



Review of the Early
Implementation of the
Resource Use Measure

**REVIEW OF THE EARLY IMPLEMENTATION OF THE
RESOURCE USE MEASURE**

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EXECUTIVE SUMMARY

Context

The Resource Use Measure (RUM) was originally intended as a tool for determining entitlement to free nursing care, promoting fair access and equitable distribution of resources for older people. It is now used to measure the relative need of older people over 65 years including those with mental health problems and dementia and/or associated behaviour.

The process of developing the RUM was designed to be interactive, drawing on the expertise of frontline practitioners but also making use of statistical evidence to determine which questions were most effective at categorising cases according to the person's relative needs. The process has spanned the 3 years from 2000.

In the two development phases, from May to December 2001 and from January to May 2002, the emphasis was upon developing the tool. During early implementation (January 2003-March 2004), whilst it continued to be important that any issues concerning the operation of the single RUM questionnaire that arose for practitioners were addressed, attention needed also to focus upon the operational experience in each of the 5 early implementation sites and the factors that were affecting the nature and extent of early RUM implementation.

This study was commissioned to consider the process of early implementation, to identify emerging issues and how the early implementation sites had responded.

The methodology involved collating existing information about the extent of RUM scoring and local arrangements to support implementation and conducting semi-structured interviews with managers and practitioners involved in implementation across the 5 early implementation sites.

The Extent of RUM Implementation

A total of 719 RUMs had been scored at the time of this review, a figure that was reported to be increasing rapidly.

The extent of RUM scoring was limited in some sites by local measures designed to contain workloads and focus attention upon initial assessments. The previous extent of assessment activity by health and social work staff influenced their respective involvement in scoring RUMs by virtue of the number of assessments that they normally completed or local practice regarding which agency led on assessments for service users with particular needs.

The time taken to complete the RUM was in line with the Scottish Executive's target of 5 minutes although more complex cases could take up to 15 minutes to complete.

Current, formal use of the RUM was limited and few staff were aware of its proposed future use. However, the RUM was being used informally for a variety of purposes including as a point of reference in meetings about admission to long-term care, as an extra piece of information to inform decisions and also to enable practitioners to reflect on the services that individual clients receive relative to the RUM scores of others.

Local Implementation

The RUM was the latest of a number of important initiatives that had required managers and practitioners to deal with significant changes in their work and as such was perceived to bring an additional burden. Whilst the RUM was designed to be brief and concise its implementation was affected by competing demands upon the time of frontline staff. In particular the relative timing of RUM implementation and Single Shared Assessment (SSA) roll-out determined whether it was possible to integrate training for both and thereby reduce the overall demand upon staff time.

Effective joint working arrangements between local partners and the presence of a strong local “*champion*” to support RUM implementation greatly assisted progress and helped to sustain staff motivation and engagement that were in some cases reduced as a result of doubts about the purpose and design of the RUM.

Arrangements to score and record the RUM were almost entirely manual and generally worked well. However transferring RUM data into an electronic or computer-based record did impose an additional administrative burden upon staff, predominantly those in health settings.

Issues concerning the SSA

RUM implementation was particularly sensitive to SSA practice. In particular, unresolved issues concerning the SSA; whether it should be completed on cases reflecting low levels of need, understanding of what is a “*re-assessment*” and the different periods of time over which SSAs are compiled, created uncertainties and practical problems that have impacted upon the extent and consistency of RUM activity.

In cases reflecting low levels of need insufficient information was often contained in the SSA to score the RUM and accordingly staff found it necessary to obtain additional information even if the type of assessment did not merit it. This issue reflected the varied application by early implementation sites of the guidance on SSA contained in Circular CCD 8/2001¹. This emphasises that SSA is for people with community care needs and who may require the services of more than one professional discipline or agency.

How well was the purpose of the RUM understood?

Some managers were clear about the purpose of the RUM and focussed upon its use for planning and resource management purposes. Many practitioners were less clear and cited a wide range of possible uses. The absence of awareness about current and future usage further reduced clarity about the purpose of the RUM and national training, guidance and ongoing support arrangements were not wholly successful in addressing this issue.

Many staff were unclear about how the RUM had been developed and why it had been designed as it had. The ability of the RUM to adequately capture and score relative needs

¹ Scottish Executive Health Department, Directorate of Health Policy and Planning, Circular No. CCD 8/2001 <http://www.scotland.gov.uk/about/HD/CCD2/00017673/ssaguidance.pdf>

and thereby fulfil its stated purpose was questioned by many practitioners on the basis of their experience of using the tool and of trying to reconcile scores with their practical knowledge of the relative care needs of their clients.

Support for Implementation

The RUM questionnaire was appropriately brief and concise but the associated guidance did not address issues regarding how the RUM was intended to capture the necessary detailed information on needs, to the satisfaction of a significant number of staff. A majority of practitioners were unaware of the Briefing and Guidance paper.

The content and delivery of the national training provided by the Scottish Executive was generally well received but local arrangements to cascade this training were informal and provided inconsistent coverage of the staff involved. An absence of additional local training, and inconsistent feedback from staff attending the Learning Network also limited effective learning opportunities despite some helpful local support groups.

Conclusions

The extent of local implementation was limited by some of the agencies involved and the previous involvement in assessment activity by health and social work staff influenced their respective involvement in scoring RUMs. Early implementation sites largely achieved the target time for completion of the RUM and despite the general absence of formal use being made of RUM data, it was being used informally and its potential was recognised by both practitioners and managers.

Effective joint working contributed positively to enabling local staff to respond to the problems and questions that arose during early implementation and this capability was further enhanced by the positive impact of strong local leadership. However, doubts about the purpose and design of the RUM affected attitudes towards implementation which in some cases undermined the positive impact of effective local arrangements.

Unresolved questions about SSA implementation and varied application of SSA guidance have affected the pattern and consistency of RUM scoring which in turn has impacted upon the way in which practitioners assess and record needs within some SSAs.

There was a lack of clarity regarding the approach that should be adopted in informing service users about, and in securing their consent to, the exchange of information relating to the RUM.

Uncertainty amongst practitioners regarding the basis for the RUM's design and doubts about its ability to take into account the factors necessary to establish relative need have reduced confidence in the RUM methodology. Many practitioners were also unclear about the purpose of the RUM and were unable to identify direct benefits for managing their work or for their clients.

The Scottish Executive's support for early implementation included guidance and opportunities for staff to receive initial and ongoing assistance from a national perspective.

Whilst initial training was found by staff to be helpful, the guidance and Learning Network did not enable the issues that emerged for them as implementation progressed to be adequately addressed.

Local support was predominantly informal and ad hoc which in some sites was an effective approach. In most however it resulted in inconsistent access to training and support leaving some staff feeling ill prepared and under supported. Some staff who wished to avoid being involved were able to remain largely disengaged from the agenda.

Future Priorities

This report concerns early implementation of the RUM and it is clear from the review itself that the nature and extent of early implementation is changing rapidly. As national and local initiatives to support implementation continue to gather pace the significance of the issues that are identified here will change.

It will clearly be important that outstanding issues relating to the SSA and the introduction of effective local joint working and management arrangements are addressed. However the views and attitudes of the people involved in actually implementing the RUM have had a significant impact upon the extent to which obstacles to progress have been overcome and early implementation has progressed. Ensuring that managers and practitioners involved in RUM implementation receive the support they need to develop a better understanding of the RUM and have regular opportunities to discuss its use, is likely to have the most significant impact upon future progress.

CHAPTER ONE INTRODUCTION

Background

1.1 In 2000 the Royal Commission on Long Term Care recommended free nursing care for the elderly in all settings. This was endorsed by the Minister for Health and Community Care in October 2000. The need for a “*resource allocation tool*”, now referred to as the Resource Use Measure (RUM), was identified for determining entitlement to free nursing care.

1.2 In January 2001 the Care Development Group was established and recommended free personal as well as free nursing care for people aged over 65 years. Once this policy objective was adopted by the Scottish Executive the RUM changed to become a tool to measure relative need rather than determining access to personal or nursing care.

Purpose and Aim of the RUM

1.3 The Scottish Executive’s paper, *Report on the Development of a Resource Use Measure*² set out in detail the purpose of the RUM and the process by which the RUM had been developed. This section and the one that follows reflect the key messages set out in that report.

1.4 The RUM consists of a questionnaire that includes guidance on how it should be completed³. In addition, the RUM briefing and guidance paper provides fuller guidance on completing the questionnaire⁴. The questionnaire requires particular aspects of need to be scored on the basis of information previously recorded in the Single Shared Assessment (SSA), which is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency.

1.5 The scores generated by the RUM questionnaire are added together at the back of the questionnaire itself, in order to assign the client to a particular RUM grouping. These groupings reflect the relative level of need of the client.

1.6 The RUM is currently designed for use in respect of older people over 65 years including those with mental health problems and dementia and/or associated behaviour. The key aim of the RUM is to apply a score to specific needs validated against the SSA process without adding any more than 5 minutes to the SSA process when calculating the RUM score.

1.7 The Scottish Executive has identified how it could be used at 3 levels; individually, locally and nationally, envisioning that:

- Individually the RUM could provide a standardised measure of relative need
- Locally it could:

² Scottish Executive Health Department Circular No. CCD 9/2002. Report on the Development of a Resource Use Measure (RUM) for Scotland. <http://www.scotland.gov.uk/library5/health/rum.asp>

³ <http://www.scotland.gov.uk/about/HD/CCD2/00017673/rumscorecard.pdf>

⁴ <http://www.scotland.gov.uk/about/HD/CCD2/00017673/rumbriefguidance.pdf>

- promote effective use of resources within and across caseloads, teams and services
- promote equity of access to, and provision of, resources
- manage unmet need and inform service planning and development
- Nationally it could:
 - ensure fair access to services through equitable resource allocation
 - monitor performance outcomes

The Development of the RUM

1.8 It was assumed that in assessing older people, there are key characteristics across their range of needs that could inform the relative level of resources required. Those key characteristics formed the basis for variables that would determine the appropriate level of resources required. In turn this would create groupings in which to place an individual's broad resource use category, reflecting their level of need.

1.9 The RUM was developed in two phases: phase 1 from April – December 2001 and phase 2 from January – May 2002. From the outset it was recognised that involvement from front line practitioners was crucial to the development of the RUM to ensure a needs led approach.

Phase 1

1.10 A total of 9 local authorities and their health partners were brought in to the development of phase 1 of the RUM. Practitioners from 4 multi-agency teams then developed 2 questionnaires derived from the Scottish Care Resource Utilisation Groups (SCRUGS) and Issacs and Neville's Interval of Need.

1.11 An analytical framework was developed via the input of expertise and statistical evidence derived from the sample to determine which questions from both sets of questionnaires were best suited to categorising cases according to the individual's relative need. From this the RUM questionnaire was developed.

Phase 2

1.12 Early in 2002, 29 teams from 24 local authorities took part in sampling around 1,000 cases by applying the RUM to current cases that had a recent assessment, and practitioners were asked to choose cases displaying a range of needs.

1.13 From a total of 1080 questionnaires issued, just under 900 were used in the analysis of phase 2. The results showed that the RUM classifications used were an acceptable predictor for the level of need. The best predictor "*fit*" was the Activities for Daily Living (ADL) scoring used in the SSA. Two subdivisions were identified: high and low cost care groups. These were then further sub-divided into Low, Medium and High ADL groupings.

Early Implementation

1.14 Currently the RUM is being implemented in 5 early implementation sites: East Renfrewshire, Glasgow, Orkney, Perth and Kinross and South Lanarkshire. Early implementation is planned to cover the period from January 2003 to March 2004 and at the time of the fieldwork the following areas were involved in the respective early implementation sites.

1.15 In East Renfrewshire the RUM was being implemented in 2 areas, Eastwood and Levern Valley. Together the teams involved the social work department and 2 different NHS trusts. This early implementation covered a relatively small urban area.

1.16 In Glasgow the RUM was being implemented by 2 Locality Planning Implementation Groups, one in South West Glasgow and one in North Glasgow. The South West Glasgow team was involved in the development stages of the RUM during May 2000—May 2002. This early implementation covered 2 relatively densely populated but compact geographical areas.

1.17 In Orkney, the RUM was being implemented across the entire islands, in both community care and care home settings. This early implementation covered one main centre of population and numerous dispersed settlements in an island setting.

1.18 In Perth & Kinross the RUM was being implemented by the North West Perthshire locality team and by reviewing officers across Perth & Kinross. This early implementation covered a large area of rural Perthshire that included a number of small population centres.

1.19 In South Lanarkshire the RUM was being implemented in the Clydesdale area only. This was a predominantly rural area with some medium sized population centres.

Aims of this Review

1.20 The principal aim of this study is to review the processes used to implement the RUM in the 5 initial sites, highlighting what went well, any problems encountered and how the problems were dealt with.

1.21 The research specification listed the specific objectives as being to:

- a. Explore what practitioners and managers understand about the purpose of the RUM
- b. Explore the processes being used to calculate and record the RUM; identifying what makes it easy to calculate and record and what problems are being encountered in so doing
- c. Describe the staff teams currently involved in completing the RUM
- d. Examine how the operation of RUM is affected by the single shared assessment
- e. Record how many RUMs have been completed, compared with how many single shared assessments have been completed
- f. Assess how long it takes to complete the RUM in practice
- g. Identify any areas where the guidance for the questionnaire requires clarification

- h. Explore how issues of confidentiality have been addressed to aid information flow between social services and health
- i. Describe what arrangements are in place for training and informing staff about RUM and its implementation
- j. Explore practitioners' views of the adequacy of training and information provided at a local and central level
- k. Describe the use being made of the RUM score and plans for future use in the 5 initial sites.

1.22 The particular focus of this study is the early implementation of the RUM within the 5 early implementation sites with particular attention being paid to the processes involved and the views of key professionals.

Our Approach

1.23 This study depended heavily upon qualitative research methods in order to be able to develop an understanding of what lay behind the number of RUMs that had been scored. Our approach involved 4 principal stages:

- Survey and Initial set-up
- Pre site visit preparation
- Site visits
- Analysis and Reporting

1.24 The survey and initial set up stage involved reviewing relevant web-based and relevant professional reports and journals in order to compile a brief context for the study. This included a review of the records of Learning Network meetings. Initial contact with the early implementation sites involved circulating a data request schedule asking for basic information about the level of RUM activity and supporting local documentation.

1.25 The data request schedule was sent to each of the 5 early implementation sites and the Scottish Executive in late September. A copy of the schedule is appended at Appendix One. Some returns were received over the following 2 weeks prior to the site visits and interviews commencing. In other cases the requested information was obtained during the site visits.

1.26 Pre site visit preparation involved analysing the data returns in order to adapt the interview schedule for local circumstances and to ensure that a suitably varied range of interviewees was identified and the necessary practical arrangements made so that time spent on-site was used as efficiently as possible.

1.27 Site visits involved semi structured interviews with staff completing the RUM and their managers, in group, individual or paired settings. This approach was designed to ensure that all key aspects of the study were covered whilst allowing interviewees the scope to identify additional issues and features of implementation that were of particular interest to them. The range of types of interview was designed to maximise the range of the staff involved in early implementation who could be involved in the study, recognising the significant time pressures under which they were working. In addition researchers collected any other documentation or records that had not been available prior to the site visits.

1.28 Interviews covered a wide range of relevant issues including the local practice and organisational settings within which the RUM had been introduced. Thereafter the interviews covered the factors that had made the RUM more or less easy to complete, training and support arrangements and more specific issues such as the available guidance, consent and information.

1.29 The great majority of interviews were completed as planned, over a three week period. A semi structured interview schedule was used which is appended at Appendix Two. The profile of those involved in the interviews was as follows:

NUMBER OF INTERVIEWS				
	Practitioners	Practitioners.& Managers	Managers	TOTAL
Group interviews	10	2		12
Paired/Individual interviews	4		21	25
TOTAL	14	2	21	37

NUMBER OF INTERVIEWEES					
	Practitioners		Managers		
	Health	S. Work	Health	S. Work	TOTAL
TOTAL	25	36	9	14	84

1.30 A total of 37 group, individual and paired interviews were conducted with managers and practitioners across the five early implementation sites. This total included 21 individual/paired interviews with managers and 2 group interviews in which managers were involved. Of the managers, 9 were health managers.

1.31 Twelve group interviews were held with practitioners, 2 of which included managers and 4 individual interviews with practitioners. Among practitioners 25 were from health and 36 from social work. Seven of the individual interviews were conducted by phone where it proved impossible to arrange face to face meetings.

1.32 The total number of people interviewed was 84, representing 49% of the total of approximately 173 staff who were involved in scoring the RUM across the 5 sites at the time of the fieldwork.

1.33 Following visits to the 5 early implementation sites, a report was provided to the Scottish Executive that flagged emerging issues and themes.

Structure of the Report

1.34 The report begins with an executive summary of the full report. Chapters 2, 3 and 4 are based upon the data generated from the fieldwork and the analysis of data, whilst Chapters Six and Seven reflect the findings based upon analysis of this data.

1.35 Following this introductory chapter, Chapter Two describes the extent to which the RUM has been implemented in the 5 early implementation sites. It considers how many RUMs have been completed, how many staff were involved in the work and how long it took them. It also reviews current and proposed future use of the RUM.

1.36 Chapter Three considers the context for local implementation including local operational factors, the SSA and local practice concerning securing user consent. It also considers the impact that people's understanding of the purpose of the RUM had upon its introduction, a factor which both influenced local implementation and was a consequence of it.

1.37 Chapter Four considers the arrangements that were put in place to support implementation including guidance, training, local support and the Learning Network. It also considers local arrangements for recording the RUM.

1.38 Chapter Five considers the key issues that emerge from Chapters Two, Three and Four as having affected early implementation and sets out the conclusions that can be drawn.

1.39 Chapter Six outlines the factors that have had the most positive impact upon early implementation and describes ongoing work and priorities for future implementation.

Key Points

The RUM provides a standardised means of grouping older people over 65 according to their relative needs

After 2 pilot phases, early implementation was taken forward across 5 sites

This review examined the extent of early implementation, the issues arising and local responses to them. It was conducted during Autumn 2003

CHAPTER TWO THE EXTENT OF EARLY IMPLEMENTATION

2.1 This chapter describes the number of RUMs completed in each site, and the number and profile of staff that had been involved in scoring the RUM. It goes on to consider time taken to complete the RUM, the use that is currently being made of the RUM scores and planned future uses.

The Number of Completed RUMs

2.2 A total of 719 RUMs had been completed across the five early implementation sites at the time of the fieldwork. These are distributed between the sites as follows:

East Renfrewshire:	82
Glasgow:	49
Orkney:	293
Perth & Kinross:	216
South Lanarkshire:	79

2.3 In all but Perth & Kinross these figures related to RUMs scored on initial SSAs only. The Perth & Kinross figure included 100 RUMs that were scored on re-assessments.

2.4 In one site clients requiring care at home or Occupational Therapy (OT) services did not have a RUM scored on their assessment. This was said by managers to be in an effort to limit workloads.

2.5 Further enquires after the site visits resulted in some updating of these figures, however revised figures are not available for all sites. Perth & Kinross reported that a total of approximately 391 RUMs had been scored by health and social work staff and in East Renfrewshire 248 had been completed by social work to 31st October. The total number of RUMs reported to have been scored across the 5 early implementation sites by the end of October was therefore over 1060.

2.6 Four of the 5 sites reported at the time of the site visits that RUMs were by then being completed on initial SSAs, case reviews and re-assessments.

2.7 The study brief required that the number of completed RUMs be compared with the number of completed SSAs. As a result of differing application of SSA guidance across the sites the researchers could not establish a consistent and comparable basis upon which to count the number of completed SSAs. In some cases it was also unclear whether figures relating to SSA and RUM numbers concerned exactly the same client group categories and periods of time. Accordingly a comparison of SSA and RUM numbers is not included in this analysis.

The Time Taken to Complete the RUM

2.8 Responses regarding the time it took to complete the RUM were largely consistent across four of the 5 sites. Only where the RUM was scored automatically as assessment data was entered into a computerized form of the SSA, was the time significantly different.

2.9 In four sites it took, on average, 5 minutes to complete the RUM. The time taken was said to vary from 5 to 15 minutes with the very great majority taking the shorter time.

2.10 The time involved in scoring the RUM therefore fell within the target of 5 minutes set by the Scottish Executive in its stated purpose. Automatic scoring understandably had a nil time impact. In more complex cases where specific issues concerning the design of the RUM were relevant, the time taken could be 15 minutes, a figure which exceeded the target time by up to 200%. The number of cases taking this length of time was unclear from the available data.

2.11 The factors reported as affecting the time it took to complete the RUM also affected how easy it was to complete. Positive views were expressed about the brevity of the RUM and when coupled with what was described as its clear and straightforward layout, the format of the RUM had a generally positive impact upon the time taken.

2.12 Experience in using the RUM was said to be important in enabling someone to complete it quickly, particularly when the SSA presented clearly the information that allowed the RUM questions to be answered. Ensuring that the same member of staff completed the RUM as had compiled the SSA, preferably immediately on completion of the SSA, were identified as other important determinants of the speed with which the RUM could be scored. Finally, knowing the person upon whom the SSA had been completed and the RUM scored also enabled staff to complete the RUM quickly and confidently.

2.13 The general guidelines within the RUM were said to affect the time taken to score the RUM by making it easy to calculate the score. However, the exact opposite was also reported. A significant number of practitioners commented that simpler, clear cut cases were easier and faster to calculate. One said it was easier if you did not read the guidelines “*as they just confuse*”. In more complex cases the time taken to ponder and review and to refer to the guidelines was said to be greater. In this context however, the guidelines were said to reduce the time that would otherwise be taken.

Number of Staff Involved In Completing the RUM

2.14 The initial response to the data request to early implementation sites did not elicit comprehensive figures regarding the number of staff that were involved in scoring the RUM. Accordingly this issue was followed up during the site visits. The figures below therefore represent a combination of documented information and the results of qualitative interviews with managers and staff.

2.15 The information available from the 5 sites regarding the number of staff involved in implementing the RUM was not always clear. In some cases, practitioners and managers from health or social work were unsure about the number of staff involved from their respective partner agency.

2.16 In others, access to RUM training was initially presented to the researchers as indicating that the staff members concerned were scoring the RUM. In some sites it proved difficult to be clear about the exact number of staff that had attended training sessions and even where this was possible the number thereby indicated did not always match the number of staff that were said to be completing the RUM. In some cases staff said that they were not in fact doing so or that they were doing fewer than they might have done. As a result of uncertainties about the purpose of the RUM and a perceived absence of response to their practical questions about scoring the tool, they were choosing not to prioritise this work.

2.17 Despite this, the following picture emerged as being the most accurate profile of the number of staff members (not full time equivalent posts) that were involved in scoring the RUM.

2.18 In East Renfrewshire a Community Care team operating in both Eastwood and Levern Valley has 12 staff, some of whom are temporary. A health team of 6 staff is based in Clarkston and the Mental Health team for the over 65's also has 6 staff. No District Nurses are currently scoring the RUM. The total number of staff scoring RUMs in East Renfrewshire was therefore 24.

2.19 In North Glasgow the Community Older Person's Team has 15 members, and includes social workers, Occupational Therapists (OTs), physiotherapists and nursing staff. Only 5 staff have been operational since September 2003. A Community Older Person's Health Service has 4 staff and up to a further 20 community based District Nurses were also reported to be completing the RUM. The total number of staff scoring RUMs in Glasgow North was therefore approximately 29.

2.20 In South West Glasgow an integrated social work and health group works from the Elderpark Clinic. It has 3 seniors who manage the team, one from health and 2 from social work. The Health Team is comprised of 2 community nurses, 1 support nurse, 1 dementia care co-ordinator and 2 rehabilitation support workers. The Assessment Team has 4 social workers, 2 care managers and 1 home maker. Finally, the Care Management Team has 5 social workers, 1 social work assistant and 1 Home maker. In addition a dietician, physiotherapist, Support Nurses, Podiatrist, and a post of income maximisation for older people also work out of the clinic. All have been trained to score the RUM apart from the rehabilitation workers and the home makers so the total number of staff scoring RUMs in South West Glasgow is therefore 23.

2.21 In Orkney a single integrated social work and OT Community Care team has 12 staff including the assistant team manager completing RUMs. In addition, 3 community nursing teams that operated across geographical and organisational boundaries covering part of mainland Orkney and outlying islands were comprised of a total of approximately 37 staff, all of whom were reported to be completing RUMs. The total number of staff scoring RUMs in Orkney is therefore approximately 49.

2.22 In Perth & Kinross the North West Perth social work locality team has 6 staff members including an OT. In addition, GP surgery-based nursing staff across North Perthshire number approximately 13 staff. Staff members at 2 local hospitals also score the RUM but the numbers involved are unclear. The total number of staff scoring RUMs in Perth & Kinross therefore exceeds 19.

2.23 In South Lanarkshire the Older People Team has 15 staff, a Community Mental Health Team has 12 staff and 2 nurses work out of the local health centre. No health visitors are completing the RUM. The total number of staff scoring RUMs in South Lanarkshire is therefore 29.

2.24 In total therefore, approximately 173 staff were involved in scoring RUMs across the 5 early implementation sites.

2.25 Most staff worked in single agency social work or health teams, with a minority working in integrated teams. The location of the health staff involved in completing the RUM included those based in GP surgeries and rural cottage hospitals. As the detailed picture above shows, RUMs were being completed by a wide range of professionals including; social workers, care managers, OTs, home care organisers, district nurses and staff nurses. In a number of sites Community Psychiatric Nurses (CPNs) and mental health practitioners were not involved with the RUM but where Community Mental Health Teams were operational, team members usually were. In most instances health visitors appeared not to be involved.

Current Use of RUM Scores

2.26 The survey data and qualitative research findings of this study show clearly that very little formal use is being made of the RUM scores. The one significant exception was Orkney where scores have been used in older people's strategy work, other specific service development plans to identify gaps in services and to review needs levels in care homes.

2.27 Most comments about use of RUM scores reflected the view that scores cannot and should not be used at this stage. The basis for this view was mixed.

2.28 Some comments reflected upon the lack of readiness of local systems whilst others focussed upon the perceived stage of development of the RUM itself. Typical comments were, "*no infrastructure to use it*", "*no use as we have not inputted the data, just have boxes lying everywhere*" and "*the RUM is not far enough advanced for us to actually use.*"

2.29 Practitioners in most of the sites were unaware of whether the RUM scores were being used or not, nor what they would be used for in the future. Few practitioners were informed about this issue, whilst managers, even if some displayed little detailed knowledge about current use, felt more able to comment. There was a clear sense that use of RUM scores was, and should be, a manager-led issue.

2.30 Informally however, there was evidence that RUM scores were being used. In 2 sites RUM scores were used as a point of reference in meetings about admission to long-term care, as an extra piece of information to inform decisions and also to enable practitioners to reflect on the services that individual clients receive in relation to their RUM score and to compare this with other users. "*...He's a B*" was said to typify how RUM scores had come to be used.

2.31 A particularly interesting "*informal*" use of RUM scores within a multi-disciplinary team was as the basis for a shared vocabulary between social work and health staff. The ability to identify individuals with a particular RUM score assisted team members to convey to their work colleagues the needs and abilities of an individual more quickly and accurately.

Future Use of RUM Scores

2.32 A small majority of practitioners did not know what future uses the RUM scores would be put to either nationally or locally. Moreover they did not see themselves using the scores in the future, most because they saw no direct benefit to it or benefit to their clients.

2.33 Managers much more readily suggested ways in which they would either like to use the scores or described what they had been told it would be possible to use them for. However managers in most of the sites said that decisions had not been taken formally and that they could not therefore be certain about future use.

2.34 It is important to note that Orkney was different to the other four in that the RUM scores collected have already been fed into operational and strategic planning.

Key Points

A total of 719 RUMs had been scored at the time of the fieldwork, with local totals ranging from 49 to 294

Most were completed within 5 minutes but complex cases could take up to 15 minutes

Approximately 173 staff representing a wide range of health and social work professions were scoring RUMs across the 5 sites

Little formal use was being made of RUM scores except in Orkney but informal use of scores was widespread

CHAPTER THREE THE LOCAL CONTEXT FOR EARLY IMPLEMENTATION

3.1 The purpose of this chapter is to consider the local context within which early implementation of the RUM has taken place. The key aspects that it considers are management, operational and joint working arrangements, implementation of the SSA and arrangements to obtain user consent for the exchange of information between partner agencies. In addition it considers the extent to which staff were clear about the purpose of the RUM.

General Operational Considerations

3.2 Across all sites implementation of the RUM was the most recent of a number of major policy and practice initiatives, the most significant and directly relevant of which was the Joint Future initiative and within that the introduction of SSA. The SSA and the RUM are tools that are to be used by a wide range of practitioners across social work, health and housing. These agencies are the principal partners within the Joint Future agenda and as such are involved in ongoing developments to introduce new and enhanced joint planning, management, working and financing arrangements, covering a range of community care and support services.

3.3 Many of the staff who were involved in the study said that they were under considerable time pressures at the time that RUM early implementation took place as a result of these other developments.

3.4 The extent to which joined up working practices were in place and operating efficiently at a local level had an important impact upon how the RUM was received by managers and practitioners and also the issues that arose in its implementation. Opportunities to discuss issues and share practice across agency boundaries were important factors in enabling a shared view to develop and implementation to be handled consistently. The presence of a lead officer who acted as a readily identifiable “*champion*” to whom all staff had ready access was also an important factor assisting implementation.

3.5 However such joint arrangements were not always enough to ensure smooth implementation of the RUM and many staff commented upon the impact of the timing of RUM implementation relative to the roll-out of SSA. The key factor was whether introduction of the RUM took place before, at the same time or after the SSA was rolled-out. This affected the opportunities for RUM training to be incorporated into SSA arrangements and the overall burden of work that staff were coping with in moving forward the implementation of both initiatives.

3.6 In most of the sites staffing issues had not had a significant impact upon RUM implementation. However, in the 2 sites where staffing issues had arisen, a shortage of practitioners reduced the number of available staff to undertake the work and a high turnover of managers reduced the available level of support for staff.

The Practical Involvement of Health and Social Work in Early Implementation

3.7 The pattern of involvement by health and social work staff varied greatly, regardless of which teams or areas had been identified as the focus of RUM early implementation. In one site 90%, and in another 80%, of the completed RUM scores were said to have been completed by social work. In other locations, health were said to have completed a similarly high proportion of the RUMs.

3.8 Health and social work staff who were co-located or who enjoyed particularly close inter-agency working relationships felt that this had enabled them to talk through their concerns and to remain better focused upon moving forward with RUM implementation.

3.9 In some areas SSA implementation was said not to be complete and the opportunity to score RUMs was thereby reduced. Others commented that the extent of health and social work scoring of the RUM was closely related to the extent of their prior involvement in undertaking SSAs. In one case, deciding which agency should produce the SSA could be described as a process of "*last man standing*". Here, most of the work had fallen to one of the partners and the pattern of RUM activity closely reflected the established pattern of SSA activity.

3.10 In 2 sites, health staff's relatively limited involvement was related to the limited extent to which health and social work IT systems were compatible. This had left health staff to cope with the additional burden of creating manual records that then had to be passed over to social work for inputting onto the computer. Practical hold-ups in arranging for this transfer of records to take place resulted in some delay in completing and processing the RUM.

3.11 Reasons that emerged for RUMs not being completed were that staff forgot, that they had not been trained to do it or that they were uncertain and concerned about the RUM itself, in particular its ability accurately to reflect relative needs. A small minority reported that they had taken a deliberate decision not to do them in view of similar concerns and other competing demands upon their time.

3.12 The effectiveness of line management arrangements for implementing the RUM was raised as an issue by both managers and practitioners in a variety of sites and work settings. Some managers were aware that not all of their staff were scoring RUMs as frequently as they might and a minority described themselves as being reluctant to push the issue in view of the other operational pressures. More generally, there was considerable sympathy for the view that frontline staff should prioritise direct work with clients.

The Affect of the SSA

3.13 Whilst the issues regarding SSA implementation that are highlighted by this study are not central to its principal aim, they nevertheless constitute an important element of the context for RUM implementation and are therefore dealt with here in some detail.

3.14 As we have seen previously, SSA is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency. To ensure the most appropriate assessment

response, whichever agency or professional is the initial contact, agencies are developing an integrated system for receiving and acting on referrals

3.15 In line with Scottish Executive guidance, all 5 sites reported that the RUM was scored using information from the SSA. However early implementation sites varied in how they had applied the guidance on SSA contained in the Scottish Executive circular CCD 8/2001 and these variations were important elements within the context for early implementation.

3.16 The written format and structure of SSAs varied between areas and within some early implementation sites, between social work and health service versions. The most significant variation in format concerned the amount of detail that was required by the basic structure of the SSA form itself, which included tick boxes and / or spaces for descriptive comment.

3.17 The significance of the SSA format was further increased by the written style of the assessment author, be it cryptic or relatively descriptive. Both of these features of SSAs influenced the ease with which the RUM could be populated from the SSA.

3.18 Where the same person completed the SSA and the RUM these problems were reduced in some cases, because practitioners used their prior knowledge of the client to complete the RUM, as well as the information that was recorded in the SSA. It was acknowledged by staff that this may not represent good practice. This practice did, however, serve to highlight the impact of variations in the amount of detail that was generally sought when completing a SSA, depending upon the level and complexity of the individual's needs.

3.19 This question of the amount of detail that is normally captured by an SSA is linked to three broader issues that also emerged concerning practice relating to the SSA. They were:

- The SSA and levels of need - whether SSAs were conducted on all older people requesting a community care service regardless of their level of need or whether only those with complex or specialist needs were assessed using this approach.
- The length of time it takes to complete the SSA - how long does it take and why and what practices have developed regarding when a RUM is completed
- What is a re-assessment? - the basis upon which a decision is taken to re-score the RUM

Each of these issues is considered in more detail below.

The SSA and levels of need

3.20 In 2 early implementation sites SSAs were carried out on all older people over 65 years requesting a community care service, regardless of the level or complexity of their needs. In 2 of the other early implementation sites a distinction was drawn between people considered to have complex or specialist needs that would require support from a number of agencies and people with lower levels of need whose requirements could be met by a single agency. In these 2 sites, only in the former case would a SSA be carried out.

3.21 This is a particularly notable aspect of the varied application of circular CCD 8/2001 guidance which describes the SSA as being

“ for people with community care needs seeking help from social work, health or housing authorities and who may require the services of more than one professional discipline or agency.”

3.22 The impact of this variation in practice was said by many practitioners to be significant in 2 respects.

3.23 Firstly, conducting SSAs only on people with complex or specialist needs excluded a significant number of service users from the SSA process and therefore from having a RUM score calculated. In most areas an alternative formal assessment would be conducted on the low needs group, but practitioners were left with a significant proportion of their caseload falling outside the parameters of the RUM initiative.

3.24 For many, excluding a large number of people with low levels of need in this way was a matter of concern because it could result in data being collected which misrepresented the overall needs profile of their client group and thereby, the relevance and potential of the RUM as an aid to caseload management and planning.

3.25 In one area a RUM score had been ascribed to each of the clients with low levels of need despite their not having been the subject of a SSA. Staff were as a result unclear as to the importance of the SSA as the basis for scoring the RUM and unsure if this alternative practice was acceptable.

3.26 Secondly, where SSAs were carried out on people with low levels of need the process of assessment involved asking for all of the information that was required subsequently to enable the RUM to be scored, even when this may not have been relevant to the assessment concerned.

3.27 The type of information that is required for a SSA is principally determined by the complexity of a persons needs. It is unclear whether the issue of adequately being able to score the RUM was related to the complexity of the persons' needs, regardless of the level of those needs, or whether people with low levels of need, regardless of their complexity, received a relatively limited assessment.

3.28 This issue resulted in difficulties in being able to score the RUM from the available information and thereby hindered efforts to implement the RUM in these types of cases.

Length of time to complete an SSA

3.29 The length of time it takes for an initial SSA to be completed varied considerably between the various early implementation sites and within individual sites, between agencies.

3.30 Some practitioners reported that SSAs were completed within approximately 5 days, others that they could take up to 4 weeks to complete. Where completion time was short, practitioners were clear that the RUM should be scored after the SSA had been completed and that information from the SSA should be used.

3.31 Where SSAs took weeks to complete however, practitioners were less clear as to the point in the process at which the RUM should be scored. Whilst many acknowledged the logic of doing so at the end of the process, others commented that scoring the RUM at the beginning and/or the middle of the process enabled a clearer picture of the full range of relevant needs and the extent of change over time to be captured.

What is a re-assessment?

3.32 In the case of initial SSAs, RUMs were being scored in all sites subject only to local variations in SSA practice, as outlined above.

3.33 However, where RUMs were being scored on re-assessments, doubts were expressed regarding the accepted definition of “*re-assessment*”. Many people’s needs fluctuate rapidly and on occasions only minor changes in the nature and level of assessed needs are apparent. Managers and practitioners were often unclear regarding the scale of change in the assessed needs that warranted the re-scoring of the RUM.

3.34 In one site, practitioners whose job it was to review service users’ care needs were completing a RUM after each review, even though they were unclear as to whether the review constituted a “*re-assessment*” in terms of the RUM. In other sites where SSAs had only very recently been introduced at the time of the site visits, RUMs had been scored by ordinary practitioners on the basis of other forms of assessment before the SSA was introduced.

3.35 At the time of the early implementation site visits all sites reported that RUMs were, or were very soon to be, scored on both initial SSAs and re-assessments.

The Affect of the RUM on the SSA

3.36 As well as the SSA having implications for the RUM, the RUM was also said to be having both a positive and negative impact upon SSAs in the early implementation sites.

3.37 The positive influences of the RUM upon the SSA concerned the extent to which it had encouraged practitioners to increase the range of issues and aspects of need that were recorded within the SSA. SSAs were now said by some to be “*covering all areas*” and therefore to be more “*comprehensive*”.

3.38 Also, information was being recorded more fully in the SSA because of the need to provide answers to specific questions in the RUM. This had challenged the assumptions of some practitioners by requiring them to ask questions that they would not normally ask.

3.39 The negative influences were largely the reverse of the positives. The SSA was now said to take longer with additional detail being recorded and less narrative text being used, in order to address the information requirements of the RUM. The lack of narrative was said to introduce the possibility that important background/contextual information could be missed. Also, a number of questions in the SSA were being asked even when they were not relevant

in the particular circumstances under consideration, to ensure that the necessary information was available to score the RUM.

3.40 Variations in the application of SSA guidance, particularly as regards its use in assessments where multiple services were not required, have led some managers to view the RUM as driving the content of assessments. However others view early implementation of the RUM as a catalyst that has led to variations in SSA practice being highlighted.

Consent

3.41 Service user consent to the exchange of information between statutory partners is a cornerstone of the arrangements that should ensure that the service user enjoys proper protection of his or her rights and is closely linked to issues of confidentiality and data protection. Accordingly all health and social work agencies should have in place policies and procedures to ensure user protection and compliance with the relevant legal requirements. They should also have arrangements in place to ensure that users are aware of their rights in this regard.

3.42 This study was able to confirm that general information about confidentiality and data protection was available from the local statutory partners but that this more general information was not provided for or discussed with service users when a SSA or RUM was being completed.

3.43 As regards securing consent relating specifically to the RUM, each of the early implementation sites reported that they were working on the basis that SSA consent arrangements concerning the sharing of information also covered RUM scores.

3.44 None of the sites provided information to people who were being assessed about the existence or use of RUM scores, although a few practitioners reported that they did give brief verbal information to some users. None of the early implementation sites had a specific policy or procedure governing this matter although 2 sites reported that it would be mentioned in future SSA information leaflets.

3.45 Concern was expressed by practitioners that information regarding a persons' RUM score was not available to the subject of the RUM themselves because as a result the person would not be able to challenge the RUM score as they could their assessment. Practitioners were also unclear about which information regarding the RUM could be shared.

The Purpose of the RUM

3.46 Staff views on the purpose of the RUM not only developed from what they were told or read but also, from how they found it to work in practice in the context of other competing pressures. Their views on the purpose of the RUM were therefore not only influenced by their implementation experience but were also influential upon how they viewed that experience.

3.47 A broad range of views regarding the purpose of the RUM were noted during this review, with over 20 different purposes being identified across the 5 early implementation sites. Some of the biggest differences emerged between managers and practitioners.

Managers' Views

3.48 Most of the managers interviewed described the purpose of the RUM in terms that reflected the stated purpose as set out by the Scottish Executive. There were also however a number of references to its use in “*assessment*” and “*as a basis for demanding*” more resources, which seemed to indicate rather less clarity about its purpose.

3.49 Most commonly managers associated the purpose of the RUM with resources and needs with a significant number also noting the RUM’s potential to support local and national planning. Managers also saw its potential to assist equitable resource allocation. A small number of managers considered the RUM to have potential as an aid to caseload management but others expressed some reservations in this regard. These reservations concerned the lack of consistency in the way that the RUM was being scored by different practitioners and in some sites the practice of not scoring the RUM on assessments reflecting low levels of need. These assessments often comprised a large proportion of practitioners’ workloads.

3.50 Some managers felt that the Scottish Executive’s definition of purpose did not go far enough. The RUM’s use for grouping and planning purposes was viewed as being directly linked to decisions about resource allocation and funding but uncertainty about how RUM data might inform future resource allocation and funding, identified through the analysis of the research findings, represented a gap in people’s overall understanding of the RUM.

3.51 Managers’ comments on the future use of the RUM often led them to reflect on the issues that they felt were emerging about current RUM practice and which could affect its future use. Many reported that future use would depend on the way in which the tool itself was finalised, implying that further development of the tool would be required before its future use could be confirmed.

Practitioners' Views

3.52 When asked directly about the purpose of RUM, most practitioners related it to resources and needs whilst other purposes of the RUM that were referred to included; identifying levels of dependency, comparing needs with resources, identifying future needs and changes over time and identifying unmet needs.

3.53 Some concern was expressed that RUM scores would be used to underpin national resource allocation. This concern related to the use of data nationally that had been collected locally under arrangements that reflected a perceived absence of agreed definitions, criteria or guidance to ensure consistent application of the RUM.

3.54 The scope for the RUM to help with caseload management was commonly referred to by practitioners with the majority expressing the view that the RUM could not assist with this aspect of their work. For some this was because the RUM was not being applied to all client groups within their caseloads, because in their area the SSA, upon which the RUM is scored,

was only completed for service users with complex needs. Others considered that it was important to view the RUM as just one tool of many, which on its own could be of little help in caseload management.

3.55 The aspects of need that were scored within the questionnaire were frequently commented upon in the context of discussing the purpose of the RUM, with uncertainty being expressed as to whether they were sufficiently specific and comprehensive. Finally, questions were raised regarding the ability of the RUM to produce a meaningful and accurate score on the basis that it is not carried out in a sufficiently consistent and reliable manner.

3.56 A significant minority of practitioners were unable to comment on the purpose of the RUM other than to say that it was “*something that the SE needs in order to generate figures*”. In one site that had been involved with RUM implementation from Phase 1, practitioners viewed their involvement with the RUM pilot as having made a positive contribution to developing arrangements that would facilitate access to free personal and nursing care. With the shift to the RUM being used as a measure of relative need, they felt that the exercise had become focussed upon the potential administrative benefits of the RUM rather than promoting user access to free care.

3.57 Some staff in all of the sites however appreciated the need for a tool such as the RUM and understood its potential in the future.

Key Points

Joint working practices between local partners provided a positive basis for RUM implementation

The timing of RUM implementation relative to SSA roll-out had an important impact upon whether training for each could be integrated

Health and social work staff involvement varied significantly and the level of their prior involvement in conducting SSAs was a particularly important influence

Scoring the RUM was not prioritised by some staff and management arrangements did not always address this problem effectively

Different interpretation of SSA guidance and uncertainty about when initial and re-assessments should be undertaken affected the extent and consistency of RUM implementation

Many staff were unclear about the design and purpose of the RUM with most views concentrating upon its planning potential

CHAPTER FOUR ARRANGEMENTS TO SUPPORT EARLY IMPLEMENTATION

4.1 The purpose of this chapter is to consider the various documents and arrangements that were put in place to support early RUM implementation and to report upon the extent to which they were effective in doing so.

The RUM Questionnaire

Layout and Style

4.2 The basic tool for scoring the RUM is the RUM questionnaire and as such it constituted the principal means by which early implementation was to be taken forward and practitioners supported in doing so.

4.3 Most interviewees were positive about the lay out and structure of the RUM questionnaire. Its brevity and clarity were said to be particularly commendable features.

4.4 Comments concerning the general guidelines for completion of the RUM questionnaire that are set out at the beginning of each section of the document reflected a wide range of views. Few practitioners had very much to say about the guidelines in general and some of the strongest comments were relatively negative. One person commented

“I have not read the guidance. If you are a nurse you do not need to read the guidance as we know what the questions mean. They are self explanatory.”

4.5 Others indicated that they would not be reading them again, and said

“The guidelines are vague and repetitious”.

4.6 Amongst those who had read the general guidelines, the most common area for comment concerned the advice within the RUM questionnaire guidelines *“to select the higher score where needs fluctuate”* as this was seen as creating the possibility that the true picture of needs could be distorted. Other issues were identified relating to coverage of specific areas of need within the guidelines and these are explored more fully in the next section.

Completing the RUM Questionnaire

4.7 A number of detailed issues were raised concerning the RUM’s ability to capture and adequately reflect some aspects of need in the scoring.

4.8 The manner in which the RUM records mental health care needs was a matter of widespread comment. Managers and practitioners alike were of the opinion that the nature and extent of someone’s mental health needs and whether and how often they fluctuated was inadequately reflected in RUM scores.

4.9 Examples of the issues raised included:

- What to do when you know that needs have changed informally, but a reassessment has not been completed
- Someone's mental health can be very stable for a while and then suddenly go "off the wall" – how are you meant to capture this?

4.10 Bowel management was another area where the scoring of need was considered to be particularly problematic. Some of the issues here were:

- The term "*bowel management*" is too all inclusive – it spans from medication for laxative use on a daily basis to the full involvement of a qualified nurse
- Nurses are more knowledgeable about bowel management and can get a better idea of what is happening and why
- How do you ask about bowel management if you are responding to a query about problems with the house?

4.11 Some staff noted the limited ability of the RUM to adequately capture and score the needs of people with a combination of a low ADL score and other high scores that were sporadic. Others were unclear how the RUM was intended to capture changes in need concerning mental health and behaviour that form part of a pattern but which were not sufficiently frequent to be captured within the 4 week timescale specified for question 11 of the RUM questionnaire. Such changes over time were considered to be important factors in determining the overall level of need of individual service users.

4.12 These issues were considered to reflect an over-emphasis upon physical and functional ability relative to the mental, social and emotional aspects of a person's needs, a feature that was reinforced by the absence of a means to record whether ability was related to motivation or individual preference.

4.13 Many practitioners felt that there was too much scope for interpretation and inconsistency in completing the questionnaire and that this belied the apparent simplicity and ease with which the RUM could be completed. Managers also reported that RUM questionnaires were not being scored consistently and that this was undermining confidence in the reliability and comparability of RUM scores.

Briefing and Guidance

4.14 The general guidelines for completing the RUM questionnaire within the questionnaire itself, which were reported on in the previous section, were supplemented by a fuller document entitled, *Briefing and Guidance for Implementation*. This document provides a more detailed explanation of how the RUM relates to the SSA, how each element of need should be scored, quality assurance arrangements and using the data. It also contains responses to a number of frequently asked questions.

4.15 Most staff were unclear about the distinction between these two sets of guidance, indeed many said they were unaware of the existence of the *Briefing and Guidance* paper. Amongst those who did know of the *Briefing and Guidance* paper views differed as regards its style, clarity and usefulness. However, to the extent that it provided a more detailed

explanation of the same information that was contained with the general guidelines, it attracted similar comments regarding the scoring of individual needs within the RUM and guidance to “*select the higher option*”.

National Training

4.16 The Scottish Executive had provided a total of 16 RUM training sessions across the 5 early implementation sites. The number in each site ranged from one to 5 and the sessions involved:

- RUM Overview presentation
- RUM Questionnaire & Score Card Presentation
- Local implementation Plan Presentation
- 2 Workshops:
 - Calculating the RUM Score followed by discussion and question and answer session.
 - Completing the RUM Questionnaire & Score Card followed by discussion and question and answer session

4.17 The Scottish Executive training sessions provided the first real opportunity for most practitioners and managers to receive a detailed explanation of what the RUM was and how it was intended to be implemented. Views about the content and delivery of the national training were predominantly positive reflecting general satisfaction with what had been provided.

4.18 Views about the practical arrangements and the composition of the groups were less positive. Health staff who had attended the training reported that their health colleagues had been under-represented at the training whilst views amongst practitioners were mixed as to whether there had been too few or too many managers in their group. The venues (arranged by local agencies) were described as being “*posh*”, implying inappropriately expensive. Finally it had proved difficult for some staff to get time away from their workplace because of time pressures and this had often determined who could and who could not attend the sessions. In the case of Orkney, travel distance was also a concern.

Local Arrangements to Cascade National Training

4.19 Arrangements were intended to be made at a local level to ensure that the learning achieved in these national training sessions was cascaded to those managers and practitioners who had been unable to attend the sessions themselves.

4.20 The extent to which this training was cascaded varied greatly, as did the format of the feedback that took place. In most cases it was provided informally at a team meeting or as and when staff members had time to talk to the person who had attended. In a small number of sites such an informal and flexible approach mirrored the working arrangements on the ground and was well suited to established local arrangements. This was particularly the case where staff members were co-located.

4.21 In those areas where staff members were dispersed across a number of different locations or were working within single agency teams however, the absence of structure in

the cascade arrangements and in some cases, the absence of a colleague who had attended a Scottish Executive session, hindered learning. The majority of practitioners who had not attended Scottish Executive training sessions reported that the feedback that they received from those who had attended had left them feeling ill prepared for RUM implementation.

Local Training

4.22 Beyond the informal cascading of national training, none of the 5 sites had provided staff with “*formal*” local RUM training.

4.23 It had been envisaged that RUM training would be integrated into arrangements for SSA training. However, in three sites training on SSA had been completed prior to early implementation of the RUM, thereby affording no opportunity to integrate the two. In these cases, local RUM “*training*” initiatives were described as having included “*catch up workshops*”, team meeting agenda items, newsletters and RUM coverage within staff induction. In the other sites SSA roll out was incomplete and where training was ongoing, training relating to the RUM had been incorporated into the programme and had been well received.

4.24 The sites where SSA roll-out was complete were more critical of the timing of RUM implementation from an operational perspective due to the time demand associated with separate, rather than integrated, training arrangements.

4.25 The extent to which there had been integration between SSA and RUM training was therefore limited but where SSA training was ongoing, steps had been taken to incorporate time to consider the RUM and in all locations it was planned to do so in the future.

Local Support Groups

4.26 In one site a RUM development group and a number of other pre-established groups where RUM was an agenda item were operating. These included practitioner support groups and SSA groups. This was noticeably different to most other sites where in general, local support arrangements were less well developed.

4.27 Another site also reported operating a SSA group, which would include RUM and earlier in the RUM implementation process small meetings had been hosted by the local RUM lead officer to allow people to ask questions and share experiences. In another site, practitioners noted the supportive role of the RUM lead officer.

4.28 Other avenues of support that were reported included peer support, good communication channels and informal discussions with colleagues. In some cases staff remained unaware of the support that was available to them even where local support arrangements were operating.

4.29 The absence of formal training was less significant where close and supportive working relationships between colleagues provided opportunities to discuss issues as they arose. Close inter agency working arrangements, co-location and, conversely, a highly

dispersed rural workforce, were all situations in which informal arrangements had proved to be an effective option.

4.30 Overall, whilst few support arrangements had been established specifically to deal with the RUM, in some locations pre-existing SSA groups were picking up on RUM issues. In other locations, positive and supportive working arrangements were helpful in enabling practitioners to address issues concerning the RUM.

The RUM Learning Network

4.31 The RUM Learning Network is the national group that was established by the Scottish Executive and partner agencies to enable discussion at a national level about issues arising during early implementation of the RUM.

4.32 Knowledge about the RUM Learning Network was greatest among those who had actually attended the meetings, but some other practitioners were aware of the group and were able to comment upon the feedback that they had received from their agency representative on the group.

4.33 Others, however, knew little or nothing about the Learning Network and one practitioner commented

“ only if you go to the Network do you know about it.”

4.34 In 2 sites, some practitioners who knew of the Network reported that they got little feedback from those who attended but they were unable to say whether information about the RUM that had been provided within the sites had come as a result of the Learning Network but had not been directly attributed to it.

4.35 Some of those who had attended acknowledged that it was their job to feedback to their colleagues, but said that they were often uncertain what was relevant or useful to feedback. In some cases this was because those attending were not sufficiently clear themselves about what had been discussed and therefore what would be useful to feedback to colleagues.

4.36 Despite the Network having been promoted as the national group for supporting RUM implementation, some of those who had attended the Network and those who had not, were unclear about its purpose. Analysis of the research findings has identified 3 key questions:

- Was it targeted at managers or practitioners?
- How much detail was it appropriate for the Network to get into?
- Was it intended to be an avenue for feedback to go from the early implementation sites to the Scottish Executive and vice versa?

4.37 The absence of clarity amongst staff regarding the answers to these questions suggests that the intended purpose of the Network had not clearly been communicated to staff in the field.

Conveying the Purpose of the RUM to Practitioners

4.38 One of the specific objectives of the training and support arrangements that have been reviewed here was to explain the purpose of the RUM to practitioners. One group of practitioners that operated in a well established multi-disciplinary setting with significant representation and attendance at the Learning Network was very positive about the way in which the purpose of RUM had been conveyed. They were satisfied with both the Scottish Executive's presentation / study afternoon and the communication within their team and ongoing feedback from their management.

4.39 Others, however, reported that the issue of purpose had come up at network meetings but that it had not been answered. At a local level communication amongst teams regarding the purpose of RUM was mentioned in only one site where joint working and the sharing of information was well established. Overall this aspect of the learning agenda had not had a particularly high profile and whilst many staff could recall discussing the development of the tool and how to score it, they could remember little being said about the actual purpose.

Arrangements for Recording the RUM

4.40 The final element of arrangements to support early implementation concerned the means by which the RUM was to be scored and recorded.

4.41 In only one site was the RUM score calculated automatically, as data was entered into the electronic SSA. But the different arrangements that were in place for health and social work staff respectively were reported to continue to cause some difficulties.

4.42 In this one site the RUM was completed by either health or social work depending upon which staff were involved at the point when the SSA was completed. Health had an IT system for SSA which did not include the facility to calculate the RUM score automatically. Social work operated a fully integrated system that enabled the RUM to be scored automatically as data was keyed into the computerised SSA record. If health scored the RUM, they passed it to social work to put onto their computer system. This involved a copy of each RUM being produced and being passed either by hand or by mailing them directly to social work. Sometimes practical difficulties led to the "*batching*" of RUMs and the associated delay in handing them over and keying in. If social work completed the RUM it was scored automatically as data was keyed into the computerised SSA record.

4.43 Four of the 5 sites were recording the RUM manually and in most cases the system was working well, however detailed arrangements did vary between these sites.

4.44 In one site the RUM paperwork completed by social work staff was passed to administration staff who logged the scores. The RUM paperwork that was completed by health staff was sent to the social work administrative staff that typed the score in and checked the manual RUM calculation.

4.45 In another, where social work and health staff worked in an integrated team, a paper RUM was completed and passed to administrative staff who typed it into the electronic version of the RUM that all early implementation sites were given and confirmed the manual score. The electronic RUM had no reporting or analysis functions and once the score had

been entered into the electronic version it was just “left”. Officers reviewing care plans wrote the RUM score onto the bottom of their review record and sent a photocopy of the RUM to the RUM Co-ordinator. These staff said that they would have preferred it to be automatically generated.

4.46 In a third the SSA was typed up and photocopied and sent to a central social work administrative team. The RUM paperwork and score stayed in the client file. In another office at this site, the RUM score only was entered onto a spreadsheet and the SSA was entered electronically.

4.47 Only a small number of comments suggested that remembering to do the RUM after having completed the SSA was at all problematic.

4.48 Most managers felt that the RUM would be less accurate if staff had to calculate it manually and promoted the use of an automated system that had its roots in the assessment. This view related to the perceived inconsistencies that were apparent in the way that different staff interpreted the guidance and scored individual elements of the RUM. Others noted that when practitioners are busy or overloaded, the detail that goes onto forms may be limited, thus reducing the accuracy of the score for manual RUMs.

4.49 Conversely, if RUM scoring were to be automated concerns were expressed that inconsistencies in recording within the SSA would not be picked up as they would if a practitioner was reviewing the data in order to score the RUM.

4.50 For many managers, automated calculation of the RUM would remove what is currently perceived to be a significant additional time burden upon their staff and generate more accurate and consistent data that in turn would generate more confidence in the tool amongst practitioners.

4.51 All areas indicated that their intention was to develop compatible or integrated health and social work software with which to record the SSA and score the RUM and most managers were aware of the RUM-Integrated Care Assessment Data Summary (ICADS)⁵ project which is being taken forward by the SE to develop an integrated data strategy.

⁵ <http://www.scotland.gov.uk/consultations/health/RUMC-00.asp>

Key Points

The RUM questionnaire was clear and suitably brief but guidelines for completion received mixed reviews

Staff were unsure as to the RUM's ability to capture sufficient detailed information to establish relative need

Few practitioners knew about the Briefing and Guidance and staff found that it provided them with little additional clarity

National training received positive comments on content and delivery but practical arrangements were less well received

Local cascading of national training was informal and coverage was inconsistent. Additional local training was largely absent.

The Learning Network received mixed reviews and some staff were unsure about its main purpose

Training and support arrangements had not increased the extent to which staff were clear about the purpose of the RUM

The RUM was recorded manually in most sites and this worked well. All sites supported automated scoring for the future

CHAPTER FIVE KEY ISSUES AND CONCLUSIONS FROM EARLY IMPLEMENTATION

5.1 This chapter brings together the key points that have emerged from the previous chapters and highlights the conclusions that can be drawn regarding the issues that have had the greatest impact upon early implementation.

5.2 It is important to recognise that this review concerns early implementation of the RUM and it is clear from the review itself that the extent and nature of early implementation is changing rapidly. The fieldwork for this review involved 84 of the staff who are implementing the RUM, a figure which represents 49% of the approximate total of 173 across the 5 sites. As such it reflects the views of a significant proportion of the staff who are actively involved in RUM implementation. However as national and local initiatives to support implementation continue to gather pace the significance of the issues that are identified here will alter.

The Extent of Early Implementation

5.3 Local measures designed to limit workloads and focus attention upon initial assessments restricted the overall level of RUM activity where they applied.

5.4 Established patterns of assessment activity by health and social work staff affected the relative level of health and social work RUM activity. This was particularly the case in respect of certain groups of health staff that were rarely involved, including health visitors, CPNs and mental health practitioners.

5.5 The time taken to complete the RUM was in line with the Scottish Executive's target of 5 minutes although more complex cases could take up to 15 minutes to complete.

5.6 Current formal use of the RUM was limited and its future use, locally and nationally, was largely unknown amongst staff. However, the RUM was being used informally for a variety of purposes.

Conclusion 1

5.7 The extent of local implementation was limited by some local agencies and by the respective prior involvement of health and social work staff with SSA. Local authorities largely achieved the target time for completion and despite the general absence of formal use being made of RUM data, it was being used informally and its potential was recognised by both practitioners and managers.

The Local Context for Implementation

5.8 Local progress in achieving joint arrangements under the Joint Future initiative, including SSA implementation, did affect the extent of early implementation. Effective communication, well established joint working arrangements and a local “*champion*” positively assisted work on the RUM.

5.9 In the face of competing operational pressures, some staff did not prioritise scoring the RUM and others more actively avoided this work. At the same time, some managers did not feel able to push for the work to be completed and thus in some instances local arrangements for managing early implementation proved to be ineffective and failed to instil momentum in the work.

5.10 Doubts about the purpose of the RUM were a significant factor affecting implementation. A lack of clarity about the basis for the tool’s design and staff’s own experience of using the tool reinforced doubts about its purpose which had not been adequately answered. This impacted upon their view of implementation and went some way to explain the lack of motivation and engagement amongst some staff that was apparent during the review.

Conclusion 2

5.11 Effective support, communication and joint working arrangements enhanced the ability of local staff to respond to the problems and questions that arose during early implementation and this capability was further enhanced by the positive impact of strong local leadership. However, doubts about the purpose and design of the RUM affected attitudes towards implementation which in some cases undermined the positive impact of effective local arrangements.

The RUM and the SSA

5.12 The manner and extent of local SSA implementation had a direct bearing upon the implementation of the RUM. Varied application of SSA guidance particularly as it relates to the type and level of needs that require a SSA to be completed, as well as the period of time over which the assessment is compiled and when a re-assessment is necessary, have posed significant difficulties for practitioners in trying to establish consistent practice in scoring the RUM.

5.13 Differences between the sites regarding whether low level needs cases are subject to a SSA have resulted in significant variations in both the number and needs profiles of those cases that have been given a RUM score.

5.14 In addition, however, scoring the RUM has heightened practitioners’ awareness of those aspects of the SSA that they know will be used to score the RUM and in so doing has led to some changes in the way that this information is recorded.

Conclusion 3

5.15 The varied application of the SSA guidance set out in circular CCD 8/2001 and other unresolved questions about SSA implementation have affected the pattern and consistency of RUM scoring which in turn has impacted upon the way in which practitioners' record needs within some SSAs.

Consent

5.16 All agencies had formal systems for informing service users about their rights and for securing consent to the exchange of information but practice in respect of the RUM had not been developed beyond that for the SSA and most service users were unaware of the RUM.

Conclusion 4

5.17 There was a lack of clarity regarding whether a more pro-active approach should be adopted in informing service users about, and in securing their consent to, the exchange of information relating to the RUM, and if so, what the core features of such arrangements might be.

Scoring and recording the RUM

5.18 Issues regarding the RUM's ability to capture the information necessary to establish relative need were a prominent feature in all interviews. Guidance to select the higher score option if needs fluctuate compounded concerns by increasing the potential gap between actual needs and the basis for the score.

5.19 This guidance was expanded in the *Briefing and Guidance* paper and this fuller guidance was considered to be little more useful than that within the RUM questionnaire itself. The majority of practitioners were unaware of the paper's existence.

5.20 These issues were said to have been raised at both a local and a national level but practitioners and some managers felt that an adequate explanation or response had not been forthcoming. In the absence of clarification, staff uncertainties regarding how to interpret the guidelines in individual cases remained and this reduced the consistency with which the RUM was scored and the confidence with which the resulting data was viewed.

5.21 Whilst paper based systems for recording RUM scores operated effectively, the transfer of paper based data into computer records was burdensome, particularly for health staff in some sites. The introduction of automatic scoring was widely supported as being likely to introduce greater consistency in scoring and remove any additional burden of work associated with the RUM.

Conclusion 5

5.22 Practitioners lacked a clear understanding of the basis for the RUM's design and had doubts about its ability to take into account the factors necessary to establish relative need. This had reduced confidence in the RUM as an effective tool and had impacted upon the extent to which scoring the RUM was afforded priority over other tasks.

Understanding the purpose of the RUM

5.23 Whilst many managers were able clearly to explain the purpose of the RUM and most readily identified its planning and resource allocation potential they were unsure about its intended long term use.

5.24 The questions that have emerged about the design of the RUM, as outlined above, have cast doubt upon the extent to which practitioners clearly understood the purpose of the RUM. A significant minority were unable to comment about its purpose at all whilst many of those that could, did so by reference to its ability, or otherwise, to capture the information that was needed accurately to reflect relative need.

5.25 Most practitioners considered the RUM to offer little in the way of direct benefit to them in their day-to-day work and could not associate themselves with its supposed benefits as regards the effective use of resources across caseloads.

Conclusion 6

5.26 Many practitioners were unclear about the purpose of the RUM and their doubts about its ability to capture the information necessary to establish relative need reinforced this lack of clarity. Most were unable to identify direct benefits for managing their work or for their clients.

Training and Support Arrangements

5.27 The RUM questionnaire and associated guidance were 2 important elements of the Scottish Executive's measures to enable and support early implementation. Whilst the questionnaire was praised by most practitioners for its brevity and clarity, the guidance did not address the doubts that have been identified concerning the design and efficacy of the tool, such that practitioners felt reassured and positively enabled to support the early implementation process.

5.28 The Scottish Executive's national training programme was the third element of their strategy to support implementation and it was well received regarding its content and delivery. Practical arrangements for the training however, were viewed less positively by most staff.

5.29 The final element of the Scottish Executive's support for early implementation was the RUM Learning Network which was established to enable discussion at a national level about issues arising during early implementation. Some of those attending the Network

found it very helpful but many practitioners were not sure what the group was supposed to achieve and how it fitted in with local groups

5.30 Local support for early implementation was the responsibility of Local Authorities, and had 3 main elements.

5.31 First, local cascading of national training was arranged at a local level and was characterised by informal approaches that were suited to working arrangements in some sites. Overall, however, this approach did not provide a sufficiently robust and consistent basis for training those staff who had not attended the Scottish Executive's sessions. As a result some staff felt unprepared for implementing the RUM and others who considered themselves not to need training were able to avoid it.

5.32 Second, other local training which was most notable by its absence. In some sites it was possible to address the RUM within ongoing SSA training but in most this training had long been concluded and no other regular arrangements were made. This left a gap in efforts to sustain learning amongst staff and to ensure that their queries were answered.

5.33 The final aspect of local support to implementation concerned support groups. Whilst few had been established specifically to deal with the RUM, pre-existing SSA groups were picking up on RUM issues and in other locations, positive and supportive working arrangements were helpful in enabling practitioners to address issues concerning the RUM.

Conclusion 7

5.34 The Scottish Executive's support for early implementation included guidance and a range of opportunities for staff to receive initial and ongoing support from a national perspective. Whilst initial training was found by staff to be helpful, the guidance and Learning Network did not enable the issues that emerged for them as implementation progressed to be adequately addressed.

Conclusion 8

5.35 Local support was predominantly informal and ad hoc and whilst in some sites this proved effective, in most, staff found that it offered them inadequate and inconsistent access to training and left many of them feeling that they were not adequately prepared or supported for scoring the RUM. In most cases other local support did provide useful assistance to staff.

CHAPTER SIX LOOKING TO THE FUTURE

6.1 This chapter reflects on the positive lessons that can be learned from early implementation and details ongoing work to move the agenda forward. It also provides a brief overview of priorities for future implementation.

A Basis for Effective Implementation

6.2 It is possible to identify a number of features from this review that are associated with effective implementation. These are:

- Involving practitioners in order to ensure that the lessons of implementation are heard and acted upon
- Actively listening and seeking out opportunities to learn and capture feedback
- Developing effective local joint working arrangements, including co-locating staff where possible
- Management arrangements that promote confidence and shared understanding amongst staff, whilst also ensuring that the necessary work gets done
- Group and individual peer support that enables questions to be raised and discussed in a supportive environment
- Appointing a “*Champion*” of change who is committed to the task and who has the knowledge and skills to motivate staff and provide effective leadership
- An automated RUM that would remove the time burden and varied interpretation associated with manual scoring of the RUM

6.3 Collectively, these features went a long way to address the issues that were otherwise identified as having hindered implementation. In addition there is considerable work in progress that will positively assist future RUM implementation.

Work in Progress

Continued progress with Joint Future arrangements

6.4 Continued progress with the introduction of Joint Future arrangements in all areas will further assist RUM implementation by enhancing shared working practices and rationalising the basis for undertaking SSAs and scoring RUMs between health and social work. The recent Scottish Executive consultation draft paper entitled *Guidance on Care Management in Community Care* outlines a proposed basis for doing so and as regards the SSA, builds upon the previous guidance in circular CCD 8/2001.

Training and Support

6.5 All sites reported that RUM training is to be incorporated into their arrangements for SSA training at the earliest available opportunity. A training framework based on the experience of the 5 early implementation areas has been produced and will be enclosed within 'The Operational Guidance' to guide implementation in other areas for the phased roll-out. A copy of the RUM Project Team's Briefing and Guidance for Implementation will also be included in the pack.

The Learning Network

6.6 Since the fieldwork for this review was carried out the Learning Network has identified key areas to progress towards implementation including:

- Direct Access scoping paper
- Quality Assurance framework
- Revised guidance notes
- Training and development plans
- Draft scoping paper on planning uses and action plan

Guidance

6.7 Operational Guidance has been produced to assist partnerships implement the RUM across Scotland and will provide a useful reference/guide for both practitioners and managers. This Guidance will support the implementation process benefiting from the experience gained during the development and initial implementation phase of RUM. It covers a range of issues on a broad basis from experience without being too prescriptive. It is planned to issue the guidance in a ring binder file to allow it to be updated as implementation evolves.

Automated scoring of the RUM

6.8 Local implementation of automated scoring of the RUM was reported to be some way off in 4 of the 5 early implementation sites, however IT and information sharing systems will continue to evolve and more robust IT systems will be in place to help partnerships with SSA and RUM. The Scottish Executive's ICADS initiative introduces for the first time the prospect of obtaining person based information on need and service provision for older people in a standardised format across the whole of Scotland. It is acknowledged that the proposed data strategy will make significant demands on the IT systems being used within Councils and partnerships and that therefore introduction of the data summary may need to be phased.

Priorities for Future Implementation

6.9 It is important that the change in use of the RUM that has occurred, from a focus upon resource allocation to recording relative need, is recognised in revised guidance and that staff are provided with the clearest possible picture of how the RUM has developed, why it is designed as it is and what it is intended to achieve – its purpose.

6.10 Enhanced clarity about the nature of the RUM will, however, only improve implementation if staff benefit from more consistent local support, training and management arrangements in order to sustain their clarity and address issues as they arise and all practitioners commit themselves to engaging actively and positively with the task of scoring the RUM until such time as it is fully automated.

6.11 Whilst it is tempting to view automatic scoring of the RUM as a panacea for many of the issues that have been identified by this review, the longer term credibility of the data and the purposes for which it is made available will only be assured if professional staff have confidence that the RUM questionnaire is based upon a true reflection of the relative needs of their clients.

6.12 This review has shown that the views and attitudes of the people involved in actually implementing the RUM have had a significant impact upon the extent to which obstacles to progress have been overcome and early implementation has progressed. Therefore, whilst it will be important that outstanding issues relating to the SSA and more generally, the introduction of effective joint working and management arrangements are addressed, ensuring that the managers and practitioners involved in RUM implementation receive the support they need is likely to have the most significant impact upon future progress.

APPENDIX ONE DATA REQUEST SCHEDULE

RUM INFORMATION/DATA REQUEST CHECKLIST

Please complete this form and return it with the information/data requested. Where the information/data is not available, could you please indicate on the form below when (or indeed if) it will be available.

Council and/or Health Board Council _____ Pilot Area _____

Category	Info/Data Requested	Is Info/Data available and being returned to Craigforth (Y/N)	If NO, please give reason	If NO, please indicate if or when it may be available
<i>Staff and structure information</i>	Health and social work agency structures or joint management arrangements relating to those teams or staff that are completing the RUM			
	Designations of senior manager(s) responsible for: <ul style="list-style-type: none"> • Joint Futures • Single Shared Assessment • RUM 			
	Direct line manager(s) of staff completing RUMs			
	Staff team details, including <ul style="list-style-type: none"> • Team title • Brief statement of role/purpose • Number of staff completing RUM • Total number of staff in each team • Professional training/qualification of each team member 			
<i>Time taken to complete a RUM</i>	Any available data or information held locally on the time taken to complete each RUM			

Category	Info/Data Requested	Is Info/Data Available (Y/N)	If NO, please give reason	If NO, please indicate if or when it may be available
<i>RUM user consent form</i>	Any information on the means by which user consent to the sharing of information is obtained			
	A copy of the confidentiality policy and processed and details of any particular local arrangements that are in place for information sharing between health and social work			
<i>RUM Training</i>	Any information on past/current/future local training for staff on the RUM and its implementation (<i>please note, this related only to training OTHER than that given by the Scottish Executive</i>)			
<i>Use of RUM data</i>	Any information or documentation relating to the current use of RUM data			
	Any future planned usage of RUM data			
<i>IT related information</i>	Brief specification of any hardware/software developed to date to assist with the RUM			
	Recording format used			
	How the software relates RUM data to the SSA			
	Alternative data recording practices and proposed IT development (<i>for those who have not yet developed IT systems</i>)			

APPENDIX TWO INTERVIEW SCHEDULE

INTRODUCTION.

The questions in this schedule should be used as appropriate, for the different categories of interviewees depending upon local practice and the mix of group/individual interviews.

All of the questions should be covered at some point during the interviews in each site with as many views from different groups being collected as possible.

Questions in normal font are to be put to the interviewee(s)

Italics indicate prompts or notes for the interviewer

Location: East Renfrewshire, Glasgow / Orkney / Perth & Kinross, , South Lanarkshire
(delete those not required)

Interview Code: PG / PI / M

INTERVIEW GROUP CODE

PG = LA/health practitioners in a group

PI = LA/health individual practitioners

M = LA/health managers

Name or description of team or grouping (where appropriate)

(This should indicate whether the group works as a single team or is comprised of staff from a number of locations/teams. If from a single team is it a single agency unit, multi-disciplinary or a joint agency team)

Name(s) and designation(s) of interviewee(s).....

(Particularly important to be clear which professions are represented amongst practitioners)

Time and date of interview.....

Location of interview.....

Question No.	Topic	Interview group
	A. PURPOSE OF THE RUM	
1.	<p>What do you understand to be the purpose of the RUM?</p> <ul style="list-style-type: none"> • <i>A general introductory question to establish any areas of doubt or alternatively, certainty</i> <p>Prompts that may be useful:</p> <ul style="list-style-type: none"> • <i>Does the RUM help individual practitioners manage their case load?</i> • <i>Do you think it could assist local prioritizing and workload allocation?</i> • <i>Do you think the RUM could assist Council and NHS partnerships in planning and budgeting?</i> • <i>Do you think it will aid national service monitoring and policy development?</i> 	Pg PI M

2.	How clearly do you feel the purpose has been presented or explained to you? <ul style="list-style-type: none"> • <i>Who/how was its purpose explained to you</i> • <i>Try to tease out any differences of view or experience and why they exist</i> 	PG PI
	B. THE PROCESSES USED TO CALCULATE AND RECORD THE RUM	
3.	What makes it easy to calculate the RUM? <ul style="list-style-type: none"> • <i>Explore experience to date</i> • <i>Identify specific examples if possible</i> • <i>Develop issues list</i> 	PG PI
4.	Can you identify any problems that are being experienced with calculating the RUM? <ul style="list-style-type: none"> • <i>Do different issues arise depending upon whether the RUM is calculated following a new assessment or a review/ re-assessment of someone's care needs?</i> • <i>Are there any issues that are particular to either health or social work agencies?</i> • <i>Develop issues list</i> 	PG PI M
5.	Can I confirm the arrangements that are in place for the RUM to be recorded? <ul style="list-style-type: none"> • <i>Written by hand and retained in a paper-based form separately from the SSA</i> • <i>Written by hand and retained in a paper-based form within the SSA format</i> • <i>Written by hand and then keyed into a RUM computer based record that is separate from the SSA</i> • <i>Written by hand and then keyed into an electronic record of the SSA</i> • <i>Keyed in directly onto computer but not integrated into the SSA</i> • <i>Keyed in directly onto computer within a previously generated SSA record</i> • <i>Automatically generated as the SSA is keyed into the computer</i> 	PG PI
6.	How well does the arrangement that you have indicated above work? <ul style="list-style-type: none"> • <i>Review experience to-date</i> • <i>Ask for specific examples of problems or positive features</i> • <i>Do you find the electronic record easy to use (eg. are drop-down menus available and/desirable?)</i> 	PG PI
	C. STAFF TEAMS <i>This item will have been requested from the lead contacts in the Data Schedule but if the information has not arrived with Craigforth or if it has gaps (which I will advise you about for each venue in due course) you may need to cover this matter in interview.</i>	
7.	Can you tell me which teams are involved in implementing the RUM? <ul style="list-style-type: none"> • <i>Number</i> • <i>Locations</i> 	M

8.	<p>Which agency does each team come from, or in the case of multi-agency teams, how many staff come from each of the agencies involved?</p> <ul style="list-style-type: none"> • <i>SWD, health, other?</i> • <i>Links into management structures?</i> 	M
9.	<p>What professional groups are represented in the teams?</p> <ul style="list-style-type: none"> • <i>Number?</i> • <i>Proportion of total</i> 	M
D. THE AFFECT OF THE SSA		
10.	<p>Are you implementing the RUM as part of the SSA process, and are there any problems with this?</p> <ul style="list-style-type: none"> • <i>Are you implementing the RUM only in respect of SSAs that have already been completed?</i> • <i>Are you implementing the RUM as part of the process and at the time that SSAs are being completed?</i> • <i>Are there any issues concerning consistency of practice in completing the SSA that impact upon the RUM?</i> 	PG PI M
11.	<p>How many RUMs have been completed compared to the number of SSAs? <i>(this data should have been obtained from the SE via the data schedule but if not, pursue here. May be useful to obtain the view from the field anyway)</i></p> <ul style="list-style-type: none"> • <i>If significantly different what factors have had the greatest impact?</i> 	PG PI M
E. LENGTH OF TIME TO COMPLETE THE RUM		
12.	<p>How long does it take to complete the RUM?</p> <ul style="list-style-type: none"> • <i>A no time (automatic from the SSA)</i> • <i>B 0-1mins</i> • <i>C 1-2ins</i> • <i>D 2-3mins</i> • <i>E 3-4mins</i> • <i>F 4-5mins</i> • <i>G over 5 minutes</i> <p><i>Record the full range of times noted by group members with particular reference to the most common / uncommon times</i></p>	PG PI
13.	<p>What is the longest and the shortest time that it has taken you to complete the RUM?</p> <ul style="list-style-type: none"> • <i>Describe as being, for example, from “B” to “D”.</i> 	PG PI

14.	<p>What factors have the greatest impact upon the time it takes to complete the RUM?</p> <p>Prompts that might be useful:</p> <ul style="list-style-type: none"> • <i>Practical experience</i> • <i>The needs profile of users</i> • <i>The particular local RUM format</i> • <i>The process by which the RUM is completed</i> • <i>When the same person who undertakes the SSA compiles the RUM</i> • <i>Known profile of needs?</i> • <i>Confidence in interpreting SSA information</i> • <i>Relatively minor adjustments during re-assessments</i> 	PG PI
15.	<p>Do overall workloads affect the time it takes to complete the RUM?</p> <ul style="list-style-type: none"> • <i>Dedicated time in a block?</i> • <i>Pressing emergency demands delay scoring/recall?</i> 	PG PI
F. GUIDANCE FOR THE QUESTIONNAIRE		
16.	<p>Do you feel any of the guidance to the questionnaire requires clarification?</p> <ul style="list-style-type: none"> • <i>Provide the opportunity to talk through the content/wording of each section of the guidance.....</i> • <i>Section 1</i> • <i>Section 2</i> • <i>Section 3</i> • <i>Section 4</i> • <i>Section 5</i> • <i>Assigning Client to RUM Grouping.</i> 	PG PI
G. CONSENT		
17.	<p>How do you secure user consent for the sharing of information between social work and health?</p> <ul style="list-style-type: none"> • <i>Discuss the process and...</i> • <i>Ask whether it is the same/consistent with arrangements for the SSA</i> • <i>Are there any differences between the way the social services and health have dealt with this matter?</i> • <i>Identify any issues that have emerged in practice</i> 	PG PI
18.	<p>What background information have users received about the RUM as a context for dealing with the consent issues?</p>	PG PI

	<p>H. TRAINING AND INFORMING STAFF <i>(Details about the training and information provided should have been covered in information received from the SE regarding national input and from lead contacts regarding local input. Where gaps in information emerge I will advise you in due course. Views on the training delivered will not have been covered.</i></p>	
19.	<p>What steps have been taken locally to provide information and training beyond that which the SE has been involved with?</p> <ul style="list-style-type: none"> • <i>Is the timing affected by the roll-out of SSA?</i> • <i>Any other factors affecting the level of information/training delivered or planned?</i> 	PG PI
20.	<p>What do you feel about the national training that has been provided on the RUM:</p> <ul style="list-style-type: none"> • <i>Format of the training?</i> • <i>Content of the training?</i> • <i>Delivery of the training?</i> 	PG PI
21.	<p>What do you feel about the local training that has been provided on the RUM:</p> <ul style="list-style-type: none"> • <i>Format of the training?</i> • <i>Content of the training?</i> • <i>Delivery of the training?</i> 	PG PI
22.	<p>In particular, does anything in the “<i>briefing and guidance</i>” require clarification?</p> <ul style="list-style-type: none"> • <i>Introduction</i> • <i>What is the RUM?</i> • <i>The RUM and SSA</i> • <i>Informing Service Users and Carers</i> • <i>How will it be introduced?</i> • <i>Completing the RUM</i> • <i>Quality Assuring the Data</i> • <i>Using the Data</i> • <i>FAQs</i> 	PG PI
23.	<p>To what extent has providing staff with information and training about the RUM been incorporated into similar arrangements for the SSA?</p> <ul style="list-style-type: none"> • <i>Has an integrated approach always seemed to work for both the SSA and the RUM?</i> • <i>Are there any aspects of the RUM that have been covered less than adequately?</i> 	M
24.	<p>Has your area experienced a turnover in the staff that are trained to complete the RUM?</p> <ul style="list-style-type: none"> • <i>If yes, scale and types of staff involved?</i> • <i>How have you responded to the ongoing information and training needs?</i> • <i>Have there been occasions when individuals have not been trained / informed before applying the RUM?</i> 	M

25.	Have all categories of staff that are completing RUMS been adequately informed about it? <ul style="list-style-type: none"> eg. community OTs employed by LAs 	PG PI
26.	Do you operate a local SSA/ RUM support group? <ul style="list-style-type: none"> <i>details about form, frequency of meetings, support issues for practitioners</i> 	PG PI
27.	What do you know about the RUM leaning network? <ul style="list-style-type: none"> <i>What involvement by local staff has there been?</i> What feedback has been provided by those who have attended meetings? 	PG PI
I USING THE RUM SCORE		
28.	What use is being made of the RUM scores? <ul style="list-style-type: none"> <i>Check by practitioners x agency</i> <i>Check by managers x agency</i> <i>Discussion should concentrate upon what is actually happening with regard to:</i> <i>Case management</i> <i>Local/ area planning</i> <i>National information</i>	PG PI M
29.	What are your future plans for using the RUM score? <ul style="list-style-type: none"> <i>Check by practitioners x agency</i> <i>Check by managers x agency</i> <i>Discussion should concentrate upon progress in preparing for planned developments</i>	PG PI M
J OTHER ISSUES		
30.	IS there anything else that you would like to comment upon regarding the RUM that has not been covered already? <ul style="list-style-type: none"> <i>A “mop-up” question, responses should be noted only</i> 	PG PI M

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