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Your ref:
Our ref: CCD3/2008
July 2008

Dear Colleague

NATIONAL MINIMUM INFORMATION STANDARDS FOR ASSESSMENT AND CARE PLANNING FOR ALL ADULTS

Introduction

1. This circular introduces an updated version of the National Minimum Information Standards (NMIS) for assessment and introduces new standards for shared care and support plans, and for reviews. It also provides a new set of national minimum information standards that cover carers' assessment and support. These standards apply to all adult community care groups.

2. This guidance supersedes the National Minimum Information Standards for Single Shared Assessment in Circular CCD3/2006. The new standards are set out in detail in Annex A. The remaining annexes cover:

- Annex B - Guidance on carers' assessments
- Annex C - The compliance arrangements
- Annex D - National Outcomes Framework: Community Care Measures

3. The standards are an integral part of the drive to improve outcomes in community care. They support professionals in social care, health and housing – to carry out holistic and effective assessments, to prepare appropriate care and support plans, and to carry out the reviews of care plans objectively and timeously. The standards themselves do not guarantee that every assessment, care plan or review is of good quality, they are a necessary prerequisite towards this goal. User and carer participation is a key element and is being taken forward through the User Defined Service Evaluation Tool (UDSET). Together, they enable the gathering of information as a bi-product of electronic information sharing that will support reporting of 10 (7 directly) of the 16 measures contained the Community Care Performance Framework. Most importantly, they promote outcomes-led assessment and care planning, which will improve outcomes for people who use services and their carers.

They will also support improved performance management and service implementation as recommended in the Sutherland Report, which is being progressed through dialogue between COSLA and the Scottish Government.

4. The drive for information standards has come from partnerships, who have welcomed the consistency and direction they offer. Development of the standards has been led by practitioners and managers from partnerships, supported by the Scottish Government and Information Services Division of the NHS National Services (ISD) Scotland who come together in the Assessment Review Co-ordinating Group (ARCG).

5. The standards set a national minimum. Partnerships can also introduce other aspects to meet local needs and to inform performance management reporting.

6. A log has been established of areas for future work. This will be updated through dialogue with community care partnerships and as part of the implementation process for the standards.

Purpose of New Standards

7. The new standards reflect the Government's desire to improve outcomes, to support personalisation, to improve the care management process, and to facilitate information sharing. The consultation on the draft standards identified the need to give greater emphasis to rehabilitation/enablement, socialisation and employment. The ARCG has amended the standards to reflect this. In addition, the standards are designed to inform many of the measures in the Community Care Performance Framework. Good quality assessment practice is key to better outcomes.

Key elements

8. These include:

- New National Minimum Information Standards for shared care and support plans, and review.
- Clarity that reviews should be carried out at least annually.
- New standards for carers' assessments and support that bring similar rigour to both users' and carers' assessments. Carers themselves were directly involved in developing the standards.
- A stronger emphasis on areas where more attention is required, such as rehabilitation/enablement, and user and carer participation in identification of desired outcomes.
- The standards as a package contribute to the national community care outcomes measures and are therefore an important element in improving results for people who use community care services.

9. There are two distinct types of standards: *Information Standards* and *Data Standards*. The former describe the subject matter that must be included without specifying exactly how it should be done or recorded. The latter specify the content at a more prescriptive level and include details of the format and codes to be used. This is important where national consistency is required, for reporting and/or other specific purposes.

Implementation and compliance

10. To comply with the standards local partnerships need to:

- Review their current arrangements against the new standards for assessment; shared care and support plans; reviews; carer's assessment and support (This compliance review should cover paper and or electronic versions as appropriate locally).
- Update their paper and information systems including guidance and business processes.
- Seek confirmation nationally that their updated arrangements comply with the standards.

11. A programme of support will be available for partnerships. Visits will be offered to discuss with each partnership their plans and support for implementation.

12. Achieving compliance will mean different things for different partnerships. Many partnerships have already reviewed their current arrangements against the earlier National Minimum Information Standards for Assessment. Those compliant with the current standards will need to concentrate on the new and updated aspects; those not currently compliant will have further work to do.

13. **Paper versions** of documentation should be compliant by the end of **March 2009**. It is recognised that their full value is linked with the capacity to share information electronically. Partnerships **should have applied the standards electronically within 6 months of having the capability to share information electronically, and/ or their next electronic upgrade. For some, that means by March 2009, and for others during the course of 2009-10.**

The Indicator of Relative Need

14. The National Minimum Information Standards include as an Appendix the Indicator of Relative Need (IoRN) – both the set of standardised questions and a description of how this leads to an assignment to an IoRN group. At present the IoRN is designed for use with older people, but we are considering its application to younger adults. The IoRN can contribute significantly to our goal of improving outcomes throughout community care. Some partnerships have already implemented it. We expect others to do so in the near future as part of the availability over the next year of electronic solutions that aid collection and analysis.

15. Partnerships are increasingly recognising the value of person-centred information, both in support of the delivery of existing services and as a vital piece of the information jigsaw when planning services for the future. The relative ease with which the IoRN is gathered following a comprehensive assessment, and its usefulness at all levels in community care makes it an attractive information resource. Examples of its uses, currently and in prospect, are :

- As a tool to describe the individual rather than the services they receive. The IoRN could provide a better, more informed way of measuring the shifting balance of care . This potential use was recognised during the development of the Community Care Outcomes Framework.
- To better inform planning and performance assessment.

- To inform decisions on care staff levels in care homes, using a modified version of the IoRN.
- To inform professional judgement on the assessed needs of individuals, as endorsed by the Sutherland Report.

Housing Support

16. The Scottish Government research has just been published evaluating the Supporting People (Housing Support) Outcomes matrix. We are accepting the main recommendations that although further work is needed to improve the tool and its associated guidance and IT platform, it has the potential to be effective in measuring the impact of housing support and other preventative services on individual clients. In developing the tool further with the Housing Support Enabling Unit, we will carefully consider the links to the attached standards and the extent to which it might help support the review of an individual's care and support plan.

Action on Standards

17. Partnerships should now begin to review their current arrangements against the new standards, as set out in paragraph 10 above, link them to the implementation of electronic information sharing, and finalise their implementation in the timescales in paragraph 12.

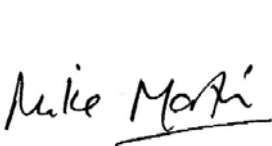
Enquiries

18. All enquiries regarding this circular and the standards should be addressed in the first instance to:

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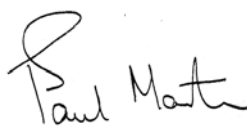
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Yours Sincerely



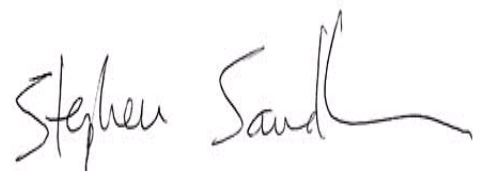
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NATIONAL MINIMUM INFORMATION STANDARDS FOR ALL ADULTS IN SCOTLAND

- **Assessment** (including Single Shared Assessment)
- **Shared Care and Support Plan**
- **Review**
- **Carers Assessment and Support**

Version 3.0

**Developed by the Assessment Review
Co-ordinating Group**

28 July 2008

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NATIONAL MINIMUM INFORMATION STANDARDS: OVERVIEW

National Minimum Information Standards: Overview

Introduction

Standardisation of the content of the various stages of assessment and care management was a pre-requisite for the effective recording and appropriate sharing of information.

The compendium sets out the National Minimum Information Standards for all adults. It covers Assessment, Shared Care and Support Plans and Review. It also includes National Minimum Information Standards for the identification of needs and support for Carers (Carers Assessment/support plan).

The standards have evolved from the original Single Shared Assessment (SSA) Guidance ([Circular CCD8/2001](#)) and complement the guidance on care management issued by the Scottish Executive in 2004 ([Circular CCD8/2004](#)) and, subsequently, the Care Management Framework published in 2006 ([Circular CCD2/2006](#)). Development of the standards, including those for carers, have been informed by the national work in early 2007 to develop Outcomes for Community Care and the standards support both the objectives and the measurement of the Outcomes.

The compendium builds on and supersedes the *National Minimum Information Standards for Single Shared Assessment for All Adults* issued in August 2006 ([Circular CCD3/ 2006](#)).

The relationship between Community Care Outcomes and the standards is important. Improving outcomes is the goal; good assessment practice is one of the keys to better outcomes; the standards are pivotal to achieving this. The intention is to measure performance through a suite of 4 national outcomes, 16 performance measures and 5 targets. 10 of the 16 measures will be informed by data in the standards.

The measures and the standards together will improve the quality of assessment, care planning, the waiting times for completion of assessment and the delivery of services. The standards will therefore contribute significantly to better outcomes for people who use services and their carers

The context, scope of the National Minimum Information Standards, with links and references to specific documents produced by related workstreams, can be found in **Appendix Three**.

The standards are the 'National Minimum' and should be adopted in all partnerships (as defined locally). They apply to all adult community care groups.

Points to Note about the Standards

- There are two distinct types of standards used throughout this document:

Information Standards describe the subject matter that must be included without specifying exactly **how** it should be done or recorded. Information Standards provide flexibility at local level into how they are incorporated into local tools and guidance. The standards enable assessors to gain good insights of, and to accurately document, the needs, priorities, careplan and review. The Information Standards do not need to be mirrored exactly in local tools for the tools to be compliant. Compliance can be achieved

through the provision of explicit **guidance** that ensures that the relevant practitioner considers the item. There may be no requirement to include unique fields in a system to match every Information Standard.

Data Standards specify the content at a more prescriptive level and include details on the format and codes to be used for each of these standards. Data Standards are particularly useful where there is a strong consensus on the exact content and where the data gathered is intended to be transferred across different systems. Compliance with the standards **does** require that local tools conform to the format and codes specified. Local partnerships may wish to specify the data standards that provide data for the Community Care Measures as mandatory to support local performance management systems.

Both forms of standards – Information Standards and Data Standards – are used in this document and are labelled accordingly.

- The standards do not contain all the information required to address a person's individualised care needs and intended outcomes. The standards set out the minimum information which all professional groups within health, social care and housing would expect to record. They are a 'core' of information to which specialist modules can be added. One underlying principle is that once this core information has been gathered it can be shared between the relevant professionals whenever appropriate. This will avoid the need to gather the same information repeatedly, with all the inconvenience and attendant risks.
- To meet the standards local assessment and care management tools, electronic systems or processes **should have the capability to record every data item in the standards. There is no presumption that every item will be recorded for every person.** For example, it is possible that fewer items will be recorded for individuals with relatively simple needs. Items will not be recorded where they are clearly not applicable [e.g. landlord details are not applicable to a home owner].

Information sharing occurs in a variety of ways. The purpose of the National Minimum Information Standards is to support good practice in the recording of information that is gathered during and for the purposes of assessment and care management. They support standardisation of the practice of assessment and related activities, they do not define the technical specification for data sharing. The latter is contained within specific eCare documentation which can be viewed on: www.scotland.gov.uk/dss.

- The order in which the standards are presented in this document is not intended to be prescriptive.
- Where a standard requires that further details should be recorded this should be done in accordance with good practice for assessment and care management.
- The **Indicator of Relative Need (IoRN)** is currently designed for use with people aged 65 and over. The IoRN questions and supporting guidance are listed in Appendix Two. The questions are fixed and should be answered based on information drawn from the assessment process.

General Principles underpinning the Minimum Standards

The Assessment Review Co-ordinating Group (ARCG) was guided by the following principles in drawing up these standards;

- The minimum standards need to “make sense” to practitioners and should reflect good professional practice.
- The standards should support the development of local assessment and care management processes.
- The standards should be a foundation for the development of supporting information systems.
- Mandatory information requirements where possible, should be supported by the standards.
- The National Minimum Information Standards issued by ARCG should complement not duplicate other work on data standards for health and social care.
- Where relevant standards have already been the subject of a separate consultation they have been adopted by ARCG and viewed as part of the National Minimum. For example, the Personal Details in Section 2 are a sub-set of the Generic Core Dataset produced by The Social Care Data Standards Programme.
- A positive approach at local level towards the benefits of compliance is crucial to the process of building standardisation of information.

The National Minimum Information Standards cannot be considered in isolation from practice. For this reason this document should be read in conjunction with relevant national policies on assessment (including SSA), care management and carers' assessment. See Links; Appendix Three

It is also recognised that good practice around assessment and care management continues to develop and evolve, and that the impact of different ways of working can be difficult to predict. The standards have been designed flexibly to reflect and respond to this. For example, the mainstream implementation of Telecare as promoted by the national Telecare Development Programme offers opportunities, to inform the assessment and review processes.

Minimum Data Standards for Personal Details

Minimum Data Standards for Personal Details

Introduction

The Data Standards in this section are the basic personal details that inform assessment, care and support planning, review and carers assessment/ support plan. They apply to anyone in contact with health, social work and housing in respect of their care needs.

It may not be necessary to record all items for every person assessed, but the **ability to record** them is needed to comply with the standards.

The Minimum Standards for personal details are all **Data Standards**. The format and codes specified should therefore be adopted to achieve compliance.

Summary of Minimum Standards for Personal Details

These data standards cover:

- Personal identification and key characteristics of the person concerned
- Person's GP
- Housing circumstances
- Basic needs (e.g. communication method)
- Crucial background information
- Some details of other important people (unpaid or professional) associated with the person receiving services and support

This section contains a listing of the data items. Full lists of values are given in **Appendix Four**.

Person Identification

Data Item	Description	Field Length	Format	
Structured Name	Person Title e.g. Mr, Mrs, Miss, Ms, Dr, Rev, Sir, Lady, Lord, Dame, etc	35	Text	Data Standard
	Person Family Name e.g. Gibson	35	Text	Data Standard
	Person Given Name e.g. Joan	35	Text	Data Standard
Unstructured Name	Person Full Name This alternative to recording structured name involves the whole name being recorded as a single character string with no separately identified elements. e.g. Mrs Joan Hazel Gibson MSc	70	Text	Data Standard
Person Birth Date	Age and age bands can be derived. e.g. 1965-12-09	10	CCYY – MM –DD	Data Standard
Person Death Date	e.g. 2008-01-05	10	CCYY– MM –DD	Data Standard
Person Identification	The unique person identifier A number which can be used as a common reference number across information systems to identify an individual or an individual's records.	Variable max 50 characters	Variable	Data Standard

Data Item	Description	Field Length	Format	
Person Identification	CHI Number The Community Health Index is a population register used for healthcare purposes in which each person is uniquely identified by the CHI number.	10	Structured	Data Standard
Gender / Sex	Person Current Gender e.g. Female	1	Pick list	Data Standard
Person Marital Status	An indicator to identify the legal marital status of a person e.g. Married	1	Pick list	Data Standard
Ethnicity	Ethnic Group (Self Assigned) There is a statutory, legal requirement for public authorities to collect data on ethnic group under <i>the Race Relations (Amendment) Act 2000</i> in the interests of eliminating racial discrimination and promoting equality of opportunity and good race relations. Ethnic group and all the other Ethnicity items are also important for ensuring that appropriate, person-focused, needs-related care services are delivered sensitively to individuals. e.g. White Irish	Up to 6 (2+4)	Pick list	Data Standard
	Religion e.g. Muslim	Up to 6 (2+4)	Pick list	Data Standard
	Interpretation assistance indicator e.g. no help needed	2	Pick list	Data Standard
Preferred Language	A person's language of preference may differ from their identified first language. e.g. English	Up to 6	Pick list	Data Standard

Data Item	Description	Field Length	Format	
Address (note that several addresses may be held for an individual, each with its address type)	Address (BS7666) or Addresses conforming with BS7666 will be stored in and retrieved from an electronic gazetteer		Gazetteer	Data Standard
	UK Postal Address Alternatively, address can be recorded in up to 5 lines of unstructured text (minimum 2 lines).	5x35	Text	Data Standard
	Post Code	8	Ref File	Data Standard
	UK Daytime Telephone Number This number may be a mobile number.	35	Character string	Data Standard
	UK Evening Telephone Number This number may be a mobile number.	35	Character string	Data Standard
	Address Type Relates to the nature and status of the address, e.g. normal domicile address, alternative contact address. e.g. normal domicile address	2	Pick list	Data Standard
	Lives Alone Yes / No	up to 3	Yes / No	Data Standard

Persons GP

GP	Person Family Name e.g. Linklater	35	Text	Data Standard
	Person Given Name e.g. Peter	35	Text	Data Standard

Data Item	Description	Field Length	Format	
	Person full Name This alternative to recording structured name involves the whole name being recorded as a single character string with no separable identified elements. e.g. Dr Peter Linklater MD	70	Text	Data Standard
Data Item	Description	Field Length	Format	
Registered GP Practice	GP Practice Code Each GP practice in Scotland is identified by a unique GP practice code. e.g. 70234 (right justified)	6	Reference file	Data Standard
	Address (BS7666) or		Gazetteer	Data Standard
	UK Postal Address	5x35	Text	Data Standard
	UK Telephone Number	35	Character string	Data Standard

Housing details (part of Social, Economic and Physical situation)

Data Item	Description	Field Length	Format	
Accommodation Type	The type of accommodation in which the service user is normally resident. e.g. Mainstream housing	Up to 6	Pick list	Data Standard
Dwelling Type	Is a description of the physical structure in which someone lives. e.g. Flat	3	Pick list	Data Standard
Tenure Type	Indicates the basis on which an individual occupies the property in which they live. e.g. Owned	3	Pick list	Data Standard

Data Item	Description	Field Length	Format	
Landlord Details	Person Title e.g. Mr, Mrs, Miss, Ms, Dr, Rev, Sir, Lady, Lord, Dame, etc.	35	Text	Data Standard
	Person Family Name e.g. Thomson	35	Text	Data Standard
	Person Given Name e.g. Gordon	35	Text	Data Standard
	Person Full Name The alternative to recording structured name involves the whole name being recorded as a single character string with no separable identified elements. e.g. Mr Gordon Thomson	70	Text	Data Standard
	Organisation Name	255	Text	Data Standard
	Address (BS7666) or		Gazetteer	Data Standard
	UK Postal Address	5x35	Text	Data Standard
	UK Telephone Number	35	Character string	Data Standard

Basic Needs

Data Item	Description	Field Length	Format	
Person Representative Required	An adult who represents or communicates on behalf of the person. e.g. No	Up to 3	Yes No	Data Standard
Preferred Communication Method	The method of communication preferred by the person to make themselves understood. e.g. Generally intelligible speech	3	Pick list	Data Standard
Impairment	e.g. Visual impairment	2	Pick list	Data Standard

Background Information

Data Item	Description	Field Length	Format	Data Standard
Crucial Background Information	This covers any factors (other than those indicated by other data items in this dataset), which it is vital to know about in the early, pre-assessment stages of dealing with the person, including relevant medical factors and cultural issues. e.g. Recent Suicide Attempt		Free text	Data Standard

Associated Person

Data Item	Description	Field Length	Format	Data Standard
Person Role	Associated people are the people who have a significant involvement or relationship with the person (e.g. main carer, next of kin, key holder, emergency contact etc). The particular involvement(s)/relationship(s) of each associated person is / are indicated by the "Person Role" data item. Data should be entered for all people significantly associated with the subject, including all members of the person's household. e.g. Key holder	3	Pick list	Data Standard
Structured Name	Person Title e.g. Mr, Mrs, Miss, Ms, Dr, Rev, Sir, Lady, Lord, Dame, etc	35	Text	Data Standard
	Person Family Name e.g. O'Reilly	35	Text	Data Standard
	Person Given Name e.g. Christine	35	Text	Data Standard

Data Item	Description	Field Length	Format	Data Standard
Unstructured Name	Person Full Name This alternative to recording structured name involves the whole name being recorded as a single character string with no separately identified elements. e.g. Mrs Chrissie O'Reilly	70	Text	Data Standard
Address	Address (BS7666) or		Gazetteer	Data Standard
	UK Postal Address	5x35	Text	Data Standard
	UK Daytime Telephone Number	35	Character string	Data Standard
	UK Evening Telephone Number	35	Character string	Data Standard
Person Birth Date	Age and age bands can be derived. e.g. 1965-12-09	10	CCYY-MM-DD	Data Standard
Relationship to Client / Patient	Relationship to Client / Patient The relationship between an Associated Person and the data subject. e.g. Parent	3	Pick list	Data Standard
Gender / Sex	Person Current Gender e.g. Female	1	Pick list	Data Standard

Associated Professional

Data Item	Description	Field Length	Format	Data Standard
Professional Person Role	Professionals are the people who are already involved with the person in a professional capacity. (e.g. Social Worker, OT etc). The particular role(s) carried out by each professional is / are indicated by the "Professional Person Role" data item. Data for as many professionals as required can be entered. e.g. Social Worker	35	Text	Data Standard
Structured Name	Person Title E.g. Mr, Mrs, Miss, Ms, Dr, Rev, Sir, Lady, Lord, Dame, etc. e.g. Ms	35	Text	Data Standard
	Person Family Name e.g. McAteer	35	Text	Data Standard
	Person Given Name e.g. Gill	35	Text	Data Standard
Unstructured Name	Person Full Name This alternative to recording structured name involves the whole name being recorded as a single character string with no separately identified elements. e.g. Ms Gill McAteer	70	Text	Data Standard
Data Item	Description	Field Length	Format	Data Standard
Employing Agency	e.g. City of Edinburgh Social Work Department	255	Text	Data Standard
Professional Contact Address	Address (BS7666) or		Gazetteer	Data Standard
	UK Postal/Simple Address	5x35	Text	Data Standard
	UK Daytime Telephone Number	35	Character string	Data Standard
	UK Evening Telephone Number	35	Character string	Data Standard

Minimum Standards for the Needs Assessment of All Adults

Introduction

Assessment is part of a wider process that includes care and support planning, resource access, monitoring and review. Assessment is undertaken to understand and document an individual's needs. The assessment should relate to agency policies and priorities and involve the person and/or their carer in identifying the intended outcomes. A well-documented assessment is a basis for ensuring a match between these elements.

When assessing needs you should focus on strengths as well as needs, issues and concerns. The person's strengths and aspirations should be considered throughout the assessment ensuring a rehabilitation / enablement focus, including capacity for individualisation, self management and making informed personal choices.

The two main levels of assessment are Simple and Comprehensive. These are described as follows:

Simple Assessment applies where indicated needs or requests for services are straightforward and can be dealt with by low level response. It may involve one or more than one agency, some co-ordination of contributions to the assessment may be needed.

Comprehensive Assessment applies where a wider range and complexity of outcomes are indicated. It is likely to involve more than one agency in contributing to a holistic assessment of needs including specialist input where necessary. In comprehensive assessment, effort needs to focus on co-ordination of contributions to the assessment. People who are at risk of admission to residential care should receive a comprehensive assessment with specialist input where necessary, and care management to explore fully the options for rehabilitation/enablement and care at home.

The ARCG took account of existing Single Shared Assessment tools, guidance and processes for a variety of community care groups, including Older People, Mental Health, Dementia, Physical Disability including (sensory impairment and brain injury), Learning Disability and Substance Misuse when preparing the Minimum Standards. The standards reflect core information (but not specialist components) and assume assessment appropriate to level of need. The standards focus on the information about the needs of the person being assessed, recognising that many people may have a range of long term conditions. They are intended to be sufficiently adaptable to fit with different local business processes, particularly since they are designed for use by partners within multiple agencies.

It may not be necessary to record all items for every person assessed, but the **ability** to cover them is needed to comply with the standards. The content of a completed assessment will depend on the complexity of need.

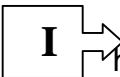
Where Information Standards are shown, the actual method used locally for incorporating the standard into local tools is flexible. Where Data Standards are shown the format and codes specified should be adopted to achieve compliance.

Local partnership may wish to specify data standards that provide data for the Community Care Measures as mandatory to support local performance management systems.

Summary of Minimum Standards for Assessment

The Standards for assessment are listed under the following headings:

- A. Person's perspective
- B. Carer's perspective
- C. Relationships
- D. Vision, hearing and communication
- E. Personal care and physical well-being
- F. Mental health
- G. Immediate environment and resources
- H. Social and cultural life
- I. Employment
- J. Education, training and life long learning
- K. Care and Protection
- L. Informed of contact and dates of assessment

Standards denoted with the following symbol  have related supplementary questions for individuals aged 65 years and over. These IoRN questions are detailed in Appendix Two.

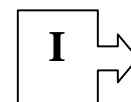
INFORMATION ABOUT SERVICE USERS' NEEDS

				Type of Standard
A. Person's perspective				
Was the person involved in the assessment process? Yes / No If No, provide reasons / detail: If Yes, describe: e.g. <ul style="list-style-type: none"> • Problems and issues perceived and conveyed by the person • What is the person's understanding for the reason for this referral / assessment • Differences or disagreements 				Information Standard
Data Item	Description	Field Length	Format	
Feeling Safe	Does the person feel safe? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons: e.g. <ul style="list-style-type: none"> • at home • in the community • when using services • emotional well being 				Information Standard

				Type of Standard
B. Unpaid Carer/s including young carers(Previously known as "Informal")				
Data Item	Description	Field Length	Format	
Unpaid Carer	Is there an unpaid Carer(s) (including young carers) <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If Yes, was the unpaid carer(s) involved in the assessment process? Yes / No If No, provide reasons: If Yes, describe: <ul style="list-style-type: none"> • problems and issues perceived and conveyed • understanding of the reason for this referral / assessment • differences or disagreements 				Information Standard

Data Item	Description	Field Length	Format	
Continuation of caring role	Does the carer feel able to continue their caring role? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons:				Information Standard
Data Item	Description	Field Length	Format	
Unpaid Carer Assessment	Has the unpaid carer been offered an assessment <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons: If Yes, was offer accepted? Yes / No Describe Care provided by carer (or carers; including young carers). e.g. <ul style="list-style-type: none"> • Times Provided • Type of Care Are there any issues regarding current unpaid caring arrangements? If unpaid carer was not available would services (or additional services) be required? Yes / No				Information Standard
Additional arrangements for young carers or those at risk of young caring 1. Has a referral been made to children services for assessment/support? Yes / No? 2. If No, provide reasons:				Information Standard

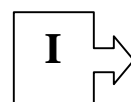
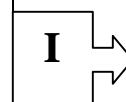
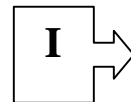
	Type of Standard
C. Relationships	
<p>Personal Relationships</p> <p>Does the person have any issues with key relationships? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p>	Information Standard
<p>Intimate Relationships</p> <p>Has / does the person have any issues with intimate relationships? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues including:</p> <ul style="list-style-type: none"> • Sexual health • Sexual wellbeing 	Information Standard
<p>Service Provision arrangements</p> <p>Are there any issues regarding service provision (previously referred to as formal caring arrangements)? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p>	Information Standard



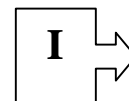
	Type of Standard
D. Vision, Hearing and Communication	
<p>Hearing and Vision</p> <p>Are there any issues? Yes / No</p> <p>If Yes, describe specific concerns:</p>	Information Standard
<p>Communication</p> <p>1. Are there any issues? Yes / No</p> <p>2. If Yes, describe specific issues: e.g.</p> <ul style="list-style-type: none"> • Speech • Language • Understanding • Reading / writing • Numeracy • Use of telephone • Other equipment (specify) 	Information Standard

	Type of Standard
E. Personal care and physical well-being	
<p>Relevant Medical Background (<i>including conditions that require ongoing care</i>)</p> <p>Are there any relevant medical history/learning disabilities/ physical disabilities that require ongoing care? Yes / No / Unknown / Not Assessed</p> <p>If yes, provide details / conditions and source of information e.g.</p> <ul style="list-style-type: none"> • Mental health • Dementia • Learning disability (as per SCDS definitions) • Physical disability • Acquired brain Injury • History of falls <p>If unknown or not Assessed detail any action taken to identify medical / mental health history.</p> <p>Has the person had any hospital admissions within the last 12 months? Yes / No / Unknown / Not Assessed</p> <p>If yes, provide details/conditions and source of information:</p> <p>If unknown or not assessed detail any action taken to identify hospital admissions.</p>	Information Standard
<p>Has the person attended any clinic / outpatient or treatment centre in the last 12 months? Yes / No / Unknown / Not Assessed</p> <p>If Yes, provide details/conditions and source of information:</p> <p>If Unknown or Not Assessed detail any action taken to identify any attendance at a clinic / outpatient or treatment centre.</p>	Information Standard
<p>Current physical health</p> <p>Are there any current relevant health issues? Yes/No/Unknown/Not Assessed</p> <p>If Yes, provide details and source of information including specific health issues.</p> <p>e.g.</p> <ul style="list-style-type: none"> • Skin care • Allergies/Sensitivities • Breathing difficulties <p>If Unknown or Not Assessed detail any action taken to identify current health issues.</p>	Information Standard

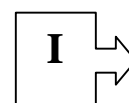
<p>Medication</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Understanding • Ordering / obtaining medication • Taking medication • Concordance – involvement of the patient in decision making (compliance) • Supports 	<p>Information Standard</p>
<p>Personal Care</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> ▪ Managing personal appearance ▪ Washing ▪ Dressing 	<p>Information Standard</p>
<p>Eating, drinking and nutrition</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Does the person require the food to be placed in front of them to prompt them to eat? 	<p>Information Standard</p>
<p>Mobility</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Transferring from a position of lying down to sitting in a nearby chair • Mobility on flat • Mobility on stairs • Mobility outdoors • Falls 	<p>Information Standard</p>
<p>Substance Use</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Smoking • Alcohol • Drugs and solvents use (including prescribed drugs) 	<p>Information Standard</p>



	Type of Standard
F. Mental health	
<p>Cognition</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Concentration • Memory • Orientation • Wandering • Awareness of danger 	Information Standard
<p>Emotional well-being</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Bereavement • Emotional difficulties arising from life events • General Mood • Anxiety • Motivation 	Information Standard
<p>Behaviour</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Agitation / Restlessness • Disturbance/Disruption towards others • Verbal Aggression • Resistiveness or lack of co-operation • Risk of harm to self or others 	Information Standard



	Type of Standard
G. Immediate environment and resources	
<p>Domestic tasks / care of the home</p> <p>Are there any issues? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>e.g.</p> <ul style="list-style-type: none"> • Food & drink preparation • Use of heating • Use of appliances or gas 	Information Standard



Level and management of finances				Information Standard
Are there any issues? Yes / No / Not disclosed / Not Assessed				
If Yes, describe specific issues:				
Data Item	Description	Field Length	Format	
Income maximisation assessment	<i>Has the person been offered an income maximisation assessment?</i> <ul style="list-style-type: none"> • Yes • No. 	3	Yes/No	Data Standard
If No provide reasons:				Information Standard
Accommodation				Information Standard
Are there any issues? Yes / No / Not Assessed (Consider the use of Telecare to provide additional detailed information).				
If Yes, describe specific issues:				
e.g.				
<ul style="list-style-type: none"> • Concerns regarding fabric of the building • Physical security • Safety hazards • Equipment and adaptations • Heating • Summoning help • Housing support 				

	Type of Standard
H. Social and Cultural Life	
Social life and leisure activities	Information Standard
Are there any issues? Yes / No / Not Assessed	
If Yes, describe specific issues:	
e.g.	
<ul style="list-style-type: none"> • Personal relationships • Social behaviour awareness • Social activities – formal and informal • Socialising – opportunities and abilities • Interests and hobbies 	

Data Item	Description	Field Length	Format	
Opportunities for social interaction	Is the person satisfied with the opportunities available for social interaction? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons / detail: e.g. <ul style="list-style-type: none"> • Family • Community • Services - peers • Services - staff 				Information Standard
Spiritual, religious, cultural matters Are there any issues that are relevant to the provision of care? Yes / No / Not Assessed If Yes, describe specific issues: e.g. <ul style="list-style-type: none"> • Requirements for worship or other religious observation • Special dietary needs • Arrangements for provision of care (e.g. gender of carer) 				Information Standard

				Type Standard
I. Employment				
Are there any issues? Yes / No / Not Assessed If Yes, describe specific issues e.g. Does the person have any health or social care issues which would inhibit seeking or retaining employment Is the person in paid employment? Yes / No				Information Standard
Data Item	Description	Field Length	Format	
Interest in employment opportunities	If not in paid employment would the person be interested in finding out more about employment opportunities? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard

	Type of Standard
J. Education, Training and Life Long Learning	
<p>Are there any issues? Yes / No</p> <p>If Yes, describe specific issues</p> <p>e.g.</p> <ul style="list-style-type: none"> • training or life long learning • health or social care issues which would inhibit seeking training or life long learning • options for education, training and life long learning 	Information Standard

	Type of Standard
K. Care and Protection	
Abuse and neglect of person	Information Standard
<p>Are there any issues / relevant history? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>Have these issues triggered a secondary process? Yes / No</p> <p>If Yes, provide details:</p>	
Other aspects of personal safety	Information Standard
<p>Are there any issues / relevant history? Yes / No / Not Assessed – Telecare - could be used to provide additional information to inform the assessment process?</p> <p>If Yes, describe specific issues:</p> <p>Have these issues triggered a secondary process? Yes / No</p> <p>If Yes, provide details:</p>	
Public safety / harm to others	Information Standard
<p>Are there any issues / relevant history? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>Have these issues triggered a secondary process? Yes / No</p> <p>If Yes, provide details:</p>	
Health and Safety at Work – Issues relating to anyone in direct contact	Information Standard
<p>Are there any issues / relevant history? Yes / No / Not Assessed</p> <p>If Yes, describe specific issues:</p> <p>Have these issues triggered a secondary process? Yes / No</p> <p>If Yes, provide details:</p>	

				Type of Standard
L Informed of Contact and Dates				
Data Item	Description	Field Length	Format	
Person Informed of Single Point of Contact	Has the person been verbally informed / given written advice as to who is the single point of contact to coordinate the contributions to assessments? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons:				Information Standard
Data Item	Description	Field Length	Format	
Carer informed who is single point of contact	Has the carer been verbally informed / given written advice as to who is the single point of contact to coordinate the contributions to assessments? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons:				Information Standard
Data Item	Description	Field Length	Format	
Start Date of Assessment	The date on which this assessment of need commences. (It is recognised that the process of assessment may be undertaken over a period of time.) e.g. 2002-06-19	10	CCYY-MM-DD	Data Standard
Data Item	Description	Field Length	Format	
End Date of Assessment	The date on which this assessment concludes and needs / outcomes are recorded. This should be the actual end date of assessment and not the proposed end date. e.g. 2008-02-13	10	CCYY-MM-DD	Data Standard

Minimum Standards for Shared Care & Support Plan

Introduction

Care and support planning supports the transition from the identification of need by assessment to the timely and effective implementation of appropriate resources. The assessment process should identify the needs and desired outcomes. In producing a Shared Care and Support Plan, the lead assessor/care manager should document any related resources and intended outcomes. The minimum standards for the Shared Care and Support Plan reflect this relationship.

The aim of care and support planning is to ensure that the person's needs/outcomes are addressed in appropriate and acceptable ways. This should involve consideration of the person's wishes for their care and their aspirations for the future particularly from a rehabilitation/re-enablement perspective (including capacity for individualisation and self management). Care and support planning allows the lead assessor/care manager the opportunity to consider all the options/opportunities available to address the person's assessed needs. These will be documented in the Shared Care and Support Plan.

The Shared Care and Support plan provides a mechanism to record multi-agency inputs in relation to a variety of needs/outcomes and resources. It should be general in scope with the facility to be augmented with specialist care plans. An individual requiring rehabilitation may have several specialist, specific, goal setting care plans which outline discrete stages in the process of addressing a particular need. The Shared Care and Support Plan should draw together the combined need, intended outcomes and agreed resources into one cohesive document. This can be shared with all the professionals involved, with the person and where appropriate, paid and unpaid carers.

An intended outcome can be:

- a change in the person such as increased confidence and skills
- an improvement to their quality of life such as improving health and wellbeing

A resource can be:

- a service e.g. meals on wheels, respite
- a piece of equipment e.g. handrail
- or a person based resource e.g. physiotherapy
- telecare

It is recognised that more than one resource might be required to address a need and not all needs will be able to be fully addressed. A Share of Care and Support plan should reflect the resources identified to best meet the need, either partially or fully. **Whenever possible the emphasis should be on enablement, with a rehabilitation and anticipatory focus.**

It may not be necessary to record all items for every person assessed, but the ability to cover them is needed to comply with the standards.

The content of a completed Shared Care and Support Plan will reflect the complexity of need/resources and intended outcomes.

Where Information Standards are shown here the actual method used locally for incorporating the standard into local tools is flexible. Where Data Standards are shown the format and codes specified should be adopted to achieve compliance. Local partnerships may wish to specify the data standards that provide data for the community care measures as mandatory to support local performance management systems.

Summary of Minimum Standards for a Shared Care and Support Plan

The minimum standards for a Shared Care and Support Plan cover:

- A. Data items including identification of the lead professional
- B. Identified need and desired outcome
- C. For each need and intended outcome:
 - the resources required
 - the objective of the resource
 - The various start and end dates:
- D. Date plan agreed and end date
- E. Planned date for review
- F. Person's Perspective
- G. Unpaid Carers Perspective

	Type of Standard
A. Data Items	
<p>At a minimum the following sub set of the Personal Details should be included in the Care and Support Plan.</p> <p>Person Details</p> <ul style="list-style-type: none"> • Structured name or unstructured name • Person birth date • Person identification • Address • Lead professional details taken from associated professional <p>The data items above are detailed set out in the Minimum Standards for Personal Details Section and are selected from the Social Care Data Standards Manual, version 2.0 (August 2005).</p>	Data Standard

	Type of Standard
B. Identified Needs and Resources	
<p>Identified Need/s</p> <p>A need, which has been identified during the assessment process.</p> <p>(Note: Dependent on local vocabulary, needs may be related to issues/problems/concerns etc. Local definitions of need should also consider disability and personal requirement needs. During the compliance review for SSA for All Adult Client Groups, partnerships should have identified preferred language in relation to 'need' which will be non-service specific.)</p> <p>e.g.</p> <ul style="list-style-type: none"> • Maintaining personal hygiene 	Information Standard
<p>Intended Outcomes</p> <p>The desired outcome/s for the person including rehabilitation / re-enablement.</p> <p>e.g.</p> <ul style="list-style-type: none"> • a change in the person such as increased confidence and skills • an improvement to their quality of life such as improving health and wellbeing 	Information Standard

	Type of Standard
C. For Each need and intended income	
Resources Identified resources such as services, professionals, equipment considered appropriate to address the identified needs. It should be recognised that there may be more than one resource required to address a need or, conversely, no resources required to address a need. e.g. <ul style="list-style-type: none"> • a service e.g. meals on wheels, respite • a piece of equipment e.g. handrail • or a person based resource e.g. physiotherapy • telecare 	Information Standard

Data Item	Description	Field Length	Format	
Start Date of Resource	The date on which a resource was initiated. This may differ from the referred or the requested date as some resources may not begin immediately. The actual start date might be agreed to coincide with other components of the Care and Support Plan, such as hospital discharge, or there may be a waiting time for the resource to become available. e.g. 2007-07-29	10	CCYY-MM-DD	Data Standard

Data Item	Description	Field Length	Format	
End Date of Resource/s	The date in practice which a resource or the need for that resource ceased. e.g. 2007-06-13	10	CCYY-MM-DD	Data Standard

Reason Resource Ended An explanation of why a particular resource ended. e.g. <ul style="list-style-type: none"> • Person refusal • Need status changed • All intended outcomes met 	Information Standard
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				Type of Standard
D. Start and End Date with reason				
Data Item	Description	Field Length	Format	
Date Shared Care and Support Plan Agreed	The date on which all contributors to the plan have agreed its content. This is an overall, generic date and is not specific to individual components of the plan. e.g. 2007-05-01	10	CCYY-MM-DD	Data Standard
End Date of Shared Care and Support Plan	The date on which it is decided the Shared Care and Support Plan is no longer required or has no current relevance. e.g. 2007-10-01	10	CCYY-MM-DD	Data Standard

Reason Shared Plan of Care and Support Ended				Information Standard
<p>A record of why the Shared Care and Support Plan has been ended.</p> <p>e.g.</p> <ul style="list-style-type: none"> • All intended outcomes met • Person moved away • Person died 				

				Type of Standard
E. Planned date for review				
Data Item	Description	Field Length	Format	
Anticipated / Planned Date of Shared Plan of Care and Support Review	The agreed date (with user and carer) on which it is intended to review the overall identified needs and resources (as outlined in the shared care and support plan). This date will <u>be no more than a year</u> from the date the 'Date Shared Care and Support Plan Agreed'. e.g. 2007-07-09	10	CCYY-MM-DD	Data Standard

				Type of Standard
F. Person's Perspective				
Data Item	Description	Field Length	Format	
Person been informed of Single Point of Contact?	Has the person been verbally informed / given written advice as to who is the single point of contact for co-ordinating the delivery of care and support? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons:				Information standard
Satisfaction with Involvement	Does the person feel satisfied with their involvement in the design of their care?	3	Yes/No	Data Standard
	<ul style="list-style-type: none"> • Yes • No 			
If No provide reasons:				Information standard

				Type of Standard
G. Unpaid Carer's Perspective				
Unpaid carer informed of single point of contact?	Has the unpaid carer been verbally informed/given written advice as to who is the single point of contact for co-ordinating the delivery of care and support?	3	Yes/No	Data Standard
	<ul style="list-style-type: none"> • Yes • No 			
If No provide reasons:				Information Standard
Satisfaction with involvement	Does the carer feel satisfied with their involvement in the design of the person's care?	3	Yes/No	Data Standard
	<ul style="list-style-type: none"> • Yes • No 			
If No provide reasons:				Information Standard

Minimum Standards for Review

Introduction

‘Review’ is a term applied to the ongoing monitoring and evaluation of needs and care provision for individuals who have been assessed and are in receipt of resourced services. Many practitioners will constantly ‘review’ needs and care arrangements as part of their management of care. However for the purposes of the National Minimum Information Standards for Review, **the term refers to the task of undertaking a formal review of a person’s overall needs and care outcomes.** To avoid confusion, the constant activity of reviewing needs and resources will be referred to as monitoring and evaluation.

Carrying out a formal review of the person’s needs is an important stage in the cycle of effective assessment, care planning, monitoring and review. The formal review allows the lead assessor/care manager the opportunity to reconsider options/opportunities available to address current and future needs. This should include discussion with the person, relevant professionals and where appropriate the carer. It is a further opportunity to consider how far the intended outcomes of the existing plan are being achieved and how well current resources are meeting the person’s needs.

Focusing particularly on re-enablement, rehabilitation and anticipating changing needs.

The review provides the person and where appropriate their carer the opportunity to express their views, needs and preferences. **The person and carers will be active participants in the review** and will have their views and preferences documented and addressed.

The way that a review is conducted may vary depending on a number of factors. The **content** of a Review will depend upon the complexity of need and the level of invested resources. The **form** of the Review will be substantially governed by what is judged to be the most effective way of involving the person and unpaid carer(s) as partners. The **frequency** will be governed by how much the needs are subject to change. **The national minimum standard for frequency of reviews is not less than once a year.** Agencies may have set guidelines for more frequent reviews related to the pace of change in the person’s needs, as this determines the need to revise the Care and Support Plans. This does not prevent an earlier review, if circumstances dictate. As detailed in these minimum standards **the date of the next planned Review should be agreed and recorded with the user and carer (where appropriate) at the end of each Review.**

It may not be necessary to record all items for every Review, but the *ability* to cover them is needed to comply with the standards. The content of a completed Review will depend on the complexity of resources and needs/outcomes.

Where Information Standards are shown here the method used locally for incorporating the standard into local tools is flexible. Where Data Standards are shown the format and codes specified should be adopted to achieve compliance. Local partnerships may wish to specify the data standards that provide data for the community care measures as mandatory to support local performance management systems.

Summary of Minimum Standards for Review

The minimum standards to reflect the purpose of the Review outlined above include:

- A. basic data items about the person and lead professionals and date of review
- B. details of contributors and method of engagement,
- C. the documented viewpoint of the person
- D. the documented viewpoint of the unpaid carer
- E. documented views of other contributors
- F. Summary of review needs - outcomes and resources
- G. Date of next review and informed of single point of contact

	Type of Standard
A. Data Items	
<p>At a minimum the following sub set of the personal details should be included in the Review</p> <p>Person Details</p> <ul style="list-style-type: none"> • Structured name or unstructured name • Person birth date • Person identification • Address • Lead professional details taken from associated professional <p>The data items above are detailed in the Minimum Standards for Personal Details Section (Pages 12 – 18) and are selected from the Social Care Data Standards Manual, version 2.0 (August 2005).</p>	Data Standard

Data Item	Description	Field Length	Format	
Date Review Undertaken	<p>The date the Review was completed. (Note: This is a general overview of the assessment and Shared Care and Support Plan and whilst it may consider specific components, the main focus is the overall status of needs/outcomes and resources.)</p> <p>e.g. 2008-02-14</p>	10	CCYY-MM-DD	Data Standard

	Type of Standard
B. Persons Contributing to Review and Methods of Engagement	
<p>Current contributors to the Shared Care and Support Plan.</p> <p>Source:</p> <ul style="list-style-type: none"> • Associated professional details • Associated person details <p>Method of engagement</p> <p>e.g.</p> <ul style="list-style-type: none"> • Telephone • Face to face • Letter • Proxy 	Information Standard

				Type of Standard
C. Person's Views				
Was the person involved in the review process? Yes / No				Information Standard
If No, provide reasons:				
If Yes, describe method of engagement				Information Standard
e.g. <ul style="list-style-type: none"> • Telephone • Face to face • Letter • Proxy 				
Did the person feel that their needs were being addressed/met through the current shared care and support plan? Yes / No				Information Standard
If No, provide reasons/detail:				
Data Item	Description	Field Length	Format	
Feeling Safe	Does the person feel safe? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons/detail: e.g. <ul style="list-style-type: none"> • at home • in the community • when using services • emotional well being 				Information Standards
Data Item	Description	Field Length	Format	
Opportunities for social interaction	Is the person satisfied with the opportunities available for social interaction? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons/detail: e.g. <ul style="list-style-type: none"> • Family • Community • Services - peers • Services - staff 				Information Standard

Data Item	Description	Field Length	Format	
Satisfaction with involvement	Does the person feel satisfied with their involvement in the design of their care? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons / detail:				Information Standard

	Type of Assessment
D. Unpaid Carer's Views	
Was the carer/s (including young carers) involved in the review process? Yes / No If No, provide reasons: If Yes, describe method of engagement e.g. <ul style="list-style-type: none"> • Telephone • Face to face • Letter • Proxy Does the carer(s) feel that the person's needs are being addressed / met through the current shared care and support plan? Yes / No If No, provide reasons / detail:	Information Standard

Data Item	Description	Field Length	Format	
Satisfaction with Involvement	Does the carer feel satisfied with their involvement in the design of the persons care? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard

If No, provide reasons:				Information Standard
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Data Item	Description	Field Length	Format	
Continuation of caring role	Does the carer feel able to continue their caring role? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard

If No, provide reasons:				Information Standard
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Data Item	Description	Field Length	Format	
Unpaid Carer Assessment	Has the unpaid carer been offered an assessment <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons:				Information Standard
Additional arrangements for young carers				
Has a referral been made to children's services for assessment/support? Yes / No?				Information Standard
If No, provide reasons:				

	Type of Standard
E. Contributor's views current shared care and support plan	
Were all contributors involved in the review process? Yes / No	Information Standard
If No, provide reasons:	
Contributors Views:	

	Type of Standard
F. Summary of Review	
Effectiveness of Current Shared Care and Support Plan	Information Standard
This would include consideration of needs , resources and outcomes e.g. in relation to re-enablement, rehabilitation, socialisation and anticipation of changing needs. It should form a summary of the effectiveness of the Shared Care and Support Plan.	
Decisions and Actions Taken	Information Standard
Identification of changes to the shared care and support plan and specific actions (if any) required as a consequence of the review.	

				Type of Standard
G. Date of next review and informed of single point of contact				
Data Item	Description	Field Length	Format	
Date of Next Planned Review or Reassessment	The agreed date (with user and carer) to review the overall identified needs, outcomes and resources (as outlined in the shared care and support plan). This date would be no more than a year from the date the 'Date Shared Care and Support Plan Agreed'. e.g. 2007-07-09	10	CCYY-MM-DD	Data Standard
Data Item	Description	Field Length	Format	
Person informed who is the single point of contact	Has the person been verbally informed / given written advice as to who is the single point of contact for co-ordinating the contributions to the Review? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons:				Information Standard
Unpaid carer informed who is the single point of contact	Has the unpaid carer been verbally informed / given written advice as to who is the single point of contact for co-ordinating the contributions to the Review? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No, provide reasons:				Information Standard

Minimum Standards for Carer's Assessment and Support

Introduction

The Community Care and Health (Scotland) Act 2002 affirms that carers who intend to or provide a 'substantial amount of care on a 'regular basis' are entitled to an assessment of their ability to provide or to continue to provide care ('carer's assessment'), independent of any assessment of the person they care for. Young carers under 16 have the same rights to assessment. N.B. The term "ability to care" in this context is not imply a reflection of the carer's competence or skills, but rather their capacity to care with support as appropriate.

As set out in Scottish Executive Circular [CCD2/2003](#) 'The fundamental principle underlying this legislation is that local authorities, the NHS and other support agencies should recognise and treat carers as **key partners in providing care.**' The accompanying guidance also emphasises that support for carers should be designed to empower carers and to make the most of their potential and opportunities, rather than allowing them to be confined or isolated in their caring role.

The Carer's Assessment and Support standards detailed below are intended to support the above purpose and, in turn, achieve good outcomes for carers.

Definition of an unpaid carer

The legal definition of a carer is someone who provides substantial amounts of care on a regular basis for either an adult or a child, where that adult or child receives, or is eligible to receive, support services under the Social Work (Scotland) Act 1968 or the Children (Scotland) Act 1995. A carer is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the carer's help due to frailty, illness, disability or addiction.

Summary

In order to achieve good outcomes the carer's assessment has to:

- Identify the care provided by the carer
- Establish what level of care the carer is willing and able to provide, and help them to determine whether their caring role is sustainable
- Identify current and potential risks to the carer's health and wellbeing as a result of the caring role
- Determine what resources the carer needs to support them in their caring role, and agree how these resources can best be provided
- Determine what resources the carer needs to enable them to have a life of their own, and agree how these resources can best be provided
- Determine what the carer needs to maintain and improve their own health and wellbeing, and agree how these resources can best be provided
- Take the carer's views into account when agreeing any support to the carer and cared-for person

Where information standards are shown, the actual method used locally for incorporating the standard into local tools is flexible, where data standards are shown the format and codes specified should be adopted to achieve compliance. Local partnerships may wish to specify the data standards that provide data for the Community Care Measures are mandatory to support local performance management systems.

The minimum standards are listed under the following headings:

- A. Data Items
- B. Caring situation
- C. Carer responsibilities
- D. Health and wellbeing
- E. Life of your own
- F. Supporting the caring role
- G. Summary of Support Needs
- H. Arrangements for reviews
- I. Informed of contact

Recording of the standards

It is not necessary to record every item for every person subject to a carer's assessment, only those items appropriate for that carer. However to meet the standards, tools and electronic systems should have the capability to cover all the standards.

	Type of Standard
A. Data Items	
<p>Person Details (Carer and Cared for Person)</p> <ul style="list-style-type: none"> ▪ Structured name or unstructured name ▪ Person birth date ▪ Person identification ▪ Address ▪ Associated person (relationship to cared-for person) <p>The data items above are set out in the 'Minimum Standards for Personal Details Section' and are selected from the <i>Social Care Data Standards Manual, version 2.0</i> (August 2005).</p>	Data Standard

	Type of Standard
B. Summary of Caring Situation	
<p>Has the cared-for person(s) had an assessment of their needs? Yes/No</p> <p>If Yes, provide details of assessor and date of assessment</p> <p>If No, provide reasons:</p> <p>Summary of cared-for person's situation</p> <p>Reason given for requesting carer's assessment</p>	Information Standard

	Type of Standard
C. Unpaid Carer Responsibilities	
<p>What care does the carer provide?</p> <p>e.g.</p> <ul style="list-style-type: none"> ▪ What tasks does the carer carry out? ▪ How often? <p>What services and support is in place?</p> <p>.e.g.</p> <ul style="list-style-type: none"> ▪ Current services ▪ Other people who are carers <p>Does the carer have any of the following responsibilities?</p> <ul style="list-style-type: none"> ▪ Appointee, Yes / No ▪ Guardian: Financial, Yes / No. ▪ Guardian: Welfare, Yes / No. ▪ Guardian: Both Yes / No ▪ Named person, Yes / No ▪ Power of attorney: Continuing (financial), Yes / No ▪ Welfare, Yes / No. 	Information standard

<p>Any support required in managing any of the above responsibilities? Yes / No</p> <p>If Yes, provide details:</p> <p>Does their caring role impact on other responsibilities, for example, childcare, family? Yes / No</p> <p>If Yes, describe:</p> <p>How does the carer feel about their caring role? e.g.</p> <ul style="list-style-type: none"> ▪ satisfaction with current services and support 	
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	Type of Standard
D. Health and Well-being	
<p>Does the caring role affect the carer's physical, mental and emotional health and well-being? Yes / No</p> <p>If Yes, details:</p> <p>What can be done to address this?</p> <p>Does the carer's health affect their ability to care? Yes / No</p> <p>If Yes, provide details:</p> <p>What can be done to address this?</p>	Information Standard

				Type of Standard
E. Life of your own				
<i>Education, training and lifelong learning</i>				Information Standard
Is there an issue with balancing caring with education, training and lifelong learning? Yes / No				
If Yes, describe specific issues: What can be done to address this?				
<i>Employment</i>				
Data Item	Description	Field Length	Format	
Retaining Employment	Are caring issues affecting the carer's ability to retain their employment? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If Yes, describe specific issues: What can be done to address this?				Information Standard
Interest in employment opportunities	If not in paid employment would the person be interested in finding out more about employment opportunities? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
<i>Social life, leisure activities, religious and cultural activities</i>				Information Standard
Is there an issue with balancing caring with social Life, leisure activities, religious and cultural activities. Yes / No				
If Yes, describe specific issues: What can be done to address this?				

Relationships				Information Standard
<p>Are there any relationship issues that impact on the caring role? Yes / No</p> <p>If Yes, describe specific issues:</p> <p>What can be done to address this?</p> <p>Does the caring role impact on the carer's key relationships? Yes / No</p> <p>If Yes, describe specific issues:</p> <p>What can be done to address this?</p>				
Level and Management of Finances				Information Standard
<p>Are there any issues? Yes / No / Not disclosed / Not Assessed</p> <p>If Yes, describe specific issues:</p>				
Data Item	Description	Field Length	Format	
Income maximisation assessment	<p>Has the unpaid carer been offered an income maximisation assessment?</p> <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons:				Information Standard

				Type of Standard
F. Supporting the Caring Role				
<p><i>Emergency / Crisis Planning</i></p> <p>Are there any measures in place for emergency or crisis planning? Yes / No</p> <p>If Yes, what are these measures?</p> <p>If No, what would need to be done if an emergency arose?</p> <p><i>The future (explore concerns and plans for the future)</i></p> <p>Are there any potential changes in the future which may affect the carer's caring role? Yes / No</p> <p>If Yes, what are these?</p> <p>What can be done to address this?</p> <p>What are the carer's hopes, plans for the future?</p>				Information Standard
Data Item	Description	Field Length	Format	
Continuation of Caring Role	Does the carer feel able to continue their caring role? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If No provide reasons:				Information Standard

Satisfaction with Involvement	Does the carer feel satisfied with their involvement in the design of the persons care? <ul style="list-style-type: none"> • Yes • No 	3	Yes/No	Data Standard
If no provide reasons:				Information standard

	Type of Standard
G. Summary of Support Needs	
Summary of support needs which have been identified during the assessment process to support the carer in their caring role. The summary should include support needs regarding tasks that the carer would prefer not to do. It should document any areas of disagreement, e.g. between the carer and cared-for person or the carer and assessor.	Information standard
Identified Actions and Agreements	Information standard
<p>Identified actions and agreements to address the support needs of the carer. The services/activities/resources that are required to address the support needs may relate to particular tasks, or behaviour and may also relate to the requirement for a further assessment. The actions should reflect the carer and assessor's agreement regarding the services/action/resource which is best suited to address the support needs. Several resources may be required to meet one support need or one resource may address more than one support need.</p> <p>Examples of services/activities/resources:</p> <ul style="list-style-type: none"> • Information, • Breaks from caring • Carer training • Emotional support • Practical support • Financial advice <p>Are there any identified needs that can't be met at the moment? Yes / No</p> <p>If Yes, detail these and possible consequences.</p>	

Data item	Description	Field Length	Format	
Date Support Plan Agreed	The date on which all contributors have agreed its content. This is an overall, generic date and is not specific to individual components of the plan. e.g. 2007-01-01	10	CCYY-MM-DD	Data Standard
Date Support Plan Ended	The date on which it is decided the Support Plan is no longer required or has no current relevance. e.g. 2007-01-01	10	CCYY- MM - DD	Data Standard

<p>Reason Support Plan Ended</p> <p>A record of why the Support Plan has been ended. e.g.</p> <ul style="list-style-type: none"> • All support needs have been addressed • Assessment of person's needs is required • Support was refused • Carer has died 	<p>Information Standard</p>
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				Type of Standard
H. Arrangements for Review				
Data item	Description	Field Length	Format	
Anticipated / Planned Review Date of the Carer Support Plan	<p>The agreed date (with user and carer) on which it is intended to review the overall identified needs/outcomes and resources. This should be no more than a year from the date of the agreed plan.</p> <p>e.g. 01/01/2007</p>	10	CCYY-MM-DD	Data Standard
<p>Does the carer feel that their needs are being addressed / met? Yes / No</p> <p>If No, provide reasons/details:</p> <p>(Note: Agreement should be reached and recorded as to whether the carers review should be carried out at the same time as that of the cared for person.)</p>				Information Standard

		Type of Standard
I. Informed of Contact		
<p>Has the carer been verbally informed/given written advice as to who is the single point of contact to coordinate the contributions to assessments and the delivery of support?</p> <p>Yes / No</p> <p>If No, provide reasons:</p>		Information Standard

Appendix One:

Membership of the Assessment Review Co-ordinating Group at July 2008

The Assessment Review Co-ordinating Group (ARCG) was formed to meet the demands of local partnerships in Scotland. The ARCG developed the national minimum information standards for the recording of information about people receiving community care services and facilitate data sharing. It was formed following a national Integration Seminar hosted by the (then) Scottish Executive in March 2004.

ARCG membership includes a representative cross-section of local partnerships, supported by staff from the Partnership Improvement and Outcomes Division (previously Joint Future Unit), the central eCare Programme, Standards Branch, the Information and Statistics Division of NHS Scotland, and the Scottish Government's Community Care Statistics Branch. Membership of the Group as at July 2008

Name	Organisation
Peter Knight (Chair)	Scottish Government, Partnership Improvement and Outcomes Division (formerly member of NHS Information Services Division)
Jane Arroll	Scottish Government, Partnership Improvement and Outcomes Division
Kirsteen Cameron	Scottish Government, Standards Branch, Transformational Technologies Division
Kerr Donaldson	Scottish Government, Standards Branch, Transformational Technologies Division
Fidelma Eggo	NHS Dumfries and Galloway
June Findlater	East Renfrewshire Community Health & Care Partnership
Lorna Jackson	NHS Information Services Division
Kate Kerr	West Dunbarton Council
Iona Lancaster	Perth and Kinross Community Health Partnership
Jane Mackie	Moray Council
Dawn McFarlane	Angus Council
Judy McGovern	Scottish Government, Partnership Improvement and Outcomes Division (formerly Joint Future Unit)
Emma Miller	Queen Margaret University
Sue Muir	Perth and Kinross CHP
Helen Nettleship	Scottish Government, Standards Branch, Transformational Technologies Division
Terry Palmer	Highland Council/NHS Highland
Stephen Pavis	NHS Information Services Division
Margaret Quinn	NHS Information Services Division
Julie Rintoul	Scottish Government Community Care Statistics Division.
Sandra Sage	South Lanarkshire Council
Winona Samet	Consultant – Joint Improvement Team (Formerly Scottish Government, Joint Future Unit)
Michael Sibley	NCDDP, NHS Information Services Division
Jane Thomson	NHS Information Services Division

Alison Wallis	NCDDP, NHS Information Services
John Wilson	Scottish Government, Standards Branch, Transformational Technologies Division
Stephen Young	Scottish Government, Partnership Improvement and Outcomes Division

Appendix Two:

Indicator of Relative Need (IoRN)

The Indicator Of Relative Need (IoRN) is a tool for categorising people, currently only older people, whose needs have been assessed, into nine groups (A to I) according to their level of need. It uses the answers to a carefully determined set of questions that cover the assessed person's need for support across activities for daily living, personal care, food and drink preparation, mental health and behaviour, and bowel management. The IoRN can be completed easily by a trained professional provided that they are familiar with the person's current health and social care needs. It is completed typically following a comprehensive assessment or SSA. It provides additional insight on a person's level of need and informs the care plan.

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The IoRN was developed by ISD Scotland [www.isdscotland.org] on behalf of the Scottish Government. More detail on the IoRN is available at [<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/SSAIoRN>]

General guidelines for completion of the Indicator of Relative Need (IoRN) questionnaire

- Answer the questions based on your most recent assessment of the person's health and social care needs drawing on mental health as well as physical needs.
- If a person's needs fluctuate between two categories, select the higher of the two codes, e.g., if the person's needs fluctuate between options 3 and 4 for a particular question, select 4.
- Answer all questions.

GUIDELINES FOR QUESTIONS 1-3

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

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

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

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

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

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

Select **D**:if the person has difficulties eating a meal because of frailty, disability or lack of awareness and so requires prompting supervision and guidance, e.g. the client can physically eat a meal without difficulty but because of their mental health needs requires their meal to be placed in front of them to prompt them to eat

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

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

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

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

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

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

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

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

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

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

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

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

- Select **A**:if the person is able to use the toilet or commode independently without the use of any equipment or adaptations, e.g., raised toilet seat, hand rails, etc.
- Select **B**:if the person is able to use the toilet or commode independently, but only with the use of equipment or adaptations e.g., raised toilet seat, hand rails. This includes those persons who independently manage a catheter or colostomy
- Select **C**:if the person requires minimal physical assistance from one person to use the toilet or commode, but performs the majority of the tasks himself / herself, e.g., if the person needs a small amount of assistance in transferring on and off the toilet, or in adjusting clothing.
- Select **D**:if the person requires encouragement, prompting or supervision to use the toilet or commode because of a lack of motivation, fear of falling, confusion or memory loss, but does not require physical assistance; OR if the person uses any equipment or adaptation that requires one person either to set it up or to supervise its use; OR if the person has difficulties using the toilet because of frailty, disability or lack of awareness
- Select **E**:if the person requires assistance with all aspects of using the toilet.
- Select **F**:if the person does not use the toilet or alternative receptacle because of physical disability or injury, or because he / she requires assistance to manage their catheter or colostomy.

Activities of Daily Living and Mobility

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

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

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

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

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

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

ADL Score

Q 1 - Eating	Score	<input style="width: 60px; height: 20px;" type="text"/>
Q 2 – Transferring	Score	<input style="width: 60px; height: 20px;" type="text"/>
Q 3 – Toileting	Score	<input style="width: 60px; height: 20px;" type="text"/>
Total ADL Score (Q1 + Q2 + Q3)	Score	<input style="width: 60px; height: 20px;" type="text"/>

GUIDELINES FOR QUESTIONS 4-7

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

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

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

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

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

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

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

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

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

For all questions 4-7 :

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

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

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

Select **D**: if the person:

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

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

Select **E**:if the person:

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

Personal care

4. Is the person able to wash his / her hands and face? Personal Care Score
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

5. Is the person able to give himself / herself a complete wash, a bath or a shower? Personal Care Score
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

6. Is the person able to wash his / her own hair? Personal Care Score
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

7. Is the person able to dress / undress himself / herself? Personal Care Score
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

continue and score on page 7...

GUIDELINES FOR QUESTIONS 8 – 10

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

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

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

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

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

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

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

For all questions 8-10:

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

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

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

Select **D:** if the person:

- lacks confidence or motivation to perform the task, but is able to do so when prompted or encouraged; OR
- has forgotten how to perform the task, or is unable to perform it safely or appropriately without supervision because of cognitive impairment or confusion. (This includes, for example, a person who may be physically able to cook, but who might leave a pot on a lit burner and walk away from it, or who might eat out-of-date food. It also includes someone who is physically able to shop, but who cannot do so appropriately without supervision); OR
- is physically able to perform the task, but usually neglects himself / herself because of a mental health need or cognitive impairment.

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

Select **E:** if the person:

- requires physical assistance from others to perform the task (for whatever reason); OR
- requires physical support from others to perform the task (for whatever reason), even if it is minimal (e.g. flask left containing hot drink)
- can not perform the task without assistance because of a lack of training (e.g., someone who needs prepared meals to be provided because they do not know how to cook, but who is able to reheat the meals once provided); OR
- does not perform the task because of disability.

Food / Drink Preparation

- 8. Is the person able to prepare, cook and serve himself / herself a main meal? Food / Drink Score**
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

- 9. Is the person able to prepare himself / herself a light snack (e.g. sandwich)? Food / Drink Score**
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

- 10. Is the person able to prepare himself / herself a hot drink (e.g. cup of tea) Food / Drink Score**
- A Without difficulty 1
 - B Without difficulty using equipment or an adaptation 2
 - C Has difficulty, even if using equipment or an adaptation 3
 - D Requires prompting, guidance, supervision or encouragement 4
 - E Cannot do without assistance from others 5

<u>Personal Care / Food / Drink Score</u>		
Q4 – Washing Hands / Face	Score	<input type="text"/>
Q5 – Complete Wash	Score	<input type="text"/>
Q6 – Washing Hair	Score	<input type="text"/>
Q7 – Dress / Undress	Score	<input type="text"/>
Q8 – Main Meal	Score	<input type="text"/>
Q9 – Light Snack	Score	<input type="text"/>
Q10 – Hot Drink	Score	<input type="text"/>
Total Personal Care / Food / Drink Score (Q4+Q5+Q6+Q7+Q8+Q9+Q10)	Score	<input type="text"/>

GUIDELINES FOR QUESTION 11

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

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

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

For each behaviour A-C, indicate how often it has occurred in the last four weeks. If it has not occurred or has occurred less than three times, select option 1 — 'Never, or less than three times'. If option 1 selected, when assigning score, score 1. Choose option 2 — 'three times or more' — even if the behaviour has occurred irregularly in the last four weeks, or if it has occurred only in certain contexts (the examples below detail where behaviours may occur in certain contexts). If option 2 selected, when assigning score, score 2

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

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

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

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

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

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

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

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

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

Mental Well-being and Behaviour

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

A. Agitation/Restlessness

Is the person agitated or restless?

- 1 Never, or less than three times in the last four weeks
2 Three times or more in the last four weeks

B. Disturbance/Disruption

Has the person disturbed or disrupted other people?

- 1 Never, or less than three times in the last four weeks
2 Three times or more in the last four weeks

C. Verbal aggression

Is the person verbally aggressive?

- 1 Never, or less than three times in the last four weeks
2 Three times or more in the last four weeks

Sub Total Score (QA + QB + QC)

D. Resistiveness

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

- 1 No
2 Yes

E. Relationships

Has the person had difficulty with key relationships?

- 1 No
2 Yes

F. Risk

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

- 1 No
2 Yes

Sub Total Score (QD + QE + QF)

Mental Well-being / Behaviour Score

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

Score

GUIDELINES FOR QUESTION 12

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

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

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

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

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

Bowel management

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

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

A Never or less than once a week, on average

B More than once a week, on average

Bowel Management

Low / No Bowel Management Option A

High Bowel Management Option B

Note : Score not required, only one question relating to bowel management

If option A, place person in low/no bowel management group.

If option B, place person in high bowel management group.

Assigning the person to an IoRN Grouping

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

Please refer to the diagram when allocating the IoRN grouping.

Step 1

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

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

Step 2

Box 1

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

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

Box 2

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

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

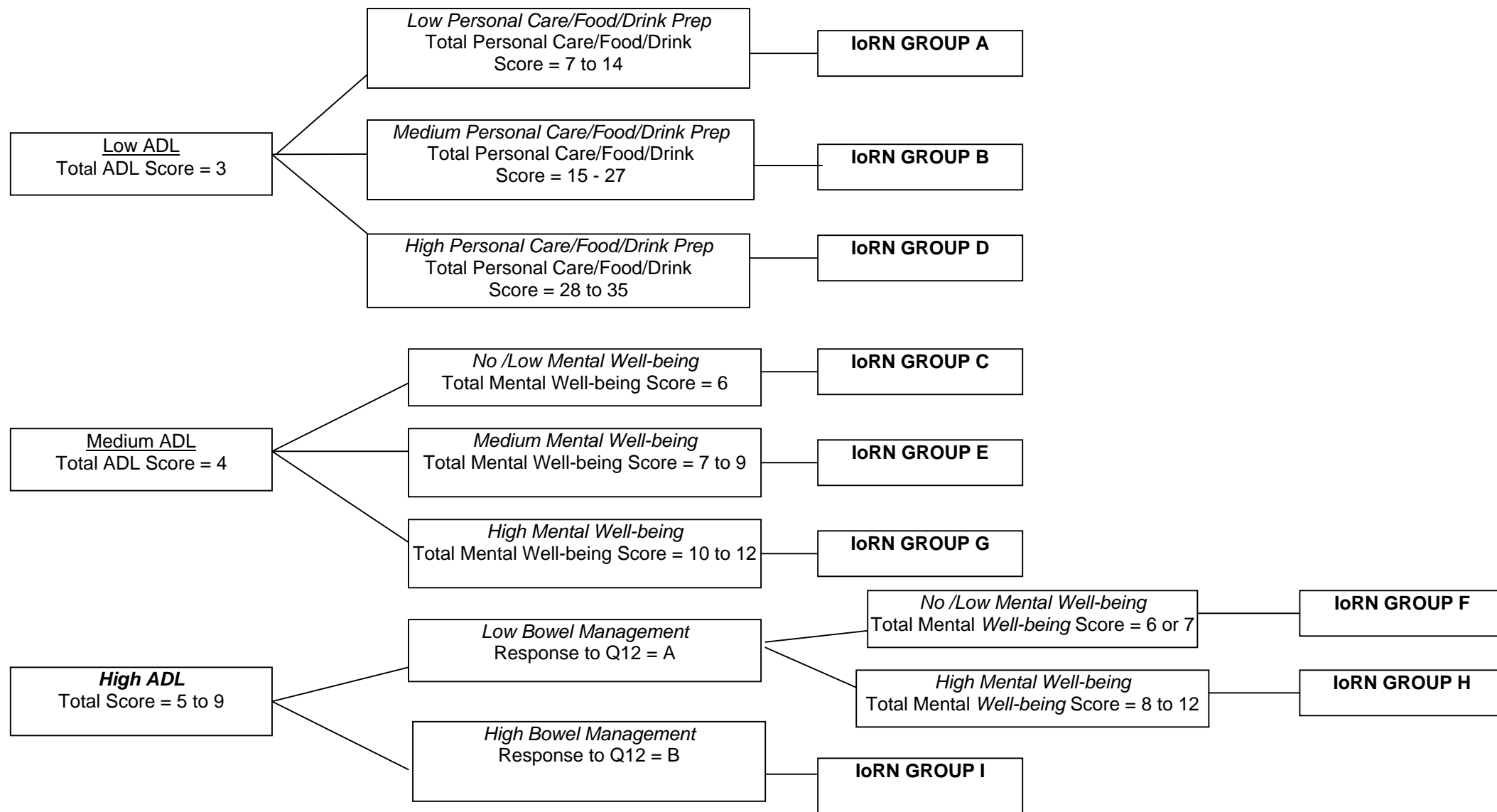
Box 3

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

Bowel Management response (see page 11)	<u>Only if option A selected -</u> Refer to Mental Well-being Score (see page 9)	IoRN Group
A	6 - 7	F
	8 - 12	H
B		I

Please record the persons IoRN grouping in box.

IoRN GROUPING DIAGRAM



Appendix Three:

Context, Scope and Links / References for National Minimum Information Standards for All Adults in Scotland

Context for the Standards

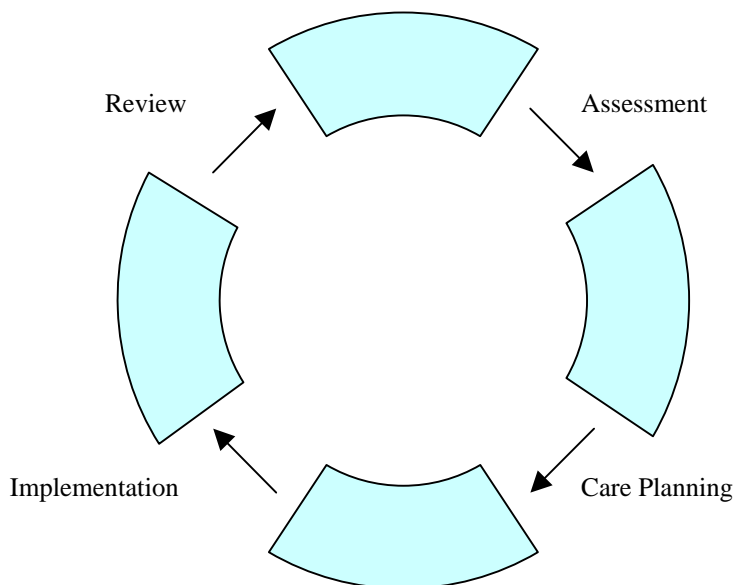
The Scottish Executive issued general guidance on Single Shared Assessment (circular CCD 8/2001).

The SSA guidance provided the initial reference point for the ARCG's work (see below). It's work has also been informed by subsequent initiatives, including:

- Local partnerships both on developing their own local assessment tools and procedures and on converting existing paper tools into an electronic form
- The agreement of core data standards for eCare, and harmonisation with generic standards for health produced by the National Clinical Dataset Development Programme (NCDDP)
- The development and incremental roll-out of the SSA-Indicator of Relative Need (SSA-IoRN). This is a standardised tool (currently validated only for use with older people) which groups individuals according to their level of relative need, and is applied following a comprehensive Single Shared Assessment.
- Early work to devise an agreed common core national dataset that will summarise the characteristics of older people (including the SSA-IoRN result) receiving community care services; It has a 'working title' The Care Assessment Data Summary (CADS).
- Establishment of Performance Indicators for Single Shared Assessment within the Joint Performance Information and Assessment Framework (commonly referred to as the JPIAF 6 PIs)
- The development of the National Outcome Measures for Community Care.
- The Guidance in Circular [CCD2/2003](#) that 'the fundamental principle underlying the new legislative provisions is that Local Authorities, the NHS and other support agencies should recognise and treat carers as **key partners in providing care.**'

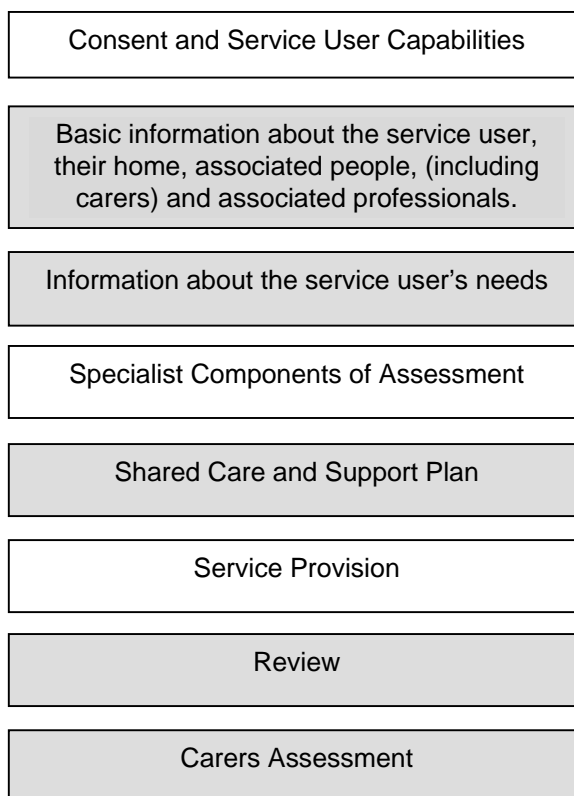
Reflecting early priorities the ARCG initially ([Circular CCD15/2004](#)) a set of minimum standards for the assessment of older people. This was superseded by National Minimum Information Standards on Assessment covering All Adults issued in August 2006 ([CCD3/2006](#)). This version now supersedes all these previous versions.

The diagram below shows the key elements in the assessment of need and care management. In health, this is commonly referred to as ***the nursing process***: within social care it is often referred to as ***the assessment and care management process***.



Scope of the National Minimum Information Standards

Broadly speaking, the shaded areas in the diagram below are the areas covered by this document.



Links/references

The paper refers to a number of specific documents produced by various related work streams. These can be found at the following locations:

Carers: The Community Care and Health (Scotland) Act (2002)

<http://www.hmsd.gov.uk/legislation/Scotland/acts2002/20020005.htm>

CHP Toolkit and Management of Long Term Conditions:

http://www.sehd.scot.nhs.uk/mels/HDL2007_10.pdf

Community Care And Health (Scotland) Act 2002

New Statutory Rights For Carers: Guidance (Circular CCD2/2003)

http://www.sehd.scot.nhs.uk/publications/cc2003_02full.pdf

Coordinated, Integrated and Fit for Purpose. A delivery framework for adult rehabilitation in Scotland.

<http://www.rehabilitationframework.scot.nhs.uk/Documents/reports/CoordIntandFitforPupose.pdf>

Data Sharing and Standards:

<http://www.scotland.gov.uk/Topics/Government/DataStandardsAndeCare>

Guidance on Care Management in Community Care (Circular CCD8/2004):

<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/ccd8>

Joint Performance Information and Assessment Framework (JPIAF) CCD1/2003:

<http://www.scotland.gov.uk/Publications/2003/03/16630/19312>

National Minimum Information Standards For Older People,(Circular CCD15/2004)

http://www.sehd.scot.nhs.uk/publications/CC2004_15.pdf

National Minimum Information Standards for Single Shared Assessment for All Adults, August 2006 (Circular CCD3/2006)

[:http://www.scotland.gov.uk/Topics/Health/care/JointFuture/InformationStandards](http://www.scotland.gov.uk/Topics/Health/care/JointFuture/InformationStandards)

National Training Framework for Care Management (Circular CCD2/2006):

<http://www.scotland.gov.uk/Topics/Health/care/JointFuture/Publications/CCD0206>

Original SSA Guidance 2001 (Circular CCD8/2001):

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

Scottish Government Data Sharing and Standards Manual

<http://www.scotland.gov.uk/Topics/Government/DataStandardsAndeCare/Manual>

SSA: Indicator of Relative Need:

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

SSA IoRN (relating to Older People) users handbook

<http://www.scotland.gov.uk/library5/health/rumhb.pdf>

The Review of Nursing

<http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/review>

UDSET:

<http://www.jitscotland.org.uk/action-areas/themes/involvement.html>

Voices from the Frontline

<http://www.euro.who.int>

Reference Material

The Elements of Nursing 4th edition. (Roper, Logan and Tierney) Churchill Livingstone, Edinburgh

Appendix Four:

Code Lists for Personal Details Data Items

These code lists are from the Data Standards Manual Version 2.0 released in August 2005. For full details of the data items, the Data Manual can be found on the Home Page of the Data Sharing and Standards Division website <http://www.scotland.gov.uk/dss>

Please note that values in *italic* are not relevant to adults, but are included so that the codes follow on.

Persons Birth / Death Date

Format CCYY-MM-DD e.g 1999-12-09

Person Current Gender

Code	Value	Explanatory Notes
0	Not Known	
1	Male	
2	Female	
8	Other specific	The person has a clear idea of what their gender is, but it is neither discretely male nor female, e.g. 'intersex', 'transgender', 'third gender'.
9	Not specified	The person is unable to specify their current gender or does not have a clear idea of what their current gender is.

Person Marital Status

Code	Value
S	Single
M	Married/Civil Partner
D	Divorced/ dissolved Civil Partnership
W	Widowed/ Surviving Civil Partner
N	Not disclosed
P	Separated

Ethnic Group (Self Assigned)

Code	Sub-code	Value
01	White	E004 Scottish E070 Other British E002 Irish Any other White background – specify
02	Mixed	Any Mixed background – specify
03	Asian, Asian Scottish or Asian British	E041 Indian E042 Pakistani E043 Bangladeshi E081 Chinese Any other Asian background – specify
04	Black, Black Scottish or Black British	E061 Caribbean E062 African Any other Black background – specify
05	Other Ethnic Background	Any other ethnic background – specify
97	Not disclosed	
99	Not known	

This is assigned by the service user themselves. Further 'Ethnic Group (Self Assigned)' subsidiary codes are available in the Data Manual.

Religion

Code	Value	Sub Code	Value
00	Atheist, Agnostic or no religious affiliation	R012 R003 R121	Atheist Agnostic None
01	Christian - Church of Scotland		
02	Christian - Roman Catholic		
03	Other Christian (specify) - see recording guidance	R137 R170 R083 R014 R153 R043 R109 R171 R131 R148 Other	Protestant United Free Church of Scotland Free Church of Scotland Baptist Scottish Episcopal Church Church of England Methodist United Reformed Church Pentecostal Salvation Army (refer to Religion Subsidiary Codes list)
04	Buddhist		
05	Hindu		
06	Muslim		
07	Jewish		
08	Sikh		
97	Not disclosed		
98	Any other religion (see Religion Subsidiary Codes)		
99	Not known		

Further 'Religion' subsidiary codes are available in the Data Manual.

Interpretation Assistance Indicator

Code	Value	Explanatory Notes
00	No help needed	Fluent in English.
01	Need help only with complex language	Usually conversant in English.
02	Help needed at all times	Interpretation in Preferred language or Preferred Communication Method required.
99	Not known	

Preferred Language

Code	Value	Sub-Code	Value
Ara	Arabic		
Ben	Bengali		
Chi	Chinese		
Eng	English		
Fre	French		
Ger	German		
Gla	Gaelic; Scottish Gaelic		
Gre	Greek		
Guj	Gujarati		
Hin	Hindi		
Ita	Italian		
Nor	Norwegian		
Pan	Panjabi; Punjabi		
Per	Persian		
Sgn	Sign Language	-GB	British Sign Language
Spa	Spanish; Castilian		
Tur	Turkish		
Und	Undetermined (Not Known)		
Urd	Urdu		

Further 'Preferred Language' subsidiary codes are available in the [Data Manual](#).

Address Type

Code	Value
00	None
01	Normal domicile (home) address
02	Alternative contact address
03	Non-domicile address
04	Invoiced address
05	Employer's address
06	Temporary domicile address
07	Professional contact address
08	No fixed abode

Accommodation Type
Italic values are not relevant for Adults.

Code	Value	Code	Value
01	Homeless	HM01	Homelessness Type unspecified
		HM02	Rough Sleepers
		HM03	Other Roofless
		HM04	Squatting
		HM05	Emergency/Temporary Accommodation
		HM06	Women's refuges
		HM07	Bed & Breakfast
		<i>HM08</i>	<i>Young People asked to leave</i>
		HM09	Unable to secure entry
02	Mainstream	MA01	Unspecified
		MA02	No adaptations
		MA03	With adaptations
		MA04	Barrier Free Housing/Lifetime Homes
03	Special Housing	SP01	Unspecified
		SP02	Amenity Housing
		SP03	Wheelchair Accessible Housing
		SP04	Ambulant Disabled Housing
		SP05	Other specially adapted housing
04	Sheltered Housing	SH01	Unspecified
		SH02	Extra Care Housing
		SH03	Very Sheltered Housing
		SH04	Integrated Very Sheltered Housing/Shared Housing Plus
		SH05	Other Sheltered Housing
05	Supported Accommodation	SU01	Unspecified
		SU02	Hostels
		SU03	Staffed Group Hostels
		SU04	Core and Cluster
		<i>SU05</i>	<i>Foyers</i>
		SU06	Supported tenancies
		SU07	Supported landlady/resident caretaker schemes
		SU08	Specialist Facilities
		SU09	Other Supported Accommodation
06	Specialist Rehabilitation Units	RU01	Unspecified
		RU02	Addiction Rehabilitation Units
		RU03	Mental Health Rehabilitation Facilities
07	Registered Adult Care Homes <i>See Recording Guidance.</i>	AC01	Unspecified
		AC02	Registered Care Homes (single status homes)
08	<i>Registered Child Care Accommodation</i>	<i>CC01</i>	<i>Unspecified</i>
		<i>CC02</i>	<i>Residential Homes for children</i>
		<i>CC03</i>	<i>Residential Schools</i>
		<i>CC04</i>	<i>Secure Accommodation</i>
09	NHS Facilities/ Hospitals	NH01	Unspecified
		NH02	Long Stay NHS Facility/Hospital – Learning Disability
		NH03	Long Stay NHS Facility/Hospital – General Psychiatry
		NH04	Long Stay NHS Facility/Hospital – Psychiatry of Old Age
		NH05	Long Stay NHS Facility/Hospital – Geriatric Medicine

10	Penal Institutions	PE01 PE02 PE03 PE04	Unspecified Prison <i>Young Offenders Institution</i> Secure (forensic) locked psychiatric facility.
11	Independent Hospitals		
12	Independent Hospices		
13	Mobile Accommodation		
99	Not Known		

Dwelling Type

Code	Value	Code	Value
01	Detached	A	Multi Storey
		B	Single Storey
02	Semi-detached House	A	Multi Storey
		B	Single Storey
03	Terraced House	A	Multi Storey
		B	Single Storey
04	Flat	A	Multi Storey – entrance on ground floor
		B	Multi Storey – entrance on upper floor (stairs only)
		C	Multi Storey – entrance on upper floor (lift access)
		D	Single Storey – entrance on ground floor
		E	Single Storey – entrance on upper floor (stairs only)
		F	Single Storey – entrance on upper floor (lift access)
05	Caravan/ Travelling Trailer /Portakabin/ Tent	A	Static
		B	Mobile
06	Water-borne craft		
98	Other		
99	Not Known		

Tenure Type

Code	Value	Code	Value
00	None (No Tenure)		
01	Owned (single or joint ownership)	A	Owned Outright
		B	Owned Mortgaged
		C	Part Owned/Part Rented
02	Social Rented	A	LA Rented – Standard
		B	LA Rented – Temporary
		C	Social Housing – Temporary
		D	Social Housing – Rented
03	Private Accommodation Arrangements		
04	Tied Housing		
05	Institutional Living		
98	Other		
99	Not Known		

N.B. Further development will take place on the codes and values.

Preferred Communication Method

Code	Value	Code	Value
01	Verbal communication	A	Generally intelligible speech (i.e. Person can be understood by all)
		B	Speech of limited intelligibility (i.e. Only some of what person says can be understood by all, OR person can be understood only by people familiar with the mode of speech)
		C	Other verbal communication (i.e. Person uses grunts or other utterances to communicate)
02	Communication based on the alphabet	A	Finger Spelling
		B	Deaf/Blind manual alphabet
		C	Block
03	Communication based on sign language	A	British Sign Language (BSL)
		B	Visual Frame signing/Close signing
		C	Hands on signing
		D	Makaton
		E	Sign Supported English
		F	Signed English
		G	Other Sign Language
04	Communication using text	A	Large Print
		B	Braille and/or Moon
05	Communication using objects and symbols	A	Objects of Reference
		B	Blissymbols
		C	Rebus symbols
06	Communication based on body language and touch	A	Body language
		B	Tadoma
98	Other preferred communication method (specify separately)		
99	Preferred communication method not known		

Impairment

Code	Value
00	None
01	Specific learning difficulties
02	Hearing impairment
03	Language and communication disorder
04	Physical or motor impairment
05	Visual Impairment
06	Cognitive impairment
07	Combined sight and hearing loss (see further information in Data Manual)
98	Other impairment (specify separately)
99	Not known

Person Role

Italic values are not relevant for Adults.

Code	Sub-code	Value	Definition
00		No role	The person does not carry out any particular role for the data subject.
01		Carer	
	A	Main carer	The main carer of the data subject.
	B	Secondary carer	Any carer of the data subject other than the main carer.
02		Key holder	
	A	Main key holder	A person holding keys which allow admittance to the data subject's normal place of residence, and who would usually be the first to be contacted by anyone requiring legitimate admittance.
	B	Additional key holder	Any person holding keys which allow admittance to the data subject's normal place of residence, other than the main key holder.
03		Appointed representative	
	A	Advocate	A person who can communicate on behalf of a data subject who has difficulty in doing so, to ensure that their opinions, wishes and needs are taken into account. An advocate cannot make decisions on behalf of the person for whom they speak.
	B	Proxy	A person with the power to take decisions or act on behalf of a data subject who does not have the capacity to do so for him/herself. The power may have been granted by the incapable person when they still had the power to do so, as in Continuing Power of Attorney or Welfare Power of Attorney, or the proxy may have been appointed by the courts as a financial Guardian or a Welfare Guardian under the Adults with Incapacity Act 2000. A person with mental health problems subject to a statutory order may appoint a 'named person' as their proxy.
04		Emergency contact	A person who may be contacted in the event of an accident, emergency or crisis befalling the data subject.
05		<i>Person with parental responsibility</i>	<p><i>Parental responsibility involves:</i></p> <ul style="list-style-type: none"> • <i>safeguarding and promoting the child's health, development and welfare;</i> • <i>providing direction and guidance;</i> • <i>acting as the child's legal representative;</i> • <i>if the child is not living with the parent, maintaining personal relations and direct contact with the child on a regular basis</i> <p><i>A person with parental responsibility, in order to enable him to fulfil his parental responsibilities, has the right:</i></p> <ul style="list-style-type: none"> • <i>to have the child living with him or otherwise to regulate the child's residence;</i> • <i>to control, direct or guide the child's upbringing</i> <p><i>Parental responsibilities are held automatically by the following:</i></p> <ul style="list-style-type: none"> • <i>a mother</i> • <i>a father if married to the mother at the time of the child's conception or subsequently</i> • <i>an unmarried father who by agreement with the mother has been registered in the Books of Council and Session as the child's father</i> • <i>a guardian who is a person appointed by a parent to act in the parent's place in the event of his or her death</i>
06		<i>Relevant person</i>	<p><i>The term "relevant person" is used for the purposes of legal proceedings, particularly children's hearings, and includes:</i></p> <ul style="list-style-type: none"> • <i>any person who has parental responsibilities under Part 1 of the Children (Scotland) Act 1995</i>

			<ul style="list-style-type: none"> any other adult with parental responsibilities and rights any person who appears to be a person who ordinarily has charge of, or control over, the child other than by reason only of his or her employment <p>following the outcome of a case in the Court of Session, foster parents who have looked after a child for a period of approximately seven months or longer</p>
07		Next-of-kin	The next of kin should be nominated by the person (patient/client). Where no nomination has been made, a next of kin default can be identified, which is likely to be the person most closely related to the patient/client.
98		Other role	Any other role not covered by the above categories.
99		Not known	

Relationship to Client/Patient

Italic values are not relevant for Adults.

Code	Sub-code	Value	Definition
01		Spouse/Civil Partner	EITHER: A person of the opposite sex who is legally married to the data subject, OR A person with whom the data subject has a committed same-sex relationship which has been granted legal recognition as a civil partnership (<i>see Further Information in Data Manual</i>).
<i>02</i>			<i>Code 02 is currently inactive. Civil Partner should be recorded using code 01.</i>
03		Partner	A person who has a relationship with the data subject having the characteristics of a marriage, but is not legally married to the data subject. Includes cohabitants; excludes civil partners.
04		Polygamous partner	A person who is accepted as another spouse of the data subject under the law of another country.
05		Parent	
	A	Biological parent	A person who gave birth to or fathered the data subject.
	B	Foster parent	A person approved by a Local Authority to look after the data subject in the capacity of parent.
	C	Step parent	A person who is married to or the partner of the person with parental responsibility over the data subject.
	D	Adoptive parent	A person who has legally adopted the data subject.
<i>06</i>		<i>Guardian</i>	<i>A person appointed by a parent to act in the parent's place in the event of his or her death.</i>
07		Child	A person under the age of 18 over whom the data subject exercises appropriate parental responsibility as per the Children (Scotland) Act 1995.
08		Sibling	A person who has at least one common parent with the data subject.
09		Other blood relative	A blood relative other than biological parent, sibling or child (e.g. Cousin, grandparent).
10		Relative-in-law	A person related to the data subject by ties of marriage, other than spouse and civil partner.
98		Other relationship not otherwise specified	
99		Not known	

Appendix Five

Key Differences between Standards for Assessment for All Adults Version 1.1 August 2006 and revised version

Page No(s) Adults Version 1.1 August 2006	Affected Item or Paragraph	Page No(s) Version 3.0 June 2008	Comments
4-11	Section 1 Background Section 2 The Scope, Nature and Purpose of the Minimum Standards	4 – 6	<p>The standards now cover Shared Care and Support Plans, Reviews and Carers Assessment/Support Plan in addition to assessment.</p> <p>Each now have their own section with both Information and Data Standards.</p> <p>The NMIS has evolved further to now support the Community Care Outcomes Framework. New Data Standards have been added to support this work.</p> <p>The understanding of the use of Standards have developed, eg the difference between Information and Data Standards – Data Standards being more prescriptive.</p> <p>A higher focus has been given to rehab/enablement, socialisation, employment and the role of 'Telecare' to reflect the consultation process and national policy drivers.</p>
12-19	Section 3 Minimum Standards for Personal Details for all Adults	9 – 16	No Change
12-19	Section 4 Minimum Standards for Assessment of all Adults	18	<p>References to the original SSA guidance have been included.</p> <p>Description of the two types of assessment, eg, Simple and Comprehensive, and the need to concentrate on the persons strengths, needs, issues and concerns when carrying out an assessment.</p> <p>This will ensure a rehabilitation / enablement focus including capacity for individualisation, self management and allow informed personal choices.</p>

	Standards for Assessment of all Adults - Continued		
20	Service User's perspective Item 1 Item 2 Item 3	20	New Data Standard Feeling Safe Person's Perspective: Change in text: Was the person involved in the assessment process? New descriptive: Does the person feel safe? If no, provide reasons New descriptive: What is the persons understanding for the reason for this referral/assessment
20	Carer's perspective Item 1 Item 2 Item 3 Item 4	20	Change in text: Unpaid Carer(s) New Data Standard Unpaid Carer ' New descriptive: Is there an unpaid carer? Unpaid Carer: Change in text: Was the unpaid carer involved in the assessment process? New descriptive: What is the carers understanding of the reason for this referral/assessment?
20		21	New Information Standard Additional arrangements for Young Carers
22	Personal Care and Physical well-being Sub heading Item 1	23	Additional text: including conditions that require ongoing care Additional text: that require ongoing care

	Section 4 Minimum Standards for Assessment of all Adults - Continued		
	Item 2	23	<p>Deleted Text: Inpatient Admission & Clinic/Outpatient/treatment Centre attendance deleted Additional Items 5-10</p> <p>5. Has the person had any hospital admissions within the last 12 months? Yes /No / Unknown/ Not Assessed</p> <p>6. If yes, provide details / conditions and source of information.</p> <p>7. If Unknown or Not Assessed detail any action taken to identify hospital admissions</p> <p>8. Has the person attended any clinic/outpatient or treatment centre in the last 12 months? Yes /No / Unknown/Not Assessed</p> <p>9. If yes, provide details / conditions and source of information.</p> <p>10. If Unknown or Not Assessed detail any action taken to identify any attendance at a clinic/ outpatient or treatment centre.</p>
22	Current physical health Item 3	23	<p>Deleted text: If no, provide source of information</p>
22/23	Personal Care Item 2	24	IoRN questions moved to end of Section

	Section 4 Minimum Standards for Assessment of all Adults - Continued		
23	Eating Drinking and Nutrition Item 2	24	IoRN questions moved to end of Section
24	Mobility Item 2	24	IoRN questions moved to end of Section
25	Behaviour Item 2	25	IoRN questions moved to end of Section
25	Immediate Environment and Resources Item 2	25	IoRN questions moved to end of Section
26	Level of Management of finances	26	Additional items Has the person been offered an income maximisation assessment? Yes/ No If No, provide reasons:
	Employment	27	New Information Standard New descriptive Are there any issues? Yes / No / Not Assessed If Yes, describe specific issues <ul style="list-style-type: none"> e.g. Does the person have a health or social care issues which would inhibit seeking or retaining employment Is the person in paid employment? Yes / No New Data Standard Interest in employment opportunities. New descriptive If not in paid employment would the person be interested in finding out more about employment opportunities? <ul style="list-style-type: none"> Yes No

	Section 4 Minimum Standards for Assessment of all Adults - Continued		
26	Care & Protection Abuse and neglect of service user Item 2 Public safety /harm to others Item 1 Health & safety at work Item 1	28	'concerns' replaced with 'issues' 'concerns' replaced with 'issues' 'concerns' replaced with 'issues'
	Contact	29	New Information & Data Standard Person informed of single point of contact Carer informed who is single point of contact
		29	New Data Standard Start Date of Assessment End Date of Assessment
	Section 4 Minimum Standards for Shared Care & Support Plan	30 - 36	New Section Minimum Standards for Shared Care & Support Plan
	Section 5 Minimum Standards for Review	37 - 44	New Section Minimum Standards for Review
	Minimum Standards for Carer's Assessment and Support	45 - 54	New Section Minimum Standards for Carer's Assessment and Support
	Appendix 1	55 - 56	Membership of Assessment Review Co-ordinating Group – Updated
	Appendix 2	57 - 72	Indicator of Relative Need (IoRN)
	Appendix 3	73 - 76	Context, Scope and links/References for Minimum Information Standards – New
	Appendix 4	77 - 86	Code Lists for Personal Details Data Items – No change
	Appendix 5	87 -91	Differences between Standards for Assessment for All Adults Version 1.1 August 2006 and Current Version

Carer's Assessment Guidance for National Standards

Version 3

1. Introduction

1.1 Right to assessment

The Community Care and Health (Scotland) Act 2002 affirms that carers who intend to or provide a 'substantial amount of care on a regular basis' are entitled to an assessment of their ability to provide or to continue to provide care ('carer's assessment'), independent of any assessment of the person they care for. Young carers under 16 have the same rights to assessment. NB. The term "ability to care" in this context is not a reflection of the carer's competence or skills, but rather their capacity to care, with support as appropriate.

As set out in Scottish Executive Circular ([CCD2/2003](#)). 'The fundamental principle underlying the new legislation provisions is that local authorities, the NHS and other support agencies should recognise and treat carers as key partners in providing care.' The accompanying guidance emphasises that support for carers should be designed to empower carers to make the most of their potential and opportunities, rather than allowing them to be confined or isolated in their caring role'

1.2 Improving outcomes

As part of the National Outcomes Framework for Community Care, measures have been introduced to improve the quality of and increase the number of carer's assessments. These measures include new national standards for carer's assessments. This document gives local partnerships details of these standards by:

- Outlining the principles and values which should underpin the implementation of the standards in day to day practice
- Detailing the minimum information standards to be implemented.

This guidance builds on and should be used in conjunction with previous guidance provided in:

- Carers – Community Care and Health (Scotland) Act 2002 – [CCD2/2003](#)
- Guidance on Single Shared Assessment of Community Care Needs [CCD 8/2001](#)
- National Training Framework Care Management (May 2006)
[CCD2/2006](#)
- Care 21 Report — The future of unpaid care in Scotland (2005)
<http://www.scotland.gov.uk/Publications/2006/02/28094157/0>

2. Carers as key partners

2.1. Definition of a carer

The legal definition of a carer is someone who provides substantial amounts of care on a regular basis for either an adult or a child, where that adult or child receives, or is eligible to receive, support services under the Social Work (Scotland) Act 1968 or the Children (Scotland) Act 1995. A carer is generally defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the carer's help due to frailty, illness, disability or addiction.

2.2 Carers as providers

There are 481,579 carers in Scotland (Census 2001), of whom 115,675 are caring for 50 hours a week or more. It is estimated that carers contribute £5 billion worth of care in Scotland each year (Carers UK 2002). Carers are providers of services, and as such they are key partners with Health and Social Care in providing community care services in Scotland. Treating carers as key partners is fundamental to the effective implementation of the carer's assessment and is the central principle upon which this guidance is built.

2.3 Appropriate terminology

Local partnerships should consider how best to refer to the assessment process. There is strong anecdotal evidence that carers find the term 'assessment' off-putting and judgemental, and therefore it becomes a barrier to involvement in the process. The terms 'carer support plan' and 'carer resource plan' are already in use in some local partnerships and more accurately reflect the aim of the process. Such terms may also help to engage carers more effectively as they reflect a partnership approach.

2.4 Valuing carers

Consultation with and research about carers provides a consistent and clear message about the way carers wish to be treated.

They wish to be:

- Supported to make informed choices, including whether they want to care and the extent of
- The caring role
- Informed, skilled and equipped to manage their caring role
- Treated as partners with other service providers
- Valued and respected, and have their expertise recognised
- Heard and have a say in service provision and the shaping of services

- Enabled to have a life of their own

These aims are entirely in line with both the outcomes sought by the Government as set out in 3.1 below, and with the fundamental principle of treating carers as key partners. They are the principles against which the assessment process should be measured.

2.5 Resourcing carers

Just as health and social care require resources to fulfil their role as care providers, so too do carers. The resources carers require can come in a variety of forms such as information and advice, breaks from caring, carer training, and financial advice. In order to agree and provide the most appropriate resources for each carer they have to be consulted and involved in discussions. The carer's assessment is the vehicle for this discussion. It provides the template around which this discussion can take place.

3. Outcomes and purpose of assessment

3.1 Outcomes for carers

The government's policy is to recognise and support carers, in order to achieve good outcomes for them. Good outcomes will occur when:

- The carer is able to cope with their caring role
- The carer can access a regular break from caring
- The carer is informed and knowledgeable about their caring role and the needs of the person they care for.
- The carer feels valued, supported and listened to
- The knowledge and expertise the carer has about the cared-for person is recognised and used
- The carer is able to have a life of their own

3.2 Purpose of assessment

In order to achieve the above outcomes the carer's assessment has to:

- Identify the care provided by the carer
- Establish what level of care the carer is willing and able to provide, and help them to:
 - Determine whether their caring role is sustainable
 - Identify current and potential risks to the carer's health and wellbeing as a result of the caring role
 - Determine what resources the carer needs to support them in their caring role, and agree how these resources can best be provided

- Determine what resources the carer needs to enable them to have a life of their own, and agree how these resources can best be provided
- Determine what the carer needs to maintain and improve their own health and wellbeing, and agree how these resources can best be provided
- Take the carer's views into account when agreeing any support to the carer and cared-for person

In summary, 'support for carers should be designed to empower carers to make the most of their potential and opportunities (Scottish Executive Circular [CCD2/2003](#)). The minimum information standards are designed to fulfil the above purpose and in turn achieve good outcomes for carers

3.3 The carer's perspective - Assessment

The assessment of the cared-for person must take into account the views of the carer, in so far as it is reasonable and practicable to do so. For further details on the standards relating to the carer's involvement in the assessment of the cared-for person see 'Section B – Carer's perspective' in the assessment section of these standards.

4. Having a choice

'Our society will allow carers to be people first and unpaid carers second who can fulfil their potential as citizens. Unpaid carers will be afforded the opportunity to choose when, and how, and if they care.' ([Care 21 Report – The future of unpaid care in Scotland, 2005](#)).

In giving practical effect to this vision and the role of carers as full partners local partnerships will as part of the assessment process:

- Consult the carer about the caring responsibility they are willing and able to take
- Do not assume or take for granted that the carer's contribution will continue at any set level.

5. Record of the assessment

5.1 Content

The record of assessment (carer support/resource plan) will include:

- The overall needs identified with and for the carer

- The carer's role and the level and type of care provided so that changes in the carer's situation and needs are identified when the support/resource plan is reviewed
- A record of any decisions about sharing of information and consent given or refused
- A record of the resources or other services provided and any needs that are not met by them.

5.2 Copy of the assessment

The carer should be given a record of the assessment (carer support/resource plan) in an accessible format.

6. Reviewing

6.1 Purpose of review

The purposes are to:

- Review the achievement of the support/resource plan
- Review the carer's satisfaction with the quality of the assessment process against the principles set out earlier.
- Review the carer's satisfaction with the quality of the resulting support and services against the outcomes set out earlier.
- Reassess current needs based on the carers willingness and ability to care
- Review the support and services required
- Set the date for the next review

As for the original assessment, the review findings should be recorded and the carer given a record in an accessible format.

6.2 Continuing choice

In order to ensure that carers continue to have a choice about the level of care they provide arrangements to monitor and review regularly the situation and the support being provided are essential and will be an integral part of a local partnership's assessment approach. The timetable and arrangements for a future review will be agreed with the carer as part of the initial support plan.

6.3 The carer's perspective - Review

As with the initial assessment of the cared-for person, the review process for the cared-for person must take into account the views of the carer, in so far as it is reasonable and practicable to do so. For further details on the standards relating to the carer's involvement in the review of the cared-for person see 'Section B – Carer's perspective' in the 'National Minimum Standards for Review (Adult Client Groups).'

7. Who should assess?

Local partnerships have powers under Section 4 of the Social Work (Scotland) 1968 Act and Section 19 of the Children (Scotland) 1995 Act to involve other bodies or persons in helping them to carry out their functions, including voluntary bodies. The Single Shared Assessment and Carer's Assessment extend the opportunities to involve a range of staff and agencies in assessment, and stresses the principle that the most appropriate professional should be responsible for carrying out the assessment, co-ordinating any other contributions, and identifying the support or resources needed. All staff carrying out assessments should be familiar with the standards set out in this guidance.

8. Confidentiality

In all cases the carer must be given the opportunity to discuss their needs and views without the cared-for person being present. Consent should be sought to share information as part of the assessment process, and formally recorded where consent is given.

9. Minimum information standards

9.1 Recording of Information Standards

The carer's assessment/support/resource plan should meet the information standards as set out below.

9.2 Recording of data items

It is not necessary to record every item for every person subject to a carer's assessment, only those items appropriate for that person. However to meet the standards, tools and electronic systems should have the capability to record all data items which are contained within the standards.

9.3 Looking to the future

The carer's assessment involve the carer in discussions of the future, as well as the present. It will enable the carer to discuss:

- Their aspirations and plans for the future, e.g. employment, education and recreational activities
- Their concerns and fears for the future e.g. health issues, the ability and willingness to continue to care

This anticipatory focus should be apparent throughout the assessment process.

The Compliance Review

Version 3

Compliance Review

1. The need for compliance Review

The intention is that the national minimum information standards should be adopted in all relevant local systems. Processes and systems that are consistent with the national minimum information standards are said to be 'Compliant'. At local discretion, relevant systems may go beyond the standards - but as a minimum they will cover all the themes listed, and will conform to the data standards where these are indicated, if they are to be deemed 'Compliant'.

In order to provide objective assurance on compliance, and offer support to partnerships on the change management process required to achieve compliance, the Scottish Government asked the Assessment Review Co-ordinating Group (ARCG) to oversee a Compliance Review process. By the end of June 2008 most partnerships have been through the review process, seeking compliance with the existing National Minimum Information Standards for Single Shared Assessments (SSA) for All Adults.

2. Compliance process until July 2008.

In summary, the current Compliance Review comprises:

2.1. SSA Position Statement

Each partnership is asked to complete an 'SSA Position Statement' as part of an initial information gathering exercise.

2.2. Compliance Review

Each participating partnership is asked to conduct a comparison between the minimum standards for assessment as outlined in this document and their SSA tool. Documentation is provided by ARCG so that partnerships can provide details of how their tool complies. At the end of the partnership's review, the completed documentation and any supplementary information, such as extracts from the tool or guidance, screen dumps, etc which partnerships feel to be helpful will be submitted to ARCG for verification.

2.3. ARCG Verification

A gap analysis of the 'Compliance Review' document is carried out. Any differences or omissions are discussed with the partnership.

2.4. Compliance status

Compliance status will be assigned to the assessment standards. Each section will be assessed for compliance separately since compliance for personal details requires the format and content of associated pick lists to be consistent with the relevant data standards, whereas the capacity to record a needs assessment data item (information standard) will be sufficient to ensure compliance. Where electronic assessment recording applications are used, compliance includes scrutiny of the data standards in the applications. In the absence of electronic SSA recording applications, compliance will be measured against paper tools, business processes, guidance etc. It is expected that the latter would include a specification which would describe progress toward electronic recording of standardised assessment information.

2.5. Resubmission

The tool and/or guidance will be submitted for reassessment whenever the tool and/or guidance in changed significantly. This may also be required if, following the gap analysis, several changes are requested. Where further changes have been identified to ensure full compliance they are set out in the compliance letter from the ARCG.

3. Future Compliance review processes

With the publication in July 2008 of the New National Minimum Standards for Assessment, Shared Care and Support Plan, Review and Carers Assessment and Support, we need to consider the most effective approach for assuring compliance.

In order to establish the best way of undertaking a compliance review process in the future the previous approach will be evaluated, with Community Care Partnerships and others invited to offer views. This evaluation will be led by the Partnership Improvement and Outcomes Division of the Scottish Government. The revised model for compliance will be in place by April 2009.

ANNEX D

NATIONAL OUTCOMES FRAMEWORK FOR COMMUNITY CARE

National Outcomes

Improved health Improved well-being
Improved social inclusion Improved independence and responsibility

Performance measures and target

Themes	Measure	Type	Data Source
User satisfaction	% of community care service users feeling safe.	Outcome	NMIS All users assessments & reviews
	% of users and carers satisfied with their involvement in the design of care package.	Outcome	NMIS All user and carer care plans & reviews
	% of users satisfied with opportunities for social interaction.	Outcome	NMIS All user assessments & reviews
Faster access	No. of patients waiting in short stay settings, or for more than 6 weeks elsewhere for discharge to appropriate setting	Output	Assessments of people delayed in hospital
	No. of people waiting longer than target for assessment, per 000 population	Output	Client databases - whole health and social care system
	No of people waiting longer than target time for service, per 000 population	Output	Client databases - whole health and social care system (and ultimately NMIS assessments and careplans)
Support for carers	% of carers who feel able to continue their role	Outcome	NMIS All user assessments, carer assessments & reviews
Quality of assessment and care planning	% of user assessments completed to national standard.	Process	NMIS User assessments
	% of carers' assessments completed to national standard.	Process	NMIS Carer assessments
	% of care plans reviewed within agreed timescale.	Output	NMIS All user and carer reviews
Identifying those at risk	No of emergency bed days in acute specialties for people 65+, per 100,000 pop.	Output	ISD – relevant admissions from whole health and social care system
	No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100, 000 pop.	Output	ISD – relevant admissions from whole health and social care system
	Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment.	Outcome	ISD – relevant admissions from whole health and social care system, local systems
Moving services closer to users/patients	Shift in balance of care from institutional to 'home based' care.	Input	Not yet defined
	% of people 65+ with intensive needs receiving care at home	Outcome	Measure to be developed & will rely on NMIS Assessments and IoRN/other tools.
	% of people 65+ receiving personal care at home	Outcome (proxy)	Analytical Services Division

Measures: 7 outcomes 6 output 2 process 1 input