

**Enhancing the Efficiency and Effectiveness of  
Assessment in Community Care**

**Volume IV  
Self Assessment Pilot Projects:  
Concluding Observations**

David Challis, Paul Clarkson, Jane Hughes,  
Michele Abendstern, Christian Brand,  
Susan O'Shea, Sue Tucker and  
Jennifer Wenborn

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**PERSONAL SOCIAL SERVICES RESEARCH UNIT**

The University of Manchester

Dover Street Building  
University of Manchester  
Oxford Road  
Manchester M13 9PL  
Tel: 0161 275 5250

The University of Kent at Canterbury

Cornwallis Building  
University of Kent at Canterbury  
Canterbury  
Kent CT2 7NF  
Tel: 01227 823963/823862

London School of Economics

London School of Economics  
Houghton Street  
London  
WC2A 2AE  
Tel: 020 7955 6238

# ENHANCING THE EFFICIENCY AND EFFECTIVENESS OF ASSESSMENT IN COMMUNITY CARE

## VOLUME IV SELF ASSESSMENT PILOT PROJECTS: CONCLUDING OBSERVATIONS

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## **PREFACE**

The report of this study entitled 'Enhancing the efficiency and effectiveness of assessment in community care' has four components:

- Executive summary
- User needs and outcomes
- Innovation implementation and sustainability
- Summary and concluding observations

This report relates to the final component and comprises a summary and concluding observations from the study.

Recent policy has confirmed that the development of self assessment within social care services for adults for support and care services is a key area for service development. This report demonstrates that the approach adopted in this study was one of programme evaluation seeking to inform policy development and implementation at both national and local levels.

As such this report complements the other three volumes. In particular, it provides an overview of the study and as such focuses on the important issues relating to the development of self assessment processes within assessment and care management arrangements, occupational therapy services and preventative services. It also seeks to evaluate the research process using the framework of programme evaluation.

Paul Clarkson and Jane Hughes led on the production of this report. Their diligence in overseeing the completion of this research study is to be commended.

David Challis  
Professor of Community Care Research  
June 2008

## **PART 1: INTRODUCTION**

As noted in the preface, this is the fourth volume of a report describing the study, 'Enhancing the Efficiency and Effectiveness of Assessment in Community Care.' Its purpose is to consider the policy and practice developments within the practice settings in which the self assessment pilot projects were located and review a number of key findings from the different elements of the study within them. In so doing, it seeks to explore the extent to which findings from the study address the government's modernisation and transformation agenda for these services in England by means of improving the effectiveness and efficiency of assessment in social care.

The assessment process is, for many people, their first encounter with statutory social care services. Ensuring that these are personalised and accessible is therefore of importance in terms of both individuals' experiences and resource allocation, providing the basis on which needs are identified and services are commissioned. Kane (1990) defined assessment as a decision making tool which aimed to collect, weigh and interpret relevant information about a person. However, it has also been acknowledged that it can have different meanings for different stakeholders in the assessment process (Challis et al., 2004). Developments in three areas of social care in which assessment occurs and the current pilot projects are located – care management, occupational therapy, and preventative services – are considered briefly below in order to provide a context for the findings and conclusions which follow. Whilst occupational therapy occupies a distinct professional role, care management is most usefully described as a set of arrangements which have traditionally been undertaken by social workers in adult social care services, although its functions can be carried out by others, including health professionals (SSI/SWSG, 1991a,b; Hughes et al., 2005). Preventative strategies are related to occupational therapy, care management and other areas of health, housing and social care, reflecting the rationale for targeting services in particular ways.

Self assessment has been discussed at length elsewhere in this study (Challis et al., 2008a). A systematic review conducted by Griffiths and colleagues (2005) indicated that self assessment may not be a replacement for professionally-based assessment but useful in adding to professionals' assessments and actions on behalf of service users. However, as noted in the earlier report (Challis et al., 2008a), it concluded that despite strong guidance and policy directives, knowledge about self assessment, the forms it takes and whether it can be effective and enhance user experience more than professional assessment, is underdeveloped. The present study has been engaged in progressing this work and is described in more detailed in two other reports (Challis et al., 2008a,b). A summary of the projects in this study is contained in Appendix 1.

A distinction between research and programme evaluation emerged as a central feature in the integration of the key findings from the different elements of the study. To understand the latter more fully we have adopted a typology generated by one of the seminal works associated with it, that by Vedung (2004). It outlined six different types of uses of evaluation or 'knowledge production' (see also Nielsen and Ejler, 2008). These elements of the utilisation of evaluation evidence, along with their

definitions as they relate to the pilot projects are listed in Box 1. Our study focussed on the first three. We sought to provide answers, however tentative, to some of the unresolved issues in relation to self assessment. These included how it might be employed, in what situations, with whom and with what possible effects. The evaluation of the pilot projects was thus not conceived of as merely a symbolic gesture to produce data where decisions regarding the use of self assessment were already made, or to legitimise current beliefs about its use. Rather, the evaluation was intended to: explicate the core themes, definitions and objectives of self assessment; use evidence to assist decision-making regarding the location of self assessment in future policy; employ processes of data collection to form a shared understanding of self assessment; and make use of knowledge to inform policy makers of the administration of projects and what this may mean for the future implementation of self assessment more widely. In the following section we describe the approach to this study of self assessment thereby explicating some of the uses of programme evaluation described by Vedung (2004).

**Box 1: Uses of programme evaluation**

<i>Uses typology</i>	<b>Definition of forms of evidence</b>
<i>Conceptual</i>	Explicating the mental framework used in the evaluation: questioning of the relevance of intervention or its objectives. ‘Enlightenment’ of core themes and definitions as they relate to project.
<i>Instrumental</i>	Using evaluative evidence as an input for decision-making.
<i>Process</i>	The actual process of carrying out the evaluation including liaison with core stakeholders, programme fundors and those implementing features of the project. Processes of data collection and relevant sanctioning of use and presentation of data to create a shared understanding of the project.
<i>Tactical</i>	Political authority invested in project; use of knowledge to convince implementers that matters are under control or that projects are responsibly administered. Can also be used to shelve a project or element of it if evidence does not confirm its utility.
<i>Ritual</i>	When evaluation is carried out for no reason other than as a symbolic gesture.
<i>Legitimisation</i>	Evidence used to justify current views, interests or policies and thus not intended to find answers to unresolved questions or provide solutions.

Vedung (2004)

**The approach**

Thus, the methodology adopted for this study was one of programme evaluation (McNamara, 2000). This was described in outline in the interim report (Challis et al., 2007a) and described in detail elsewhere (Challis et al., 2008a,b). The principal hallmarks of this approach are the classification of the concept of self assessment and the identification of the settings within adult social care services in which it can be located. Therefore, as an example of programme evaluation, the study collected data about initiatives in relation to self assessment in the local authorities so as to understand the concept more clearly and make decisions on its utility. In respect of data collection it is important to note that the participating authorities differed in what might be termed their ‘research capacity’. For example, authorities varied in the extent to which they had available data as part of their routine performance management and in their capacity for special data collections for the research study. Therefore, the methodology adopted in the study differed from what could be

considered as pure research evaluation in which robust statistical methods and the design of the enquiry are considered as paramount. For example, although the study used the most appropriate statistical tests on the data where possible, the research design could not comply with the gold standards adopted in many large-scale research projects. Moreover, the methodology for collection and analysis of cost data was not in place at the time our interim report was completed and was developed as the capacity of the local authorities to provide these data became evident. Findings from this part of the evaluation are therefore provided with the caveat that best use was made of the available information rather than the projects being chosen and developed with the collection of cost data as a prime requirement. In terms of considering the implementation and sustainability of the pilot projects interviews were conducted with managers and by studying documentation findings from the beginning and end of the study were compared to extrapolate key features of innovation within social care at the beginning of the 21<sup>st</sup> century.

More generally, it is important to note that the sites selected for study were chosen by the Department of Health and the data collection was predetermined and limited to a ten month period from November 2006 to September 2007. These constraints upon the evaluation made it different from other experimental research and demonstration projects (Challis and Davies, 1986; Challis et al., 1995; Davies and Challis, 1986). Furthermore, in this evaluation local data collections were employed, albeit under the framework set by the PSSRU at the University of Manchester as the external evaluators. Within these parameters we attempted to be as robust and comprehensive as possible. However, because of the nature of the enquiry it is important to conceptualise the study not as pure research evaluation but more as a formalised approach to studying the goals, processes, and impacts of the pilot projects in order to understand the concept of self assessment more fully (Rossi et al., 2004).

More will be said of these different uses to which the evaluation material was applied in the final part of this report when we review the findings as a whole. However, it may be first noted that one of the distinctive components of the evidence arising from the evaluation was, in fact, defining the terms and 'mental framework' in which self assessment is conceptualised. As noted above, policy has not clearly defined self-assessment and this lack of clarity is reflected in the literature. How agencies conceive of and operationalise self-assessment is different and it takes many forms. This lack of clarity makes it difficult to define and evaluate. In the evaluation of the pilot sites, we saw this function of evidence – to define more clearly the concepts and objectives within which self assessment may be located – as one of the most important initial findings. To this end, as noted in Appendix 1, we categorised the 13 initiatives within the 11 pilot sites into one of three groups characterised by the settings in which self assessment may be employed: assessment and care management arrangements; occupational therapy services; and preventative services. Most of our findings are reported in this format rather than by individual sites using the key domains of user characteristics; service receipt; timeliness; user satisfaction (summary score); and efficiency. We now turn to a consideration of each of these settings; first providing a context in relevant policy and practice and then describing some of the main findings of the evaluation.

## PART 2: ASSESSMENT AND CARE MANAGEMENT ARRANGEMENTS

### Context

Care management has been a central component of community care since the publication of the White Paper *Caring for People* (Cm 849, 1989) and was subsequently reinforced in the White Paper *Modernising Social Services* (Cm 4169, 1998). The support given to the principles of care management by the Griffiths Report (1988) and subsequent White Paper (Cm 849, 1989) was based on the results of a number of demonstration studies undertaken by the Personal Social Services Research Unit during the 1980s in partnership with local authorities (Challis and Davies, 1986; Challis et al., 1995; Davies and Challis, 1986). The projects featured a range of specific characteristics. In particular, they were targeted at people with complex health and social care needs, caseloads were small, involvement was long term, and budgets were devolved to care managers (Challis and Davies, 1986; Challis et al., 1995). The findings from these demonstrated successful outcomes for service users at no increased cost to the public purse. The key characteristics of care management as defined by these projects can be seen in Box 2 below.

### Box 2: The key characteristics of care management

<i>Functions</i>	Coordination and linkage of care services.
<i>Goals</i>	Continuity and integrated care; increased home-based care; promote user wellbeing; more efficient resources use.
<i>Core tasks</i>	Case finding and screening; assessment; care planning; monitoring and review; case closure.
<i>Characteristics of recipients</i>	Long-term care needs; multiple service need
<i>Main features</i>	Intensity of involvement; breadth of services spanned; lengthy duration of involvement.
<i>Multi-level response</i>	Linking practice-level activities with broader resource and agency-level activities

From Challis et al., 1995, p.20

The translation of this model of care management into national policy, however, following the implementation of the National Health Service (NHS) and Community Care Act of 1990, was not straightforward. Despite detailed guidance issued by the Department of Health (SSI/SWSG, 1991a,b) subsequent research suggested that the development of care management arrangements bore little relation to the original studies. Some have commented that, although the guidance was detailed, it offered considerable capacity for interpretation (Challis et al., 1995; Challis, 1999; Lymbery, 2005). A number of inspection studies carried out by the Social Services Inspectorate (SSI) during the 1990s as well as other research revealed a range of shortcomings. These included poor assessment documentation (SSI, 1993a,b; Challis et al., 1996; Stewart, et al., 1999); limited involvement of health care professionals (SSI, 1993a); the bureaucratisation of social work as a result of the purchaser provider divide (Lewis et al., 1996, 1997) and a trend towards an administrative form of care management (SSI, 1994; Payne, 2000; Postle, 2002); a lack of continuity of involvement and a neglect of monitoring and review (Lewis and

Glennerster, 1997; Stewart et al., 2003); limited budgetary devolution (SSI, 1997); and little evidence of targeting (SSI, 1994; Bauld et al., 2000).

Of particular concern was the lack of a differentiated approach within care management meaning that it was, in effect, being provided for all service users irrespective of level of need. This was found to reduce both efficacy and efficiency (Challis et al., 1999, Weiner et al., 2002). The practice guidance, issued following the implementation of the NHS and Community Care Act of 1990, specified six assessment tiers within care management, ranging from a referral for a simple service to comprehensive assessment which would involve two or more professions and be undertaken where people had complex health and social care needs (SSI/SWSG, 1991a, b). National studies of care management arrangements some years later, however, indicated that only a minority of local authorities operated more than two levels (Weiner et al., 2002; Stewart et al., 2003; Challis et al., 2005), with the exception of mental health services (Hughes et al., 2005). The 1997 SSI report identified three types of care management that it believed were necessary to achieve an effective response to a variety of needs. These are summarised in Box 3 below. Again, research since that time found that, other than in services for adults with mental health difficulties (Hughes et al., 2005), an intensive care management service only operated in a very small minority of local authorities in England (Challis, 1999, Challis et al., 1999, 2001).

**Box 3: Types of care management**

<i>Administrative</i>	Reception or customer service staff provide information and advice
<i>Co-ordinating</i>	Deals with large volume of single service or range of straight forward services. Must be properly planned and administered
<i>Intensive</i>	Designated care manager who combines planning and coordination with therapeutic, supportive role for much smaller number of users with complex and frequently changing needs

SSI, 1997

The concept of care management as primarily a role or a function has been a contested area within its development (Lymbery, 2003). A national study of care management arrangements in all English local authorities in 1997 reported that almost two thirds described it in terms of an organisational process, one fifth as a specific role and the remainder as a mixture of the two (Challis et al., 1999). The same study reported that although there was evidence of occupational therapists, home care managers, and health professionals operating as care managers across the country, the majority of care managers were social workers. The Green Paper *Independence, Well-being and Choice* (Cm 6499, 2005), suggested that the functions of the care manager might be undertaken by community matrons as part of a multidisciplinary team, supporting the concept of care management as a function to be operationalised by a range of professionals, in line with original policy statements on this topic (Cm, 849, 1989).

Although the notion of needs-led assessment was a key element of assessment practices introduced under the auspices of care management (SSI/SWSG, 1991a, b), a number of commentators reported that despite the professed intentions of care managers to promote a participatory model, which placed the service user at the



heart of the assessment, this occurred infrequently (Ellis, 1993; Glenister, 1994; Myers and Macdonald, 1996; Richards, 2000; Worth, 2001). The literature noted that this failure was related to an inextricable link between care managers' concepts of need and service availability and eligibility criteria (Ellis, 1993; Caldock, 1994; Hardy et al., 1999; Richards, 2000). Concern has also been expressed about the use of structured assessments which were found to be incompatible with users' own perceptions (Preston-Shoot, 2003). Assessments of carers, a requirement since the introduction of the Carers (Recognition and Services) Act, 1995, have also been reported as failing to recognise predictors of carer stress due to the task oriented approach used (Challis et al, 2005).

It has been suggested that the community care reforms of the early 1990s, despite intentions to the contrary, have resulted in a care system which was unresponsive to individual need (Her Majesty's Government, 2007) and a professional culture that paid only lip service to the notion of personalisation (Ellis, 1993; Ridout and Mayers, 2006; Henwood and Hudson, 2007). A number of recent policy initiatives have sought to tackle these issues by emphasising a differentiated and personalised approach to assessment within care management. The Single Assessment Process (Department of Health, 2002a), for example, identified four levels of assessment: contact, overview, specialist and comprehensive. The latter typically comprised an overview and one or more specialist assessments, described in the guidance as only being required where complex needs are identified. The Green Paper *Independence, Well-being and Choice* (Cm 6499, 2005), has returned to the theme of differentiation in assessment, promoting a four tiered response, outlined in Box 4 below, each applicable to a different level of need. Within this approach it is suggested that the care manager or skilled social worker was only required where people had complex and long-term needs. Thus, almost two decades after the demonstration studies which launched care management in England, policy statements would appear to support its original incarnation.

The model of care management supported in recent policy is one that is tailored to individual needs and circumstances, uses professional expertise where it is most needed and provides information to service users to enable them to take control and make informed choices about their care and treatment (Cm 6737, 2006). The development of self assessment as part of the overall assessment process is in concordance with this approach (Department of Health, LAC (DH) 2008-1).

#### **Box 4: Models of professional assessment practice**

- A person centred planning facilitator to support the person to develop their own aspirations as the basis for future service plans
- A care manager working alongside the person who may need services to undertake the needs assessment and act as lead professional to care manage the care package
- A care navigator with knowledge of mainstream and specialist services, working with the person using services to develop a sustained pathway of care
- A care broker who might help the individual to formulate the care plan, negotiate funding and help organise and monitor services.

Cm 6499, 2005

## Self assessment in assessment and care management arrangements

Despite its centrality to the care of vulnerable adults and older people in the community, only three of the participating local authorities explored the use of self assessment in this context. Unsurprisingly, in this setting of assessment care management, its use was for a subset of the less vulnerable. The principal findings from the study are presented in summary form below.

- One important finding in this respect was that two aspects of self assessment are reflected in this setting. These are summarised in Box 5.

### Box 5: Self assessment and care management arrangements

Self assessment, as a **contributor to the assessment process**, effectively identifies the range of needs of individuals.

Self assessment as a **contributor** to service planning

Challis et al., 2007a

- The characteristics of those whom self assessment within care management is viable and appropriate constitute a second finding. People who undertook self assessments offered as part of assessment and care management arrangements were somewhat younger, notably healthier and less likely to be forgetful than people who had face-to-face assessments in the same setting.
- A third finding relates to the timeliness of assessment processes within care management. For example, in this setting, users who undertook some form of self assessment waited less time between referral and the completion of assessment than when receiving a traditional assessment. However, there was no significant difference in the time the two groups waited between completion of assessment and receipt of first service. Therefore, whilst self assessment may facilitate a prompt initial response to identify the problem, it is not indicative of a more timely response to identified need.
- Satisfaction with the assessment process constitutes a fourth finding of note. Overall, the picture is mixed. There is a suggestion that people who had a traditional assessment in this setting were generally less satisfied than those people who completed a self assessment. On closer inspection, however, this difference stems from just one of the questions that contributed to the overall satisfaction rating in the survey completed by users. In one of the studies, satisfaction levels between self and traditional assessments showed no difference.
- A final finding related to efficiency. The only two projects which demonstrated cost savings and benefits (higher user satisfaction) were both located in assessment and care management services. This suggests that there may be some potential to develop self assessment for some service users in this setting.

## **PART 3: OCCUPATIONAL THERAPY SERVICES**

### **Context**

Occupational therapists work in both health and social care systems with staff employed by local authorities accounting for around a third of the UK profession (Mountain, 2000). In England this amounts to approximately 1,760 whole time equivalent therapists, compared with roughly 40,100 social work staff (The Information Centre, 2007a). Despite their relatively small numbers, however, occupational therapists play a major role in the delivery of mainstream services to older people, adults and children with disabilities. Indeed, reports suggest that the profession manages around 25 per cent of all referrals to social services departments, and that in some authorities the proportion is as high as 40 per cent (Mountain, 2000; College of Occupational Therapists, 2002).

Occupational therapists were first employed by social services departments in response to the statutory requirements of the Chronically Sick and Disabled Person's Act of 1970. It obliged local authorities to provide equipment and housing adaptation services for disabled people. Subsequent legislation, including the 1990 NHS and Community Care Act, has successively increased the responsibilities of local authorities for the promotion of older and disabled people's independence (Mountain, 2000; Winchcombe and Ballinger, 2005). Thus whilst professional definitions of occupational therapy stress the use of environmental modifications and the use of activity to help people achieve health and life satisfaction (Creek, 2003), the work of occupational therapists and their assistants in social services departments has been dominated by a demand for housing adaptations, community equipment and assistive technology (Mountain, 2000; College of Occupational Therapists, 2002; College of Occupational Therapists and Housing Corporation, 2006; Riley, 2007). This represents a substantial financial commitment. In 2006/7 more than 491,000 people received equipment and alterations, whilst public spending on housing adaptations costs more than £220 million a year (Heywood, 2001; The Information Centre, 2007b).

Whilst there is some evidence that the provision of equipment and adaptations can improve service users' quality of life and independence and obviate the need for complex and costly care packages or inappropriate admissions to institutional care, the effectiveness of such interventions depends upon their timely implementation (Mountain, 2000; Heywood, 2001; Audit Commission 2002; Awang, 2004; Tse, 2005; College of Occupational Therapists and Housing Corporation, 2006). Delays can lead to dependency, accidents and hospitalisation, as well as to the stress of unmet expectations (Wielandt and Strong, 2000; Heywood, 2001; Stewart et al., 2005; Riley, 2007). The typically lengthy waiting lists for assessment and subsequent intervention at the end of the twentieth century thus caused much concern and dissatisfaction (Audit Commission, 1998, 2000, 2002). Furthermore, it was found that although many referrals were for relatively minor and inexpensive adaptations (grab rails, ramps, steps etc) these often received low priority, in line with the targeting of resources during this period on those with the most complex needs (Cm 4169, 1998). There was also a perceived lack of funding and of options for service users (Hawkins and Stewart, 2002; Awang, 2004; College of Occupational Therapists and Housing Corporation, 2006).

In 1999 the Royal Commission on Long Term Care recommended that budgets for equipment and adaptations should be included in and accessible from a single budget (Cm 4192-1, 1999). This was followed by an Audit Commission report in which the organisation of equipment services was described as 'a recipe for confusion, inequality and inefficiency' (Audit Commission, 2002, p4). Marked geographical variations were found in all aspects of service delivery and the appropriateness of the established division of labour between occupational therapists working for health and social services was challenged (Audit Commission, 2000, 2002). The Government's response aspired to the development of single integrated (health and social care) community equipment services that would enable a significantly greater number of people to access a much wider range of products (Cm 4818-1, 2000; Department of Health, 2001). Despite such reorganisation and the implementation of the first national eligibility framework for adult services (Department of Health, 2002b), equipment provision remained variable. Moreover, there were mounting concerns, that by excluding clients with low-level needs, increasing levels of dependency might result in the longer-term (Winchcombe and Ballinger, 2005; Lett et al., 2006; Riley, 2007).

In a policy environment which placed a growing emphasis on the prevention of ill health and dependence, the provision of more choice and control for service users and the delivery of services closer to home, such concerns were taken seriously (Department of Health, 1999a, 2001; Cm 6737, 2006). This set of values is closely aligned to the beliefs of occupational therapists' (Creek, 2003) and the desire to improve access to smaller pieces of equipment and adaptations without unnecessary bureaucracy has already led to the implementation of new models of service provision. These include the training of trusted assessors, the use of direct payments and, in some authorities, access to a limited range of equipment on the basis of self-assessment (Winchcombe and Ballinger, 2005; Cm 6499, 2005; College of Occupational Therapists and Housing Corporation, 2006). The principles of self-determination and self-help lie at the heart of plans to further widen and transform community equipment services. This includes the introduction of a retail model, with both an online self assessment component and the facility for existing state bodies or new 'independent needs assessors' to issue users with a prescription for equipment from an approved/accredited retailer (CSED, 2007; Her Majesty's Government, 2007). The rationale is that if minor pieces of equipment and adaptations are provided by others, occupational therapists and their assistants working in social services departments can focus on working with people with complex needs to help them achieve the optimum level of independence (CSED, 2007).

### **Self assessment within occupational therapy services**

The majority of studies in this evaluation related to occupational therapy when the two preventative projects piloting web-based assessment tools for occupational therapy services are included. This is perhaps unsurprising in view of historical concerns to reduce waiting lists for assessment and service provision alongside initiatives to co-opt 'trusted assessors' into their procedures as noted above. Indeed the role of these people within self assessment arrangements is perhaps one of the conundrums of policy implementation, particularly in relation to the personalisation of social care which remains unresolved at the completion of this evaluation. The principal findings from the study are presented in summary form below.

- The first finding of note is that two aspects of self assessment are also reflected in this setting. These are summarised in Box 6.

#### **Box 6: Self assessment and occupational therapy services**

Self assessment as a component of **screening** identifies individuals for whom further professional assessment is appropriate

Self assessment facilitates **direct access** to services

Challis et al., 2007a

- A second finding is that, as with respect to assessment and care management arrangements, those people who undertook self assessments for occupational therapy services appeared to have a particularly young profile. Those who did were also more ethnically diverse, more likely to live alone, in better general health (with less incontinence) and more independent in their ability to undertake a number of daily activities than people who received traditional assessments. In this context it is also relevant to note that high levels of concern about forgetfulness were reported amongst people undertaking self assessments in this setting.
- The third finding relates to service receipt. Given the relatively low levels of disability of those people who completed self assessments in occupational therapy settings reported above, it is perhaps not surprising that a substantial proportion of the services provided to this group sought to provide assistance with bathing and showering, the first activity of daily living with which most people experience difficulty.
- A fourth finding, in terms of timeliness, was that users received their assessment more quickly. The mean time from referral to completion of assessment for the self-assessment group was less than that for those who had a professional assessment. However, overall, the time from referral to first service was almost identical. Therefore, as for the evidence in assessment and care management arrangements, self assessment does not in itself necessarily contribute to more timely service delivery.
- Fifth, in terms of user satisfaction, in the majority of occupational therapy projects, respondents who self-assessed did not differ from those who were assessed in traditional ways. This domain is largely unaffected by the method of assessment employed and, moreover, is at a generally high level.
- Finally, in terms of efficiency, the findings are inconclusive and present a mixed picture. Some of the projects within occupational therapy services were more effective but more costly whilst others were less costly but less effective. It is not therefore appropriate to generalise from these findings about possible efficiency gains in occupational therapy services consequent on the introduction of a form of self assessment.

## PART 4: PREVENTATIVE SERVICES

### Context

The balance between the use of resources to target the needs of the most vulnerable compared with those with fewer care needs is of growing interest and concern to policy makers (Joseph Rowntree Foundation, 1998). Preventative services designed to meet low level needs have formed a part of primary and secondary health care for some time, for example in occupational therapy led falls prevention programmes, as well as community, public, and mental health promotion schemes (Secker et al., 2003; Moyer et al., 1999; Harris et al., 2005; Tayler et al., 2004; Rubenstein, 2006; McClure et al., 2005; Lansley et al., 2004). In social care, preventative initiatives are currently negotiating their roles within a specific policy context which has shifted the emphasis of development and delivery of services towards the less vulnerable (Wistow et al., 2003; Grundy, 2006; Schroder-Butterfill and Marianti, 2006).

The notion of prevention, encompassed within the White Paper *Caring for People* (Cm 849,1989) and the subsequent community care reforms of the early 1990s, was framed around preventing the most vulnerable from entering institutional care and promoting their continued residence and care in the community. Preventative services in social care during the 1990s were consequently targeted at the most vulnerable with the intention of prolonging their ability to continue to live in the community and included day, respite and domiciliary services (Godfrey, 2001). The relationship between prevention and independence was manifestly promoted slightly later by policy developments which supported both the provision of convenient, user-centred services (Cm 4169, 1998) and encouraged the development of services to support carers (Department of Health, 1999b). The introduction of direct payments (Department of Health, 2000), which gave service users or their carers direct access to funds with which to purchase services was a further support to the concept of the maintenance of independence. The White Paper *Modernising Social Services* (Cm 4169, 1998) provided grants to local authorities to develop low level support for people most at risk of losing their independence. The link between the loss of independence and the development of preventative services was also made in the document, *Fair Access to Care Services: Guidance on Eligibility Criteria for all Adult Social Care*. It obliged councils to publish eligibility criteria which included how they were addressing 'preventative issues', including the provision of assistance to those whose risk of loss of independence appeared low but might become more serious over time (Department of Health, 2002b, p5-6). More recent policy initiatives have supported this notion, whilst also increasing the emphasis on service user dignity, choice and autonomy (Cm, 6737, 2006; Department of Health, 2006). Together, these policies have shifted the definition of prevention towards services which seek to provide low level support to people with relatively modest or less complex needs whose deterioration might be prevented or delayed by the input of small amounts of service.

Despite this policy shift, debate regarding what is meant by prevention, continues (Godfrey, 1999, 2001; Godfrey et al., 2000; Joseph Rowntree Foundation, 2000). The social care literature discusses the meaning of preventative strategies in numerous ways reflecting the particular disciplinary expertise of the authors. The

disability rights movement, for example, relates prevention to the service user's ability to exercise control and autonomy over their situation (Vernon and Qureshi, 2000). It replaces the concept of independence as the absence of reliance on others with the notion of interdependence where self-determination, self-reliance and self-esteem play equal roles in exercising autonomy (Secker et al., 2003). Themes of social inclusion and exclusion, of well-being (Wistow et al., 2003) and of citizenship (Craig, 2004) have also featured in the literature on prevention, along with an exploration of what is meant by the concept of vulnerability (Schroder-Butterfill and Marianti, 2006; Grundy, 2006). Lewis and colleagues (1999) defined preventive strategies as services that prevent or delay the need for more costly or intensive service interventions and promote the quality of life of older people and their engagement with their community. The Joseph Rowntree Foundation has explored preventative strategies on a number of occasions and in relation to a number of service user groups, including low intensity support services in the housing sector and what it terms 'floating support' where a single person or a couple live in their own self-contained property, with staff providing support for a specified number of hours each week (Joseph Rowntree Foundation, 1998, 1999a, 1999b, 2000, 2007). They found that such services, whilst increasing the possibility of independence also increased the experience of loneliness (2007).

It is clear in the literature that preventative strategies have suffered from the divide between health and social care, which has served to reduce the effectiveness of inter-agency partnership work (Roberts, 2001). Research into housing issues has demonstrated that many of these have implications for health and social care linked preventative strategies. Studies of food consumption (Percival, 2002); of routine activities in domestic spaces (Sidenvall et al., 2001); and of the home as the environment where most adaptations and assistive technology is used (Lansley et al., 2004) and supports implemented (Joseph Rowntree Foundation, 1998) have provided a greater understanding of the potential of preventative strategies to cross health and social care boundaries (Parkinson and Pierpoint, 2000). The Department of Health's *Partnerships for Older People Programme* (Department of Health, 2006) is a recent example of an initiative which aims to bridge the health and social care divide within the prevention arena. This scheme emerged from the 2004 Spending Review which ring-fenced £60 million to be used between 2006 and 2008 by local authorities to establish innovative pilot projects in partnership with primary care trusts, the voluntary, community and independent sectors (Department of Health, 2006). Its aim has been to push forward large scale reform of health and social care services with greater emphasis on prevention. The pilot projects have been charged with evaluating a range of models of service delivery, resource allocation and partnership mechanisms in order to 'create a sustainable shift in resources and culture towards prevention' (Department of Health, 2006).

The evidence base regarding the efficacy of preventative approaches, in terms of perceived or actual benefits to service users, remains limited in both social care and housing. As noted in Volume II of this study, evidence regarding the cost savings of such approaches is also limited (Challis et al., 2008a). In relation to the effectiveness of low intensity support services within supported housing, the Joseph Rowntree Foundation (2000) reported a poorly developed body of research. They commented that studies reviewed by them were largely descriptive, concentrated on processes rather than outcomes, were snapshots rather than longitudinal studies,

and were largely small scale with a focus on a single user group, making generalisation from the findings problematic. Within the context of social care of older people, Godfrey and colleagues have commented on the dearth of information on the outcomes of preventative services (Godfrey, 1999, 2001; Godfrey et al., 2000). Godfrey (2001) viewed this as the result of both a lack of clarity regarding the meaning of prevention alongside a lack of appropriate outcome criteria that could be used to evaluate the effectiveness of provision. She has called for the development of a theoretical framework which locates prevention within a model of successful ageing which recognises loss in old age (e.g. of function, social networks, intimacy) and the need for older people to find ways to adapt to and compensate for this. Preventative services might then be seen as a resource to aid adaptation to loss in old age whilst outcomes related to specific aspects of such services could be used to evaluate their effectiveness. The message from the literature is that this area of work requires further development and study.

### **Self assessment within preventative services**

Unlike the other settings considered within this evaluation the area of preventative services has no group within traditional services with which it can be compared. This means that judgements are partial and arguments for sustainability difficult to generate. In recognition of the importance attached to preventative services within recent policy guidance it is unsurprising that five projects within this evaluation are within this service setting (including the two which evaluate the use of web-based tools in occupational therapy services). The principal findings from the study are presented in summary form below.

- The first finding in this respect was that two aspects of self assessment are reflected in this setting. These aspects are the same as for occupational therapy services above and are summarised again in Box 7.

#### **Box 7: Self assessment and preventative services**

Self assessment as a component of **screening** identifies individuals for whom further professional assessment is appropriate

Self assessment facilitates **direct access** to services

Challis et al., 2007a

- A second finding related to user characteristics. Those who self assessed within preventative services were older people, disabled adults or carers. However, irrespective of age, individuals accessing self assessments provided with a view to preventing future deterioration constituted a healthy sub-group who were independent in terms of performing activities of daily living.



- Third, it is relevant to note that it was not possible to gather comprehensive information relating to service receipt in respect of preventative services within this evaluation. However, in respect of one project most of the equipment supplied was designed to help people dress, and nearly all of items were of low cost. It is likely that data will be absent in full or in part in any further evaluation in preventative services because self assesses are likely to be to take responsibility themselves to meet their own needs.
- Fourth, with regard to the timeliness of assessment, it is relevant to note that comparative data with traditional forms of assessment was only available for one project. Moreover, this related only to the assessment itself and in this respect, the project enabled users who self assessed to complete the process more quickly. The absence of data in this domain again reflects the nature of service provision and also the choice of projects for inclusion in the evaluation.
- The fifth finding relates to user satisfaction. As noted above, the nature of preventative initiatives means that there is no logical comparison group. The summary scores are nevertheless very similar to those noted above in both occupational therapy services and assessment and care management arrangements, with the majority of self assessment recipients highly satisfied with their experience.
- Sixth, in terms of efficiency, the same site which provided data about timeliness also provided evidence of both costs and benefits. In this, self assessment was found to be less costly but less effective than traditional approaches.

## **PART 5: ENDNOTE**

This final section is divided into two parts. The first examines the process of programme evaluation. In the second part, a wider application of the findings is presented in the light of some of the most relevant themes in current policy guidance.

### **Programme evaluation**

Revisiting the typology developed by Vedung (2004), this study has demonstrated the uses of programme evaluation in terms of operationalising the concept of self assessment of value to both policy makers in central government and those seeking to implement initiatives in the delivery of adult social care services. For both these audiences it has also demonstrated the instrumental use of programme evaluation in providing evidence to inform future decision making. Furthermore, for managers in the local authorities in which the pilot projects were based, this evaluation has provided the opportunity to both develop and demonstrate data which helped to embed self assessment within existing service structures. In this way the process of establishing self assessment procedures locally has contributed to a greater understanding of its potential and actual utility.

What have we learned about the process of evaluation in the context of the self assessment pilot projects? Some years ago it was concluded that the purpose of research in social services departments was “to stimulate new thinking and open up new ways of looking at things which help to introduce or foster a new emphasis or direction in the political debate about policy” (Booth, 1979, p. 185). In this study we have sought to accomplish this in respect of the role of self assessment within adult social care. The steps in this evaluation process are summarised in Box 8 below. Above all this was a pragmatic evaluation with the location, services, and timeframe prescribed by the funders. It is within these parameters that the achievements of the evaluation documented in Box 9 must be judged.

### **Box 8: Key steps in the evaluation process**

- Research proposal agreed by fundors in advance.
- Pilot sites selected by fundors.
- Identification of four types of self assessment and three service settings.
- Development of tools: user characteristics; user satisfaction; assessment pathways; service receipt and cost data; and management perceptions of innovation and sustainability.
- Set up meeting with representatives of each authority.
- Research agreements secured with all participating authorities.
- Research governance received from ADASS, Manchester University Ethics Committee and from each participating authority.
- Detailed plans outlined in interim report and subsequently developed when data collection capacity of authorities became clearer.
- On-going meetings facilitated by fundors to maintain momentum and share learning.
- Data collection within prescribed timeframe.
- Literature review and document analysis to identify factors influencing innovation and sustainability in social care.
- Meetings with managers in all sites to elicit perceptions of the factors which influence the sustainability of their pilot project.
- Data analysis and report writing.

### **Box 9: The achievements of the evaluation**

- Categorisation of pilot projects by service type.
- Interrelationship of type of self assessment and service type made explicit.
- Agreement between researchers and manager in each site at the outset and commitment to local data collections largely maintained.
- Transfer of data by electronic or paper means from pilot sites to research team. User characteristics of 1,500 self assessments and 600 traditional assessments. 1,800 user satisfaction questionnaires completed. Cost data for all projects. Service receipt data from 11 projects. Information on factors which promote innovation and sustainability.
- Profiles of users for whom self assessment is appropriate, levels of satisfaction and details of service receipt. Some comparison with traditional approaches to assessment.
- Exploration of the costs and benefits of self assessment.
- Perceptions of prerequisites for long-term viability of projects within host organisation.
- Report detailing uses, cases and processes, user satisfaction and costs and outcomes.
- Report identifying 'embedded-ness', links with core business and catalysts for change as crucial to long term sustainability.
- Demonstrating greater understanding of concept of self assessment and its potential to contribute to the personalisation of social care.

### **A wider application of the findings**

In this section messages from the evaluation of self assessment are discussed in respect of: the use of self assessment; the characteristics of those who use it; the processes; and sustainability.

This study has revealed that self assessment may be located at various points in the assessment process. However, self assessment was not frequently used as a component of screening, as a precursor to assessment. As noted elsewhere, this is at variance with approaches in health settings, which in the UK, for example, have traditionally related to the area of screening for further enquiry. Examples include the General Health Questionnaire (GHQ) (Goldberg, 1972) which was used in primary care (whilst waiting for the GP) and the various screening tools in primary

care which were originally used for case-finding (Tulloch and Moore, 1979; Bowns et al., 1991). In this study the opportunity for using self-assessment as a means of checking pre-client status has therefore not been demonstrated. Rather, it has been used to contribute to the assessment process and in some cases subsequent allocation of service. In these circumstances it was initiated by professional assessors reviewing self assessment documentation, i.e. this function was generated by the process not the tool.

Overall, self assessment appears to have greatest utility when it complements existing processes rather than attempts to substitute for them. In this way it can contribute to the assessment and care planning processes, thereby linking with the personalisation agenda since it facilitates the user's involvement in the assessment. In contrast, requiring the user to complete the assessment process alone could be conceived of as disempowering. The findings from the evaluation indicate that self assessment has greatest utility when there is a facilitator (mediator) and / or a 'professional' person (not necessarily professionally qualified) to translate the assessment into an appropriate response.

Findings from the study also suggested that those who avail themselves of the opportunity to self assess are atypical of those who hitherto have comprised social services user groups: they are healthier. This suggests that existing assessment processes will continue to be required for frail service users, particularly those who are elderly. A profile emerges of users for whom self assessment may not be viable: people with cognitive impairment and generally poor health. It is also noteworthy that people with low mood were less satisfied with assessment processes whether they be self initiated or a more traditional approach. Poor health was associated with greater difficulty of self assessing and this was compounded if the assessment process was electronic.

More cautiously, since the evidence is taken primarily from one site and relates to a single group, it would appear that the difficulties of completing online assessment are exacerbated for members of black and minority ethnic groups. This suggests that online assessment has the potential to reduce access to service provision for traditionally hard to reach groups, counter to guidance and legislation which requires equality of access.

As reported in the literature, overall levels of satisfaction with assessment processes were also high in this study. Irrespective of the manner of the assessment (self assessment or traditional approaches) people with cognitive impairment or low mood were less satisfied with the former; a finding confirming previous PSSRU research (Challis et al., 2007b).

Most of the self assessment pilot projects produced some cost reductions, predominantly in 'front office' costs as distinct from the 'back office' costs (Chase, 1978; Tinnilä and Vepsäläinen, 1995) identified as potential areas of saving by central government. These savings predominantly related to staff costs suggesting that less qualified staff undertook work in relation to self assessment enabling more qualified staff to focus on service users with complex needs. In the majority of projects there was a trade off between costs and efficacy. More expensive

interventions tended to be more effective whilst less expensive ones tended to be less effective.

The self assessment pilot projects have provided some limited evidence of the widening role of the third sector in line with recent policy guidance. Representatives of voluntary organisations have acted as mediators in the self assessment process within both assessment and care management and occupational therapy services. They have also been the purveyors of information about self assessment.

Within the self assessment projects overall, the use of information technology was not as successful or important as it was anticipated it would be at the outset. It was most successful when employed in conjunction with a person. Generally speaking, information technology was not a driver for change in encouraging users to self assess. Nevertheless, there were examples of authorities linking self assessment to other local electronic initiatives. Furthermore, there was some evidence that self assessment by electronic means was incompatible with a personalised response. In fact, people accessing on-line assessment were significantly less satisfied, except where there was a personal mediator involved interpreting the findings of the assessment into appropriate service provision or identifying the need for a professional assessment. Self assessment alone can only provide a service response from 'a set menu'. A response which has been determined by an assessor is more tailored to individual needs and circumstances. The analogy can be made with the distinction between block contracting and individual commissioning of services.

In terms of sustainability, the evaluation suggests that the extent to which the pilot projects are 'embedded' within existing service structures is important. This is not a concept we found elsewhere in the literature review but, nevertheless, appears relevant to the discussion of innovations in social care at the beginning of the 21<sup>st</sup> century. Two issues emerged as central to this concept of 'embedded-ness' within existing services: whether self assessment was integral to the core business and whether funding from the Department of Health was used for pump priming purposes. The scale of the change, often cited in the literature as important in this context, did not appear to be so. Forces for change and innovation within the pilot sites were both external and internal. However, internal motivation to change appeared to be more powerful, demonstrating the importance of the link between the pilot project and associated core business.

The current study holds a key message, above and beyond those which match the findings already present in the literature, of particular relevance to innovation in social care. The means adopted to achieve 'embeddedness' might vary although a number of attributes appeared to be significant. These are: the status of the pilot projects; their purpose in testing out ideas for adaptation to better fit user need; the adoption of a marketing approach in respect of changes in the way services are delivered; the ability of projects to demonstrate their success to provide leverage for political support; and their capacity to act as catalysts for wider change. The latter is particularly important in that it signifies the influence of innovations over and above their particular brief, irrespective of whether they were sustainable as entities in themselves.

Another consideration relates to the transformation of adult social care, which is rooted in the principles of consistency (Cm 4169, 1998), efficiency (Gershon, 2004), inter-agency collaboration (Department of Health, 2002a) personalisation and choice (Cm 6737, 2006) and early intervention (Department of Health, 2008). Care management, occupational therapy, and preventative services are all in the process of change, reflecting the centrality of their roles in adult social care. Self assessment is a fundamental part of this change, affecting and affected by them all. The question remains, however, where does self assessment fit with 'progressive universalism' (Johnson, 2007) in social care? Our findings suggest emergent tensions in respect of the introduction of the personalisation agenda in social care, future funding for self assessment for low level services, and costs and efficiency.

In particular, this evaluation indicates that whilst the standardisation of service receipt consequent on self assessment may be appropriate for some is not appropriate for all. This study has indicated that for vulnerable older people and adults a personal assessment is the most appropriate means of assessing need. In terms of the delivery of social care the potential role of self assessment is unclear. Whilst this evaluation does suggest a role, albeit limited, for self assessment in the newly emergent configuration of care services it is not yet possible to clearly delineate this. A second area of debate in the context of self assessment is its future funding for preventative services including small pieces of equipment. If self assessment is used to identify health needs, particularly as part of a prevention strategy, arguably they should be jointly commissioned. There is also a possible tension when the information giving role of the local authority extends into giving out information about health issues. This raises the issue of whether or not information giving about social care should link with other parts of the local authority or become more integrated with local health services. In respect of costs, the debate is around the delivery of high quality services to a wider group of users and the quest for greater efficiencies in service delivery. Both goals cannot be achieved and so a balance has to be sought between them. Overall, in policy terms, this evaluation suggests that in order to operationalise the concept of self assessment in social care a feasible goal must be identified which incorporates aspects of both quality and efficiency.

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## Appendix 1: Description of Study Sites

Local authority	Project aim	Target group	Focus
Birmingham	To improve access to equipment, the customer experience and cost efficiencies by piloting and evaluating the use of the SARA tool	Adults over 18 years	Occupational therapy services
Bristol	To develop and pilot a paper and an online self-assessment tool for carers	Carers	Preventative services
Derby City Council	To promote and test the provision of a third sector person centred service that will improve the quality of disabled adult's experience of the care management processes	Disabled adults	Assessment and care management arrangements
East Riding of Yorkshire Council	To implement and evaluate a 'fast track' client led self-assessment system that expands existing opportunities to self-assess for minor adaptations to include minor aids and pieces of equipment	All service users over the age of 18 years	Occupational therapy services
Kingston upon Hull City Council	To promote and evaluate direct access to occupational therapy services and access to equipment through customer service centres and reduce waiting list times	All service users over the age of 18 years	Occupational therapy services
London Borough of Barnet	To evaluate the piloting of a self review system within care management arrangements to enable existing users to review their needs and request additional services	Older people	Assessment and care management arrangements
London Borough of Barnet	To evaluate the introduction of self assessment for simple pieces of equipment and moderate levels of home care	Older people and disabled adults	Occupational therapy services
London Borough of Croydon	To develop and pilot an online self-assessment tool based on the SARA tool customised for local use	All adults	Preventative services
London Borough of Hammersmith and Fulham	To evaluate the screening by senior occupational therapists of service users as to their suitability for entry into one of three assessment routes with the primary focus on access to shower/bath adaptations	Adults of all ages with a physical disability	Occupational therapy services
Nottinghamshire	To evaluate the introduction of self assessment for simple items of community equipment	Older adults (60 plus) and disabled adults	Preventative services
Royal Borough of Kingston upon Thames	To pilot and evaluate the introduction of a web-based (ADL Smartcare) self assessment tool for assistive equipment	Older and disabled adults	Preventative services
St Helens Metropolitan Borough Council	To promote and evaluate self assessment for older people who would usually be seen to fall outside of the authority's eligibility criteria	Older people and carers	Preventative services
St Helens Metropolitan Borough Council	To evaluate the impact of self assessment for 'low level' services within care management arrangements	Older people	Assessment and care management arrangements