect (e.g. putting on trousers or shirt, washing themselves once in the bath).

Select **D**: if the person:

- lacks confidence or motivation to perform the task, but is able to do so when prompted or encouraged. This includes, for example, someone who requires clothing to be laid out for them, but is able to dress themselves once this has been done; OR
- will not perform the task without someone present because of a fear of falling, a phobia or other anxiety disorder; OR
- has forgotten how to perform the task, or is unable to perform it *safely* because of cognitive impairment or confusion. This includes, for example, someone who may leave the bath water running if they are not reminded to turn off the tap.

Choose this option if the person generally does not require physical assistance with the task, but nevertheless (for whatever reason) often requires someone to be present in order to perform it themselves.

Select **E**: if the person:

- requires physical assistance or support from others (for whatever reason), even if it is minimal; OR
- requires physical assistance for one aspect of the task (e.g. putting on socks and shoes, getting into a bath), even if they require no assistance for another aspect (e.g. putting on trousers or shirt, washing themselves once in the bath); OR
- does not perform the task because of disability.

Personal care

4. Is the person able to wash his/her hands and face? **Personal Care Score**

- ❑ **A** Without difficulty 1
- ❑ **B** Without difficulty using equipment or an adaptation 2
- ❑ **C** Has difficulty even when using equipment or an adaptation 3
- ❑ **D** Requires prompting, guidance, supervision or encouragement 4
- ❑ **E** Cannot do without assistance from others 5

5. Is the person able to give himself/herself a complete wash, a bath or a shower? **Personal Care Score**

- ❑ **A** Without difficulty 1
- ❑ **B** Without difficulty using equipment or an adaptation 2
- ❑ **C** Has difficulty even when using equipment or an adaptation 3
- ❑ **D** Requires prompting, guidance, supervision or encouragement 4
- ❑ **E** Cannot do without assistance from others 5

6. Is the person able to wash his/her own hair? **Personal Care Score**

- ❑ **A** Without difficulty 1
- ❑ **B** Without difficulty using equipment or an adaptation 2
- ❑ **C** Has difficulty even when using equipment or an adaptation 3
- ❑ **D** Requires prompting, guidance, supervision or encouragement 4
- ❑ **E** Cannot do without assistance from others 5

7. Is the person able to dress/undress himself/herself? **Personal Care Score**

- ❑ **A** Without difficulty 1
- ❑ **B** Without difficulty using equipment or an adaptation 2
- ❑ **C** Has difficulty even when using equipment or an adaptation 3
- ❑ **D** Requires prompting, guidance, supervision or encouragement 4
- ❑ **E** Cannot do without assistance from others 5

continue and score on page 7

GUIDLINES FOR QUESTIONS 8-10

Food/drink preparation tasks are often affected by the individual's associated mental health needs. In responding to these questions please consider and draw on the person's mental health needs as well as their physical needs. This may be most relevant to Option D, the response related to "requires encouragement, prompting and supervision".

Q8: Is the person able to prepare, cook and serve himself/herself a main meal?

This question relates to a person's ability to prepare a hot meal for himself/herself. It includes the ability to operate any appliances required (microwave, cooker, oven), and to obtain *appropriate* nutrition. (See below for guidance, on each option.)

Q9: Is the person able to prepare himself/herself a light snack (e.g. sandwich)?

This question relates to a person's ability to prepare himself/herself a snack between mealtimes. No cooking or use of electrical equipment, e.g. cooker/grill required. (See below for guidance on each option.)

Q10: Is the person able to prepare himself/herself a hot drink (e.g. cup of tea)?

This question relates to a person's ability to boil a kettle, and pour the water into a teapot or coffee pot and cup, without injury or scalding. (See below for guidance on each option.)

For all questions 8-10:

Select **A**: if the person requires no assistance, prompting or supervision from another person to perform the task AND does not require equipment or adaptations to do so.

Select **B**: if the person requires no assistance, prompting or supervision from another person to perform the task, but uses equipment or adaptations to do so.

Select **C**: if the person is able to perform the task, but because of frailty, disability or recent injury, finds it difficult to do so, even when using equipment or adaptations.

Select **D**: if the person:

- lacks confidence or motivation to perform the task, but is able to do so when prompted or encouraged; OR
- has forgotten how to perform the task, or is unable to perform it *safely* or *appropriately* without supervision because of cognitive impairment or confusion. (This includes, for example, a person who may be physically able to cook, but who might leave a pot on a lit burner and walk away from it, or who might eat out-of-date food. It also includes someone who is physically able to shop, but who cannot do so appropriately without supervision) OR
- is physically able to perform the task, but usually neglects himself/herself because of a mental health need or cognitive impairment.Select this option if the person generally does not require *physical* assistance with the task, but nevertheless (for whatever reason) often requires someone to be present in order to perform it themselves.

Select **E**: if the person:

- requires physical assistance from others to perform the task (for whatever reason); OR
- requires physical support from others to perform the task (for whatever reason), even if it is minimal

  (e.g. flask left containing hot drink)
- can not perform the task without assistance because of a lack of training (e.g. someone who needs prepared meals to be provided because they do not know how to cook, but who is able to reheat the meals once provided); OR
- does not perform the task because of disability.

Food/Drink Preparation

8. Is the person able to prepare, cook and serve himself/herself a main meal? **Food/Drink Score**

- ❑ A Without difficulty 1
- ❑ B Without difficulty using equipment or an adaptation 2
- ❑ C Has difficulty even when using equipment or an adaptation 3
- ❑ D Requires prompting, guidance, supervision or encouragement 4
- ❑ E Cannot do without assistance from others 5

9. Is the person able to prepare himself/herself a light snack (e.g. sandwich)? **Food/Drink Score**

- ❑ A Without difficulty 1
- ❑ B Without difficulty using equipment or an adaptation 2
- ❑ C Has difficulty even when using equipment or an adaptation 3
- ❑ D Requires prompting, guidance, supervision or encouragement 4
- ❑ E Cannot do without assistance from others 5

10. Is the person able to prepare himself/herself a hot drink (e.g. cup of tea) **Food/Drink Score**

- ❑ A Without difficulty..... 1
- ❑ B Without difficulty using equipment or an adaptation 2
- ❑ C Has difficulty even when using equipment or an adaptation 3
- ❑ D Requires prompting, guidance, supervision or encouragement 4
- ❑ E Cannot do without assistance from others 5

Personal Care/Food/Drink Score

Q4 – Washing Hands/Face	Score	
Q5 – Complete Wash	Score	
Q6 – Washing Hair	Score	
Q7 – Dress/Undress	Score	
Q8 – Main Meal	Score	
Q9 – Light Snack	Score	
Q10 – Hot Drink	Score	
Total Personal Care/Food/Drink Score (Q4 + Q5 + Q6 + Q7 + Q8 + Q9 + Q10)	Score	

GUIDELINES FOR QUESTION 11

Q11: Has the person exhibited any of the following behaviours in the last 4 weeks?

When answering question 11, please consider the possible impact of any of these behaviours on the person's activities of daily living, personal care and food/drink preparation needs. This is to ensure the person's needs as a whole are reflected in each section, and a recognition that there may be overlaps across sections.

This question relates to the behavioural signs and symptoms of mental health problems such as **dementia (or other forms of cognitive impairment), anxiety, depression, schizophrenia, etc**. It also covers **behavioural problems** which may result from **alcohol or drug dependencies, or acquired brain injury**. Tick one box for each behaviour to indicate how often the behaviour has occurred in the last 4 weeks. *Focus only on the last 4 weeks, even if the person has displayed a certain behaviour frequently in the past, but not in the last 4 weeks.* It is recognised that the successful treatment and management of certain mental illnesses may result in a reduction in the frequency of some behavioural problems.

For each behaviour **A-C**, indicate how often it has occurred in the last 4 weeks. If it has not occurred or has occurred twice or less, select **option 1** – "twice or less". If option 1 selected, when assigning score, score 1. Choose **option 2** – "three times or more" – even if the behaviour has occurred irregularly in the last 4 weeks, or if it has occurred only in certain contexts (the examples below detail where behaviours may occur in certain contexts). If option 2 selected, when assigning score, score 2.

For each behaviour **D-F**, indicate whether or not it has occurred at all in the last 4 weeks. Choose **option 1** – "No", if it has not occurred at all in the last 4 weeks. If option 1 selected, when assigning score, score 1. Choose **option 2**, "Yes" – even if the behaviour has occurred three times or more in the last 4 weeks, or if it has occurred only in certain contexts (the examples below detail where behaviours may occur in certain contexts). If option 2 selected, when assigning score, score 2.

Answer the questions exactly as they are stated. The responses to the questions will clearly be subjective in nature. However, in all cases, they should be based on the professional assessment of the assessing practitioner. If a person presents a particular behaviour, please indicate this by ticking the appropriate box. In some cases, the presentation of a behaviour may not particularly pose a problem to the person or others; indicate the frequency with which the behaviour is presented, *irrespective of whether it poses a problem to the person or to others*.

The following examples are provided to reduce any ambiguity in the questions.

Qstn **A**: **Agitation/Restlessness** – Agitation/Restlessness may include, for example, pacing, unable to sit for a period of time or unable to settle to a particular task.

Qstn **B:** **Disturbance/Distruption** – Disturbance/Distruption may include, for example, a person waking a spouse/relative during the night or a person making excessive contact with family/neighbours for no reason.

Qstn **C:** **Verbal aggression** – Verbal aggression may be directed towards other people, animals or objects.

Qstn **D:** **Resistiveness** – Resistiveness may include not only a person's active refusal to co-operate with their care, but also to situations where a person apparently agrees to receive care, but then is consistently out when the care worker arrives, etc.

Qstn **E:** **Relationships** – Key relationships are considered to be those which are significant to the person, or which are necessary for their care. They may include individuals such as a spouse, a daughter or son, a carer, a member of the social work services team, a nurse or a doctor, for example.

Qstn **F:** **Risk** – Risk of harm might include, for example, dangers relating to accidental explosion, fire, poisoning (including medication, food or carbon monoxide poisoning), disorientation out with the home, self neglect leading to reduced activity, abuse (e.g. emotional, verbal, physical, financial, sexual), etc.

Mental Well-being and Behaviour

11. Has the person exhibited any of the following behaviours in the last 4 weeks? ***(Please tick one box for each behaviour, the scores for the questions are simply the value of the box ticked, either 1 or 2.)***

A. Agitation/Restlessness

Is the person agitated or restless?

1 ❑ Twice or less in the last 4 weeks

2 ❑ Three times or more in the last 4 weeks

B. Disturbance/Disruption

Has the person disturbed or disrupted other people?

1 ☐ Twice or less in the last 4 weeks

2 ☐ Three times or more in the last 4 weeks

C. Verbal Aggression

Is the person verbally aggressive?

1 ☐ Twice or less in the last 4 weeks

2 ☐ Three times or more in the last 4 weeks

Sub Total Score (QA + QB + QC) ☐

D. Resistiveness

Is the person unco-operative or resistant to help with their care?

1 ☐ No

2 ☐ Yes

E. Relationships

Has the person had difficulty with key relationships?

1 ☐ No

2 ☐ Yes

F. Risk

Has the person's behaviour constituted a risk of harm to themselves or to others?

1 ☐ No

2 ☐ Yes

Sub Total Score (QD + QE + QF) ☐

Mental Well-being/Behaviour Score

Sub Total Score (QA + QB + QC) plus Sub Total Score (QD + QE + QF) Score ☐

GUIDELINES FOR QUESTION 12

Q12: Does the person require any of the following interventions or treatments relating to bowel management?

These questions relate to the person's need for assistance with bowel management for both day or night. Please tick one box. If the person requires no intervention or treatments for bowel management, select 1.

Question **12** relates to a person's ability to maintain a healthy bowel function. It includes the care required to prevent both constipation and faecal incontinence. If a person is incontinent only in certain situations or circumstances, indicate how often this occurs.

Select **A**: if the person is fully continent, does not require, or rarely requires assistance from another person OR if the person is independent with pads or other continence aids, equipment or adaptation OR if the person requires a prompt to take the oral medication on a daily basis to maintain healthy bowel function such as laxatives, forming agents, e.g. methylcellulose or antimotility drugs, e.g. codeine phosphase OR if the person requires prompting, supervision or assistance to maintain a healthy bowel function or to manage problems relating to faecal incontinence, but on average, less than once a week.

Select **B:** if the person requires prompting, supervision or assistance to maintain a healthy bowel function or to manage problems relating to faecal incontinence, on average, more than once a week OR if the person requires assistance at least once a week during the day or night for stoma care.

Bowel Management

12. Does the person require any of the following interventions or treatments relating to bowel management? *(Please tick one box)*

Provision of assistance, guidance, prompting or supervision to maintain bowel function

A ☐ Never or less than once a week, on average

B ☐ More than once a week, on average

Bowel Management	
Low/No Bowel Management	Option A
High Bowel Management	Option B

Note: Score not required, only one question relating to bowel management
If option A, place client in low/no bowel management group.
If option B, place client in high bowel management group.

Assigning Client to SSA-IoRN Grouping

The purpose of completing the SSA-IoRN is to allow practitioners to assign their client to a SSA-IoRN grouping. There are 2 steps to this process: **Step 1** is to allocate the ADL group (low, medium or high). **Step 2** works out the SSA-IoRN group – this is done by following the instructions in one of the boxes below.

Please refer to the diagram on **page 13** when allocating SSA-IoRN grouping.

Step 1

To allocate client to a low, medium or high ADL group, please refer to the total ADL score calculated on **page 3**.

ADL Score (see page 3)	ADL Group	Step 2
3	Low	Go to Box 1
4	Medium	Go to Box 2
5-9	High	Go to Box 3

Step 2

Box 1

For Low ADL Group – refer to total personal care/food/drink score calculated on **page 7**.

Personal Care Food/Drink Prep Score (see page 7)	SSA-IoRN Group
7-14	A
15-27	B
28-35	D

Box 2

For Medium ADL Group – refer to total mental well-being score calculated on **page 9**.

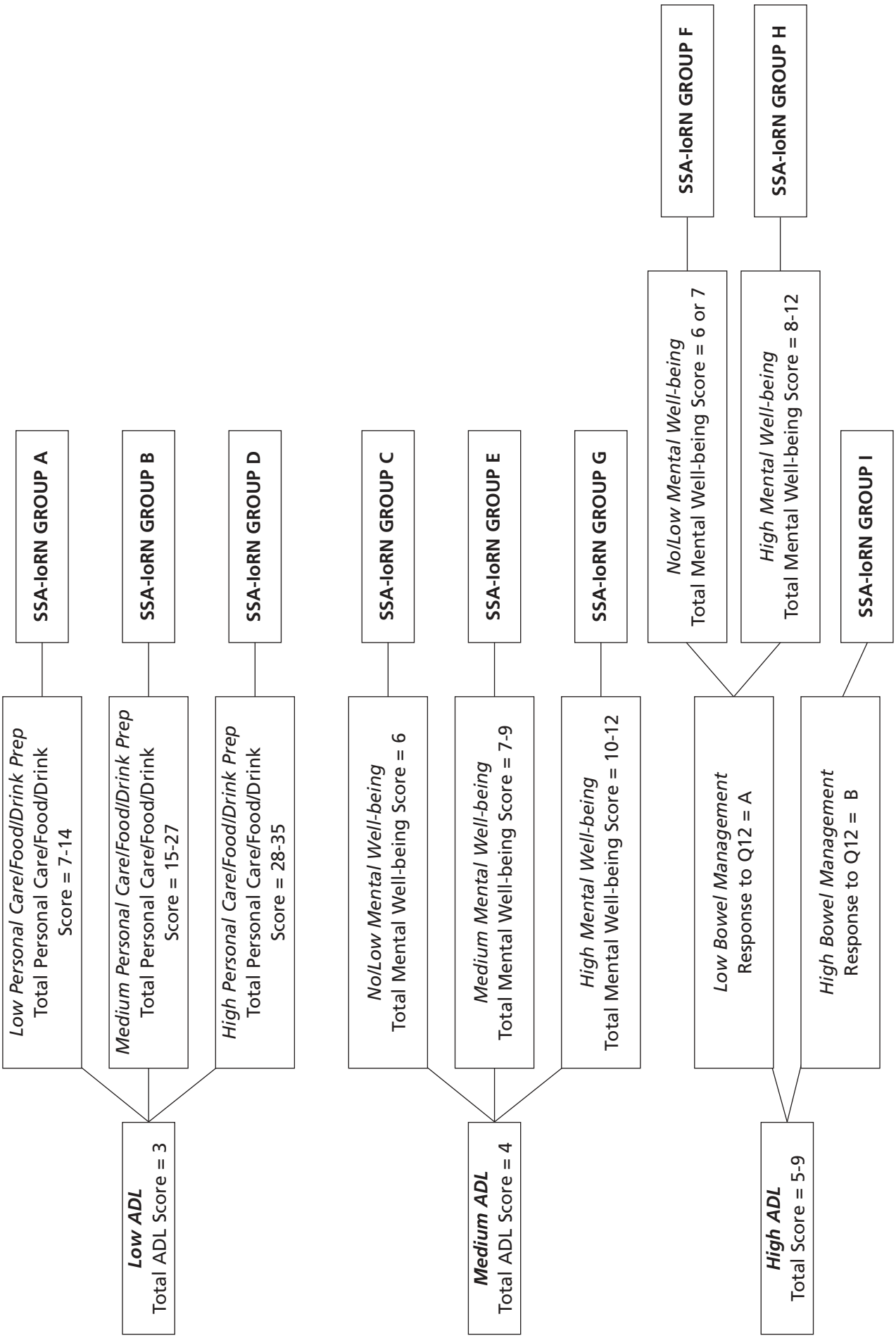
Mental Well-being Score (see page 9)	SSA-IoRN Group
6	C
7-9	E
10-12	G

Box 3

For High ADL Group – refer to bowel management response on **page 11**.

Bowel Management response (see page 11)	*Only if options A selected* – Refer to Mental Well-being Score (see page 9)	SSA-IoRN Group
A	6-7	F
	8-12	H
B		I

Please record client SSA-IoRN grouping in box.


Low Personal Care/Food/Drink Prep
Total Personal Care/Food/Drink
Score = 7-14
Medium Personal Care/Food/Drink Prep
Total Personal Care/Food/Drink
Score = 15-27
High Personal Care/Food/Drink Prep
Total Personal Care/Food/Drink
Score = 28-35
Low ADL
Total ADL Score = 3
SSA-IoRN GROUP A
SSA-IoRN GROUP B
SSA-IoRN GROUP D
No/Low Mental Well-being
Total Mental Well-being Score = 6
Medium Mental Well-being
Total Mental Well-being Score = 7-9
High Mental Well-being
Total Mental Well-being Score = 10-12
Medium ADL
Total ADL Score = 4
SSA-IoRN GROUP C
SSA-IoRN GROUP E
SSA-IoRN GROUP G
Low Bowel Management
Response to Q12 = A
High Bowel Management
Response to Q12 = B
High ADL
Total Score = 5-9
No/Low Mental Well-being
Total Mental Well-being Score = 6 or 7
High Mental Well-being
Total Mental Well-being Score = 8-12
SSA-IoRN GROUP F
SSA-IoRN GROUP H
SSA-IoRN GROUP I

SCOTTISH EXECUTIVE

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Chief Executives, Local Authorities
Chief Executives, NHS Boards
Chief Executives, NHS Trusts
Directors of Social Work
Directors of Housing
Directors of Finance, Local Authorities
Directors of Nursing of NHS Trusts and NHS Boards
Chief Executive, Communities Scotland
Chief Executive, State Hospital
Core List
Relevant Professional and Voluntary Organisations
Care Assessment Group
RUM Reference Group and RUM Information Sub-Group
Key Contacts of 5 Implementation Sites

Your ref:
Our ref: GKG/1/4/2/12

7 July 2003

Dear Colleague

JOINT FUTURE: DATA STRATEGY RESOURCE USE MEASURE (RUM) AND THE INTEGRATED CARE ASSESSMENT DATA SUMMARY (RUM-ICADS)

I enclose a consultation paper setting out the proposed Joint Future: Data Strategy for the RUM and the Integrated Care Assessment Data Summary (RUM-ICADS). **Your views are invited by 29 September 2003.**

Context

Circular No 9/2002 of 24 September 2002 introduced the Report on the Development of a Resource Use Measure (RUM) for Scotland. The RUM is a standardised tool that will group individuals according to their level of relative need following a Single Shared Assessment (SSA). The "Next Steps" letter issued on 28 February 2003 on behalf of the Executive, COSLA and NHSScotland confirmed that implementation of the RUM had begun in 5 implementation sites. It set out the expectation that all partnerships will begin to use the RUM by end of 2003-04. The plan for full implementation assumes that all SSAs of people aged 65 and over in Scotland should have a RUM grouping assigned. The RUM appendix to the "Next Steps" letter stated that the ongoing work with the 5 sites and the RUM Information Sub-Group and RUM Reference Group included looking at how RUM scores could be combined with other information already collected. This would provide a data set that **could** inform planning locally and be made available for national collection.

What are we consulting on?

The consultation paper provides an overview of the development of the data summary for RUM-ICADS, which consists of RUM and associated data derived from the SSA process. The strategy has been produced in collaboration with the 5 implementation sites, the Care Assessment Group (CAG), and the RUM Reference Group. The CAG was set up to oversee the implementation of SSA and RUM. The RUM Reference Group oversees the development and implementation of the RUM and reports to the CAG.

The fundamental strategic purpose of the RUM development is to support the provision of better services for Scotland's older people. The RUM-ICADS development introduces for the first time the prospect of obtaining person based information on need and service provision for older people in a standardised format, with coverage extending over the whole of Scotland. It is a substantial step in the development of client level information collected across traditional NHS and local authority boundaries. It will therefore be useful to both health and social care interests, and will provide information across a range of levels from front-line practitioners to a Scotland-wide level. For example:

At local level:

- support for strategic planning and the development of jointly delivered services, caseload management, benchmarking for best value and local resource allocation; and
- the provision of a source of regularly updated information for local authorities and their health partners to use together.

At national level

- a more complete insight into the needs characteristics of older people receiving services across the whole of Scotland;
- a means for identifying and reviewing differences and similarities between different parts of Scotland by matching levels of service provision to need; and
- supporting balance of care work and national benchmarking associated with best value approaches.

IT Considerations

From the outset the RUM development team has been considering methods of delivery of the RUM-ICADS information requirements by electronic means. With the emergence of the eCare Programme it is apparent that this technology would offer an effective means of sharing the RUM data between practitioners. Despite this it is acknowledged that the proposed data strategy will make significant demands on the IT systems being used within Councils and partnerships to support the assessment process. In parallel with the consultation, discussions will be held with Carenap/eCare project teams to explore ways of minimising the impact on local IT systems, for example, the possibility of incorporating the RUM into a Networked Carenap and developing a web front-end. This would enable the RUM to be integral to the assessment.

What are we asking?

We ask that you share this paper with your constituents and feed back comments to the Joint Future Unit by 29 September. We would particularly welcome your comments on:

1. The potential uses of the aggregated RUM-ICADS information
   - Locally
   - Nationally
2. The linkages across the RUM-ICADS data set and with other sources for effective local planning purposes (see paragraphs 10, 11 and 17-22 of the paper).
3. Whether the data set (at appendix 1 of the paper):
   - is clear?
   - is feasible and useful to collect?
   - is useful for local planning?
4. Whether the proposed data set is seen as essential information to have locally within each partnership. This question is based on the principle that national information should be built upon the information required to manage and plan services at the local partnership level.
5. Phased introduction of data summary. It is recognised that all the data items in the proposed RUM-ICADS may not be readily available in the short term. For this reason, it will be necessary to consider the possibility of phasing the introduction of the data summary. Thus, for example, some of the information from data item 15-20 may need to be introduced at a later date. **Please therefore indicate which elements of the data set (item 1-20, appendix 1) partnerships would consider essential locally for planning purposes and feasible to collect in the short term.**

Where to send comments

Please could you send comments on the consultation paper by 29 September 2003 to:

Derick Wilson
Joint Future Unit
Scottish Executive Health Department
St Andrew's House
Regent Road
Edinburgh EH1 3DG
Email: Derick.J.Wilson@scotland.gsi.gov.uk

Questions on points of detail in the consultation paper should be addressed to Winona Samet on 0131-244 5317 (Winona.Samet@scotland.gsi.gov.uk) or Brenda Kerr on 0131-244 3744 (Brenda.Kerr@scotland.gsi.gov.uk).

Electronic copies of this letter and the consultation paper can be found at www.scotland.gov.uk/views/views.asp.

Comments will be assumed to be accessible publicly through a file held in the Scottish Executive's library unless you request otherwise.

Yours sincerely

Adam Rennie

J A RENNIE

JOINT FUTURE: DATA STRATEGY FOR THE RESOURCE USE MEASURE (RUM)[1] AND THE INTEGRATED CARE ASSESSMENT DATA SUMMARY (RUM-ICADS)

Introduction

1. This paper provides a strategic overview of the development of the Resource Use Measure Integrated Care Assessment Data Summary (RUM-ICADS), which consists of RUM and associated data derived from the Single Shared Assessment (SSA) process. The RUM is currently being implemented in 5 local area partnerships across Scotland, as a first stage towards full national coverage. This paper outlines the importance of RUM-ICADS information through its potential to inform decisions at different organisational levels, from front-line practitioners to national level. The paper also outlines some of the issues for collating RUM-ICADS information to enable its effective use in the immediate future and in the longer term.

2. The fundamental purpose of the RUM-ICADS development is to support the provision of better services for Scotland's older people. This paper begins the task of developing a comprehensive information strategy based around the RUM-ICADS dataset.

Background

3. The development of the Resource Use Measure (RUM) was led by professional staff at the Joint Future Unit of the Scottish Executive, working in partnership with information specialists in ISD Scotland and, crucially, with a range of local authority and health staff from across Scotland. A report on the development was accepted by Scottish Ministers and published on 24 September 2002. Subsequently the Joint Future Ministerial Group agreed on 23 January 2003 that the RUM should become a key element in the Joint Future programme for older people. Details were contained in the "Next Steps" letter recently issued by the Scottish Executive in February 2003.

4. The RUM is currently being implemented in 5 sites[2] across Scotland as part of an overall plan that all areas begin using the RUM by the end of 2003-04. The plan assumes that after full implementation all single shared assessments (SSA) of people aged 65 and over in Scotland should have a RUM grouping assigned. These assessments are usually carried out in conjunction with services being provided, and re-assessments made if clients' levels of need or circumstances change significantly. Clients should be re-assessed annually in any case. The assumption is that the RUM should be completed on each occasion, giving a score and relative need grouping.

5. The RUM should not be seen as a stand-alone application – from the outset of development it has been firmly embedded in the Single Shared Assessment (SSA) process and is an important component of the Joint Future Agenda for older people. Standardised information, collected uniformly across Scotland using agreed guidelines and positioned cohesively alongside the SSA requirements, will allow for better informed decision making at a variety of levels.

6. The strategy assumes that information will be collected on clients receiving support or care in a mixture of settings, from their own homes with informal carer input, through to supported housing and care homes.

1 see "Report on the development of a Resource Use Measure (RUM) for Scotland" (2002); Scottish Executive. http://www.scotland.gov.uk/health/jointfutureunit

2 East Renfrewshire, Glasgow, Orkney, Perth and Kinross and South Lanarkshire

7. It is envisaged that data requirements will be comprehensive, providing details on care setting (e.g. own home, sheltered housing, care home), type of service provided and details of the clients, including levels of need (i.e. the RUM score).

8. The RUM-ICADS development introduces for the first time the prospect of obtaining person based information on need and service provision for older people in a standardised format with coverage extending over the whole of Scotland. It is a substantial step in the development of client level information collected across both traditional NHS and local authority boundaries. It will therefore be useful across health and social care interests, and provide information across a range of levels from front-line practitioners to a Scotland-wide level.

Informing Service Teams

9. At service team level the RUM will provide a client level summary complementing the more detailed and descriptive information obtained through the SSA. The changing needs of a client over time will be documented in detail through the SSA and in a concise standardised format through the RUM. The data compiled from the RUM scores when linked to other key service information will become an important resource to assist local teams to monitor service effectiveness, review workload and plan for future service demand.

At Local Level

10. At local level (local authority, unified health boards and partnership bodies) data aggregated from the RUM-ICADS will provide an important source of information to support strategic planning and the development of jointly delivered services, caseload management, benchmark for best value and local resource allocation. This data will become an essential component in monitoring progress on joint working locally and in informing discussions about the balance of service provision in local areas.

11. The use of personal identifiers for records allows the possibility of the elimination of double counting of care episodes and hence the assembling of service users' care histories. This would contribute to the development of a more integrated care service in the longer term. A more detailed discussion on linkages across RUM-ICADS is included in paras 17-22.

At National Level

12. The potential uses of RUM-ICADS data at a national level will be subject to careful, measured discussion and dialogue with all key stakeholders. Nationally compiled information based on the RUM-ICADS has the potential to offer a number of distinct benefits. The national standardised approach contributes at both local level and national level to:

- a more complete insight into the needs characteristics of older people receiving services across the whole of Scotland;
- a means for identifying and reviewing differences and similarities between different parts of Scotland by matching levels of service provision to need;
- supporting balance of care work and national benchmarking associated with best value approaches;
- the provision of a source of regularly updated information for local authorities and their health partners to use together.

13. The RUM-ICADS information (see para. 22 and 23) would also support, for example, monitoring of the longer term impact of the Joint Future Agenda and would help inform the development of future policies for older people. Issues such as the variation in services provided and quality of access for people with similar needs may be explored using the RUM-ICADS data. Another possibility referred to in the original RUM report[1] is, over time, and with discussion and agreement from all the relevant stakeholders, the exploration of whether – and how – RUM-ICADS data may inform resource allocation.

Use of the RUM in Care Homes

14. The Scottish Commission for the Regulation of Care (the Care Commission) has expressed an interest in working with the Scottish Executive in using the RUM to inform staffing levels in care homes, although this is not the immediate priority for the implementation of the RUM. Further discussion is planned with the Care Commission to agree a possible timetable for this project.

15. It is acknowledged that there are overlaps with the interviewer-based dataset on Scottish Care Resource Utilisation Groups (SCRUGS) and ISD Scotland will review the possible harmonisation of RUM and SCRUGS data.

16. Note that the new Scottish Care Home Census return (introduced for period ending 31 March 2003), which will be conducted biannually by the Scottish Executive on a multi-agency basis, will also include a question about the RUM score for all long-stay residents on the census night. This will be used in a complementary way to the RUM-ICADS information to provide snapshot information about care home residents.

Linkages Across RUM-ICADS Data, and with Other Data Sources

17. When the needs of an individual change the person will require review or re-assessment. The linking of RUM-ICADS over time (internal linkage) offers the prospect of describing an individual's care history.

18. Important insights are also possible however from linking RUM-ICADS to other related information (external linkage). For example linkage to repeat emergency hospital admissions and/or delayed discharges from hospital, may provide information that can inform the development of strategies to avoid hospitalisation where this is not clinically necessary.

19. These potential uses, based on linked records, will only be possible if certain person-unique information is included in the national data set and it is essential that procedures for collection of such data must be consistent with the various legal and ethical requirements that apply.

20. Once the necessary confidentiality safeguards are in place it becomes possible to envisage, in the longer term, the prospect of the development of comprehensive care records for patients. Such data might describe the older person's journey of care from the community through the NHS and back into a care home or supported in the community.

21. The development of outcome and quality measures – e.g. waiting times, appropriateness of placement decisions, success in maintenance of independence, would also be facilitated by the availability of such data.

22. It is emphasised however that in addition to ensuring the safeguards mentioned above are in place, the complexity of linking data will require substantial development, testing and liaison with key stakeholders.

1 see "Report on the development of a Resource Use Measure (RUM) for Scotland" (2002); Scottish Executive. http://www.scotland.gov.uk/health/jointfutureunit

RUM-ICADS Draft Dataset

23. Detailed preparatory work has already been carried out to specify a possible common standard data set that could be used alongside the RUM scores to provide a comprehensive view of each client following a SSA. The content of the draft RUM-ICADS is the product of consultation with representatives from the five shadow implementation sites,[2] with supporting input from the Scottish Executive and ISD Scotland. The proposed content is listed at Appendix 1. It includes personal details (age, sex, postcode of residence), current situation (own home, sheltered housing, etc.), any underlying problems (e.g. dementia), details of services to be provided, carer details, and the RUM score.

24. It is recognised that all the data items in the proposed RUM-ICADS may not be readily available in the short term. For this reason, the possibility of phasing the introduction of the data summary will be necessary. Thus, for example, some of the information from data item 15 and higher may need to be introduced at a later date.

Electronic Processing of Data

25. From the outset the RUM development team has been considering methods of delivery of the RUM-ICADS information requirements by electronic means. With the emergence of the eCare Programme it is apparent that this technology would offer an effective means of sharing the RUM data between practitioners. Despite this it is acknowledged that the proposed data strategy will make significant demands on the IT systems being used within Councils and partnerships to support the assessment process. In parallel with the consultation, discussions will be held with Carenap/eCare project teams to explore ways of minimising the impact on local IT systems, for example, the possibility of incorporating the RUM into a Networked Carenap and developing a web front-end. This would enable the RUM to be integral to the assessment.

26. The mechanisms for the collection of RUM data should be integrated into local systems supporting case management and SSA. The assumption is that data will be held and extracted electronically for subsequent local, authority or national use. As part of their role in early implementation, South Lanarkshire, East Renfrewshire, Orkney, and Perth & Kinross are beginning to develop such systems. Data sharing between councils and NHS organisations, supported by the E-biz 2000 middleware, creates the potential for RUM-ICADS data to be available for automatic extraction and transmission for local and national information purposes.

Interim Arrangements

Alternative Electronic Systems

27. Because of the lengths of time often involved in developing new integrated systems, it may be necessary to consider other interim solutions if the RUM-ICADS information detailed in this paper is to be available in the shorter term. Collated information would depend on other arrangements being made to extract data pre-punched into local electronic systems (e.g. by writing and supporting extraction software) or, where data can only be collected on paper, by establishing arrangements for data entry of paper forms.

2 East Renfrewshire, Glasgow, Orkney, Perth and Kinross and South Lanarkshire

28. One possible example of a technical solution to capture RUM-ICADS scores electronically would be to develop a web-based system with reporting facilities built in for analytical output. Such a system properly supported would require local availability of PCs with internet access and a standard browser. One important advantage of this approach is that IT support costs would be minimised. It is also feasible using this kind of approach to develop an on - line programme to enable practitioners to complete and calculate the RUM scores and relative need groupings for individuals electronically.

Paper Systems

29. It is estimated that approximately 10,000 RUM "forms" will be completed per month, once the RUM is fully implemented across Scotland. In the absence of electronic systems at present it is worth considering whether, very much as an interim measure, a paper based method might be employed to gather the required dataset in some areas.

30. The use of optical character recognition (OCR) processing of paper forms is one possible solution. It is not without its problems and its viability would need to be tested. OCR has obvious benefits in that it does not require staff responsible for completing the RUM to have access to a PC. It minimises the cost of data entry and ensures speedy data processing.

The Development of Data Quality Assurance Arrangements

31. In accordance with normal arrangements for collecting data, responsibility for the quality of data lies at a local level. In line with best practice, establishing arrangements for occasional quality review is beneficial to both local staff and to other users of the data. It is proposed that the implementation of the RUM-ICADS should be supported by a programme of Data Quality Assurance (DQA), involving regular (perhaps annual) quality reviews to check consistency and maintain standards.

32. Initially, DQA might involve a dedicated group of staff who would visit local teams by arrangement and would compare the completed RUM-ICADS data against the SSA and other relevant sources. In the longer term it may be preferable to establish arrangements locally to carry out DQA checks internally. Less frequent National DQA data audit may still be required to assure that the RUM-ICADS is used consistently, in order to maintain confidence in the reliability of the data across Scotland.

RUM-ICADS

DRAFT

1. Unique Reference Number (See Note 1)

2. CHI Number

3. Gender (1 = Male, 2 = Female, 9 = unknown/unspecified)

4. Date of Birth — Day Month Year

5. Postcode of Permanent Residence

6. Current Accommodation Situation (See Note 6)

7. LA Responsible for Care (See Note 7)

8. NHS Board of Residence (See Note 8)

9. Ethnicity (See Note 9)

10. RUM Scores (See Note 10) — ADL PC/FD MH/B B Mgt

11. RUM Group (See Note 11)

12. Date of RUM Score — Day Month Year

13. Reason(s) for Referral (See Note 13) — Reason 1 Reason 2 Reason 3

14. Underlying Problems (See Note 14) — Problem 1 Problem 2 Problem 3

15. Carer Present (Please tick) — Yes No – **Please go to item 20**

16. Age of Main Carer (Please tick) — 0-15 16-64 65-74 75-84 85+

17. Carer's Gender (1 =M, 2= F, 9 = unknown/unspecified)

18. Carer's Relationship to Service User (1 = Spouse, 2 = Other relative, 3= Other)

19. Unpaid Carer Input, Hours per Week (Please tick) — 1 – 4 hr 5 – 19 hr 20-34 hr 35+ Unknown

20. Services Provided/To Be Provided Following Assessment (See Note 20)

		Service Currently Provided (✔)	Service to be Provided Following Assessment (✔)	Service Not Available/Unmet Need (✔)
Service 1				
Service 2				
Service 3				
Service 4				
Service 5				
Service 6				

Notes

1. Unique Reference Number

This should uniquely identify the client to you and should be consistent for all assessments.

6. Current Accommodation Situation

01	Homeless
02	Mainstream Housing
03	Special Housing
04	Sheltered Housing
05	Supported Accommodation
06	Specialist Rehabilitation Units
07	Registered Adult Care Homes
08	NHS Facilities/Hospital
09	Penal Institution
99	Not Known

7. LA Responsible for Care

100	Aberdeen City
110	Aberdeenshire
120	Angus
130	Argyll & Bute
150	Clackmannanshire
170	Dumfries & Galloway
180	Dundee City
190	East Ayrshire
200	East Dunbartonshire
210	East Lothian
220	East Renfrewshire
230	Edinburgh, City Of
235	Eilean Siar
240	Falkirk
250	Fife
260	Glasgow City
270	Highland
280	Inverclyde
290	Midlothian
300	The Moray
310	North Ayrshire
320	North Lanarkshire
330	Orkney Islands
340	Perth & Kinross
350	Renfrewshire
355	Scottish Borders
360	Shetland Islands
370	South Ayrshire
380	South Lanarkshire
390	Stirling
395	West Dunbartonshire
400	West Lothian
420	OUTWITH Scotland

8. NHS Board of Residence

C	Argyll and Clyde
A	Ayrshire and Arran
B	Borders
Y	Dumfries and Galloway
F	Fife
V	Forth Valley
N	Grampian
G	Greater Glasgow
H	Highland
L	Lanarkshire
S	Lothian
R	Orkney
Z	Shetland
T	Tayside
W	Western Isles

9. Ethnicity

00	White
01	Indian
02	Pakistani
03	Bangladeshi
04	Chinese
05	Other Asian
06	Black Caribbean
07	Black African
08	Black Other
09	Other or mixed ethnic group
10	Not Know/Refused

10. RUM Scores

Scores from sections of the questionnaire to be recorded.
ADL = Activities of Daily Living
PC/FD = Personal Care and Food/Drink Preparation
MH/B = Mental Health and Behaviour
B Mgt = Bowel Management

11. RUM Group

This has been developed to enable older people receiving services to be classified into groups with similar levels of need: from 'A' – lowest need to 'I' – highest need

13. Reason(s) for Referral

This is the reason why the person has presented for assessment.

01	Discharge following hospital admission
02	Physical incapacity
03	Mental incapacity
04	Injury
05	Breakdown of carer provision
06	Request for assessment
07	Other

14. Underlying Problem(s)

These are long-term problems that are present at the time of assessment

01	Chronic medical condition
02	Dementia
03	Other mental health condition
04	Learning disability
05	Social circumstances
06	Housing problems
07	Other
08	None

20. Services Provided/to be Provided Following Assessment

01	General information and advice, counselling and support and befriending	Giving information (both verbal and written) about available services, eligibility criteria etc. Includes public information leaflets, application forms, referring to other agencies, etc.
02	Welfare benefits and concessionary travel advice	Informing and advising people on benefits entitlements and assistance with claims, concessionary travel scheme, e.g. blue badge.
03	Equipment	Items related to the management of an illness, to rehabilitation, or to assist with activities of daily living (such as bedpans, walking frames, wheelchairs, removable bath and toilet aids, or stair lifts).
04	Adaptations	'temporary' and can be redeployed (such as grab rails) and 'permanent' (such replacing a bath with a shower, building an additional toilet facility downstairs, or creating ramped access).
05	Home Services (outwith own home) • Shopping and pension-collection • Community meals • Laundry	 This provision includes both accompanying the service user or going on their behalf to help with errands such as shopping, visiting the library or post office, collecting prescriptions and collecting pensions. The provision of pre-cooked or frozen meals which are delivered to the person's own home. A dedicated laundry service which is undertaken outwith the person's own home.
06	Domestic and home care (other than personal care)	Practical services which assist the client to function as independently as possible and/or continue to live in their own homes eg. housework, laundry, meal preparation, lighting fires, etc.
07	Personal care (as defined by the Regulation of Care (Scotland) Act 2001	Care which relates to the day to day physical tasks and needs of the person cared for, and to related mental processes, including assisting with: personal hygiene; eating requirements; problems of immobility; medication; getting dressed; surgical appliances, prosthesis and equipment; getting up and going to bed; devices to help memory and safety; behaviour management and psychological support. (Sources: Regulation of Care (Scotland) Act 2001, Community Care and Health (Scotland) Act 2002).
08	Day Services/Day Hospital	The provision of services to people outside their normal place of residence.
09	Respite/short breaks	Services provided to people with carers to support both the carers and the cared-for person by providing alternative care for a temporary period (from a few hours to a few weeks) overnight and/or during the day in the person's own home, in another's home, in a residential facility or elsewhere.
10	Residential care	Long-stay residential care
11	Therapeutic/intensive behaviour management	Intervention aimed at changing or containing individual's behaviour which presents risk to themselves or others, e.g. challenging behaviour, offending dementia, substance misuse.
12	Rehabilitation following illness or acquired disability	Care or treatment given to improve the existing level of functioning, when a potential for improvement exists, but the capacity for full recovery is uncertain.
13	Specialist treatment or counselling	Interventions delivered by specified skilled staff aimed at restoring normal level of ability, functioning or health, e.g. mental illness, bereavement, substance misuse.
14	Regular maintenance services (intensive housing management)	Decorating, gardening, etc.