



Are you ROOT Ready?

The value of the RCSLT Online Outcome Tool

29th November 2018

1.00 – 1.45

Q&A

With the ROOT based on the TOMs framework, will we have access to all the scales in the Enderby and John book?

All of the 47 condition-specific TOMs scales, along with the core scale, are available in the ROOT.

Will there be an addition of cognitive communication disorder or dysgraphia? Or will these only be scored using the core scale?

There are a number of condition specific TOMs scales currently being developed by experts, one of which is cognitive communication disorder. Once the new scales have undergone thorough reliability testing, it will be appropriate for these to be added to the ROOT. Until this point, the core scale can be used and the specific communication and swallowing needs can be recorded using ICD10 codes. If you are interested in being involved in the development of new scales, such as for dysgraphia, please contact ROOT@rcslt.org and a member of staff will put you in contact with the TOMs authors to discuss opportunities.

Do the outcomes reflect patient reported outcomes? I.e. if you were to ask “so what” about the intervention would the outcome measure answer that question?

The ROOT uses TOMs, which is not a patient-reported measure. Nevertheless, with TOMs, it is best practice to involve service users in the process by gathering information about their views to inform the rating made by the professional.

In terms of the ‘so what’, TOMs involves looking at the individual holistically and evaluating the impact of SLT on the individual not just in terms of their communication/swallowing needs but the wider impact on their everyday lives.

During the webinar, Jade illustrates the value of the data for the purposes of clinical decision making, supporting service change and in developing business cases.

How does a SLT get help to use the ROOT whilst in the process of using it? Will there be a telephone helpline because it can be really difficult to use online help, especially where that online help isn't individualised by being 'in real time'.

There are a number of resources available to support SLTs using the ROOT including FAQs and training modules. These are currently being updated to be more interactive. Staff at the RCSLT are also available to contact for help and advice, either via email, phone or via the tool itself, in relation to any queries about TOMs or the ROOT.

How is the data from the online tool held and does the RCSLT access it or use it? i.e. if the data will be used for research purposes etc., or will the data belong those inputting it. How do we access the data? Does the tool have the ability to export?

The data on the ROOT is held on a secure server and is stored and used in compliance with ISO standard 27001. The specific details are set out in the [ROOT Information Governance Pack](#).

The RCSLT has access to anonymised service-level and national-level reports and has started working with the SLT services using the ROOT to put together case studies, including for national influencing purposes.

SLTs using the ROOT can access a number of different reports on the data and can export these to Word, Excel, PowerPoint and pdf.

We use an episodes of care model and so have debated when we should do the final rating of TOMS, as an 'episode' can vary greatly in length. Have any other departments experienced similar issues and how have you managed this?

There is no specific guidance that we are aware of in ABMU that defines an episode of care to correlate with when to score TOMs, but the authors of TOMs are currently developing a detailed User Guide to support with a more consistent approach. An episode of care is related to the focus of the treatment/intervention and a new episode of care is determined if this focus is changed. Thus it may be appropriate to have an episode of care focusing on the well-being of the parent followed by a separate episode of care focusing on the participation of the client.

As long as all therapists within the setting are doing the same thing then this appears to be the most important thing currently, but parity would be needed with other areas and Health Boards for effective benchmarking going forward.

Within Wales we have identified that there is variation between how Health Boards define start, interim, final scores and what an episode of care is. An All Wales TOMs working group has this on their work plan to try and gain some parity moving forward.

In ABMU we follow a [process map](#) developed by the RCSLT which is designed to assist with when to rate patients which have multiple episodes within the patient's journey.

Do you separate the outcome measures into different areas e.g. outcome of different therapies targeting the same problem, or divide them into different difficulties e.g. speech, social communication, dysfluency?

The ROOT collects information about individuals receiving speech and language therapy, including their communication and swallowing needs and any underlying medical diagnoses (where relevant). When analysing the data, it is possible to separate out the data in this way by applying parameters to the reports, as Jade talked about during the webinar. The type of therapy an individual is receiving is not currently collected by the ROOT, but it is possible to collect this information by setting up a custom field so that you can collect this information locally, if required. This would then enable you to also look at different therapies targeting the same problem.

How long does a service need to have been using Therapy Outcome Measures before having sufficient information to use ROOT?

There is no minimum amount of time that a service needs to have been using TOMs before using the ROOT. Once all members of staff are confident with using TOMs and inter-rater reliability has been established, a service can begin entering data into the system.

If using the direct entry method, it is worth noting that it may take a while for services to gather a sufficient amount of data in order to make full use of the aggregated data reports, as these will only display when there are start and final TOMs scores for at least five service users. Therefore, if you wish to look at outcomes for specific subsets of your caseload by applying a number of parameters, you will need to have established a reasonably large dataset to support with this. Furthermore, the more data you have, the more robust your analysis of it will be.

The same applies with the upload method. Whilst there is no minimum number of cases that need to be uploaded at any one time, it may be that you need to upload data a couple of times before being in a position to make a detailed analysis of the data.

Nevertheless, with both methods, there is also the ability to access reports on individual service users, which show change over time across the dimensions of impairment, activity, participation and wellbeing. These reports display from the moment the initial TOMs rating for an individual has been entered on the system, so you do not need to wait until the service user has both start and final ratings.

How was inter-rater reliability gained?

In ABMU we set up groups of SLTs (initially within clinical specialities but also included within wider groups that were already in existence) to work on inter-rater reliability. Therapists would bring real cases to discuss, all in group would score individually and then compare responses to assess reliability. Any variation would be discussed and addressed within the group and with implementation group support if required. Chapter 3 of the third edition of the TOMs (Enderby and John, 2015) contains information about establishing inter-rater reliability.

To support with establishing inter-rater reliability, there is a website where you can share case histories with colleagues to compare ratings as well as rating other cases. Please see: <https://en.medshr.net/>

Is any support with the evaluation of reports offered? Some teams may be new to interrogating data and need guidance at first?

The RCSLT has developed some training resources to support with using the reports and we will be building on these over time. Staff at RCSLT are happy assist those using the ROOT with interrogating the data they have collected for various purposes.

Furthermore, the system developers are still building on the types of reports available on the ROOT in response to feedback from those using the reports about potential improvements and/or alternative ways of presenting the data.

Can you compare only against similar services? Is there any service information collected to allow us to do this e.g. population size / therapy or purely consultative etc.

Currently, the ROOT enables very broad comparisons to be made as there are a relatively small number of services using the ROOT. The reports currently operate such that, once parameters are applied to a report, the system matches data collected by your service with that collected by other services involved in the pilot.

Longer term, the development of more sensitive benchmarking reports is planned, once we have a sufficient number of services involved to better understand the requirements.

If we start using ROOT with direct entry, can we move to data upload once we have integrated into our system?

It is possible to switch between the different methods, and if required, for different parts of the service to use different methods.

TOMs questions

How often are progress measures taken?

As an outcome measure, TOMs is used to examine change associated with a course of intervention. Thus, measures are taken at the beginning and the end of an episode of care, there may be several episodes over the period of intervention. Ratings should always be made after assessment and at discharge.

How often did you take TOMs recordings eg before and after block therapy?

In ABMU we follow a [process map](#) developed by the RCSLT. As shown in the diagram, the TOMs is designed to be used before and after intervention, but ratings can also be made at any point in the course of intervention (interim ratings).

When do you rate if only doing assessment and advice?

The TOM can be used even if you are only seeing the person once as it will help you to report the types of individuals seeking assessment and advice. Some assessment and advisory services undertake an audit of their services by contacting a random sample of clients a few weeks later, by phone or in person, to re-evaluate using the TOM for a second time.

Are you able to do TOMS for the pre referral assessment clinic? How and when do you do both ratings?

A TOMs rating should only be ascribed to an individual when you have gathered all relevant information. With some individuals you will be able to do this fairly quickly having received the referral, taken a case history, interviewed and observed. With other clients you will need to get more information which may take several weeks as you will need to undertake a range of assessments, discuss with relevant others e.g. teachers, other health professionals involved or family members. It is only after you have gathered this information that you will be able to decide on a treatment approach or intervention programme for that episode of care. So in this case it would be at this point that you would rate the individual. Typically, the first TOMs rating is made when you are ready to start your treatment/ intervention.

Is anyone using ROOT on acute stroke unit/ acute wards. We struggle to record participation and well-being outcomes in this environment when we have a very medically focussed intervention

Yes, in ABMU we use TOMs in all acute services. We score based on the information available to us in the environment they are in and although less information is available to us, we do still find that we are able to make effective observations and judgements that are also reliable when rated in inter-rater reliability sessions.

We are aware that some acute settings decided not to score participation and wellbeing in the acute setting but we have not found this to be an issue in ABMU.

You talked about the service agreement, so this refers to BIG organisations, what about Independent therapists who work alone?

All organisations, including sole traders, will need to complete a data processing agreement. Different Class Solutions Ltd, the data processor, has developed a document that can be used, which can be signed electronically.

As mentioned during the webinar, some services have been asked to complete local documentation prior to using the ROOT in addition to the data processing agreement to ensure compliance with local policies.

Are there any areas of the service where Jade has found it difficult to implement TOMs measures?

Some areas did encounter more complexities to work through regarding defining episodes of care and when to rate but these issues were worked through with clinical/team leads with support from the implementation group.

Some clinical areas have also found that the scales are not always perfect but a number of these are in the process of being updated or due to be in the near future.

Whilst you can check reliability within the service using service, is there any work looking at consistency across services?

Whilst we cannot check for inter-rater reliability for SLTs working in different services, the RCLT has specified a minimum standard for TOMs training to ensure that ROOT users are familiar with the principles of the TOMs to enable the measure to be used as accurately and consistently across the profession as possible. When TOM has been used in specific research studies involving more than one site then interrater reliability trials have been undertaken and found that there is good reliability across sites. Furthermore, there is a website where you can share case histories with colleagues to compare ratings as well as rating other cases. Please see: <https://en.medshr.net/>

Do you have data on reports of services who have used TOMS with rapidly deteriorating progressive neuro caseload such as MND. We work only with people who have progressive neurological conditions and use TOMS with PD, MS and PSP but finding it hard to use with MND. It would be helpful to see data from ROOT with this caseload.

We use TOMS for our progressive neuro cases and palliative patients as well as rehabilitation cases. The focus of intervention may be more about maintenance or supporting wellbeing and participation despite the unavoidable deteriorating nature of impairment and therefore reports will not show as much improvement as a rehab focussed caseload but this is expected and justifiable within the context of the caseload and aims of intervention.

Is there a consistent/suggested carer/parent wellbeing scale and should this be used routinely?

The carer/parent wellbeing is an optional domain of the TOMs, which is designed to be used when the carer/parent is involved and this can be measured. This would not be used if you do not see/know the carers or if improving the well-being of the carer is not one of the objectives of the intervention. The descriptors for the carer well-being domain are the same as for the client well-being.