Providing community equipment and adaptations in adult social care: lessons from an evaluation of the use of self-assessment in five English local authorities

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Abstract
Whilst community equipment and adaptations promote the independence of millions of people, ongoing problems have been identified with the delivery of such services by local authorities. Self-assessment has been identified as one possible means of improving service effectiveness, giving service users more choice and control and providing faster, easier access to services. However, little is known about the use of self-assessment in social care. Against this background, this paper reports the findings of a mixed methods evaluation of the use of self-assessment in five local authority occupational therapy services. This drew on internal documents, management interviews, service user and administrative records, and a service user satisfaction survey. Important insights are provided about the operationalisation and possible functions of self-assessment in local authority occupational therapy departments; the characteristics of service users for whom self-assessment may be suitable (and those for whom it may not); the range of equipment suitable for provision via self-assessment; the costs of self-assessment; and service users’ experience of self-assessment. The results are discussed in the context of the relevant policy and legal framework and a number of important lessons are highlighted for service commissioners and providers.

Keywords: Self-assessment, social care, occupational therapy, community equipment

Introduction and policy background
This paper reports an evaluation of the use of self-assessment for the provision of community equipment and adaptations, a function long recognised as an important element of local authority adult social care’s remit. Indeed, occupational therapists were first employed by local authorities in response to the introduction of the 1970 Chronically Sick and Disabled Persons Act which obliged local authorities to provide equipment and housing adaptation services for disabled people, and over the past five decades the work of occupational therapists in social care has been dominated by this requirement (Mountain, 2000; Department of Health & College of Occupational Therapists, 2008). This entails a substantial financial commitment. In 2006/7 an estimated £230 million was spent on adaptations (Department for Communities & Local Government, 2007), whilst in 2007/8 more than two million items of community equipment were delivered to service users (NHS Information Centre for Health and Social Care, 2008).

Although evidence suggests that the provision of equipment and adaptations can improve service users’ quality of life, enable independence and obviate the need for inappropriate admissions to institutional care, the effectiveness of such interventions depends upon their timely implementation (College of Occupational Therapists & Housing Corporation, 2006; Riley, 2007). Nevertheless, over the years a series of concerns have been voiced about this aspect...
of care provision, including the historically lengthy waiting lists for occupational therapy assessments, the complexity of different funding streams and the low priority given to referrals for relatively inexpensive pieces of equipment and adaptations (Audit Commission, 1998; Department of Health, 1998). Summarising these, two highly critical Audit Commission reports pointed to marked geographical variations in all aspects of service delivery (Audit Commission, 2000 & 2002). Services were said to lack leadership, commissioning standards were weak, and the wisdom of the established division between the supply of equipment for home nursing (by the NHS) and daily living (by adult social care services) was challenged.

The Government’s response aspired to the development of single integrated (health and social care) community equipment services that would enable a greater number of people to access a wider range of products (Department of Health, 2000 & 2001). In addition, the first national eligibility framework for adult services was introduced, following which it was confirmed that community equipment services should be delivered in accordance with local eligibility criteria, with items up to £1,000 provided free of charge (Department of Health, 2002 & 2003). Despite such reorganisation, however, equipment services remained variable, and as growing numbers of authorities tightened their eligibility criteria in response to successive spending reviews, there was concern that by excluding clients with low-level needs, increasing levels of dependency might result longer-term (Riley, 2007; Commission for Social Care Inspection, 2008).

In 2008 a subsequent Audit Commission report warned that local authorities were not ready to meet the needs of an ageing population and proposed a radical re-engineering of the way adult social care was delivered. Demographic change is not the only challenge facing social care services today, however. Further pressures stem from the ongoing drive to support more service users (with more complex needs) in their own homes, current trends in obesity and lifestyle related diseases and people’s rising expectations (Department of Health, 2008a & 2009). Moreover, in a climate of tight financial constraint, local authorities are simultaneously being asked to achieve large cost savings and become ever more efficient (Appleby & Humphries, 2010).

Acknowledging these tensions, central government announced plans to transform the provision of adult social care in England (Department of Health, 2008b). These included two flagship policies: a focus on prevention, early intervention and enablement (on the grounds of long-term cost-effectiveness); and a desire to give service users more choice and control (Wanless et al., 2006; Her Majesty’s Government, 2007; Department of Health, 2005, 2006 & 2008b). At about the same time a further review of community equipment services was undertaken and a new service delivery model proposed that would move the provision of simple aids to daily living into the retail marketplace, improving access via the establishment of independent needs assessors and online assessment tools (Care Services Efficiency Delivery, 2007; Her Majesty’s Government, 2007). Participation was not mandatory, however, and subsequent roll-out has been patchy, whilst those authorities that have participated have retained discretion about which items to distribute via the retail sector (Centre for Economics and Business Research, 2009; The Homecare Industry Information Service, 2010).

In the meantime, the desire to improve access to smaller pieces of equipment and adaptations has led some authorities to explore other ways of working. These include the training of trusted assessors and the use of mediated or supported self-assessment (Winchcombe & Ballinger, 2005; College of Occupational Therapists & Housing Corporation, 2006; Department of Health & College of Occupational Therapists, 2008; Glendinning et al., 2008). Whilst the employment of self-assessment in the
provision of community equipment and adaptations sits comfortably with recent government policy in having the potential to provide faster, easier access to services, promote self-determination, release staff time and save costs (Department of Health, 2005, 2006a & 2006b; Care Services Efficiency Delivery, 2007), its use in social care is a relatively new phenomenon. Evidence about virtually every aspect of its employment – its form, scope, acceptability, cost and effectiveness – is thus undeveloped.

Against this background, in August 2006 the government in England published details of 11 local authorities that would pilot the use of self-assessment in adult social care (Department of Health, 2006b). The intention was to determine if self-assessment was feasible in this sector and identify its risks and benefits and, to this end, a multi-site evaluation was commissioned. This aimed to classify and describe the different approaches taken to self-assessment, gauge service users’ experience of self-assessment, evaluate the cost-effectiveness of self-assessment and appraise the implementation and sustainability of new assessment practices (Challis et al., 2008). The work described in this paper formed part of this evaluation and concentrates on the first three of these aims using data collected in five projects located in local authority occupational therapy services. It addresses the following key questions:

- How might self-assessment be employed?
- Who is self-assessment suitable for?
- What services should be provided via self-assessment?
- What does self-assessment cost?
- How satisfied are service users with self-assessment?

**Methods**

An extensive data collection exercise was undertaken in 2006-7 using a mixed-methods approach. Six strands of this are relevant to this paper.

Firstly, research staff examined internal documentation and interviewed key personnel in each pilot site to identify how they perceived self-assessment and its place within the care process. Together with the results from a selective literature review (Challis et al., 2008) this information was used to formulate a classification of the employment of self-assessment in social care. This identified both its location (within occupational therapy, assessment and care management or preventative services) and function (screening to identify individuals who require further professional assessment, contributing to a wider professionally-led assessment, contributing to care-planning or providing direct service access).

Secondly, local sites collected a range of information about the socio-demographic characteristics, health and functioning of service users who completed self or traditional (usually professional, face-to-face) assessments. Each item was drawn from the EASY-Care assessment tool (Philp, 2000) and information about user dependency was combined to identify the number of daily activities with which people needed help (Katz et al., 1963). The statistical significance of any variation between groups was assessed by the use of 95 per cent confidence intervals and, where applicable, chi-square, t-tests and non-parametric Mann-Whitney tests, with differences reported at the conventional 5 per cent significance level. As the breadth and process of the data collection varied between authorities (with some building this into their usual assessment process and others employing an independent data collection exercise) and the samples were not random, a selection of key variables (e.g. age, gender, ethnicity and dependency) were compared with information from a large national study (NHS Information Centre for Health and Social Care, 2008) to confirm the studied groups were not untypical of the expected service user group. This also surveyed service users receiving community equipment and adaptations (if not some of the more major adaptations offered within the current study),
and provided the best comparative information available.

Thirdly, local authorities collated data on the services received by people receiving self or traditional assessments. Whilst in most sites this was available by individual service user, some could only provide aggregate figures. This information was subsequently summarised in a 24-cell matrix according to its cost and function. Unit costs (4 bandings based on a classification used by Care Services Efficiency Delivery, 2007) were estimated from a range of equipment brochures, websites and local sources supplemented, where applicable, by installation costs calculated from nationally published data (Curtis & Netten, 2006). The primary function of each item of equipment (eight categories, including the provision of assistance with meal preparation, bathing and dressing) was coded according to guidance developed by the occupational therapist within the research team (Challis et al., 2008).

Fourthly, pilot projects provided data on the length of time between three key aspects of the assessment process as experienced by people receiving self and traditional assessments: the time from first contact (referral) to assessment; the time from completion of assessment to first service receipt; and the aggregate time from referral to first service receipt.

Fifthly, the costs of self and traditional assessment were estimated from information provided by the authorities. The methodology for calculating costs followed that adopted in previous research and demonstration projects (Netten & Beecham, 1993) and detailed full economic costs, not just expenditure employed. Capital or set-up (investment) costs encompassed both the initial funding received from the Department of Health and the authorities’ own matched funding, whilst revenue costs comprised both the costs of the assessments themselves and the costs of the services received consequent upon assessment. In those instances in which self-assessments essentially replaced traditional assessments, the additional (marginal) costs or savings incurred by adopting self-assessment were considered. However, where these could not be calculated or data was unavailable, costs were calculated in aggregate form (Challis et al., 2008).

Lastly, a structured satisfaction survey was administered to individuals receiving self and traditional assessments. This was based on a tool developed by research staff and service users in a previous study (Challis et al., 2007) and contained 13 pre-coded questions facilitating the development of three summary scores. These were: an ‘ease of use’ score, capturing whether respondents found it easy to self-assess or be assessed (maximum value 9); an information score, reviewing the extent to which the assessment embodied certain elements of good practice with regard to the collection and sharing of information (maximum value 4); and a general satisfaction score, expressing the respondent’s overall user satisfaction (maximum value 12) (Challis et al., 2008). Reflecting the different nature of the pilot projects, there was some variation in the quantity and timing of the questionnaires distributed. Nevertheless, all were administered within a month of the assessment and were returned by post. The Mann-Whitney test (again set at the 5 per cent significance level) was used to compare summary satisfaction scores between groups.

The majority of the analysis was thus descriptive in nature, exploring the reality of self-assessment in practice and, wherever possible, comparing this with traditional assessment procedures. Approval for the study was given by the Association of Directors of Adult Social Services (ADASS) Research Group and the Committee on the Ethics of Research on Human Beings at the University of Manchester and research governance procedures in each pilot site were fulfilled.
Table 1 The aim and form of the self-assessment projects

<table>
<thead>
<tr>
<th>Project number*</th>
<th>Aim</th>
<th>Target group</th>
<th>Primary form of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To improve access to equipment, the customer experience and cost efficiencies by piloting the use of an electronic tool</td>
<td>Adults and older people</td>
<td>Electronic</td>
</tr>
<tr>
<td>4</td>
<td>To expand existing opportunities to self-assess for minor adaptations and equipment by a ‘fast track’ client-led self-assessment system</td>
<td>Adults and older people</td>
<td>Telephone, or paper plus telephone</td>
</tr>
<tr>
<td>5</td>
<td>To promote direct access to occupational therapy services and access to equipment to reduce waiting list times</td>
<td>Adults and older people</td>
<td>Electronic</td>
</tr>
<tr>
<td>7</td>
<td>To evaluate the introduction of self-assessment for simple pieces of equipment and moderate levels of home care</td>
<td>Adults and older people</td>
<td>Paper</td>
</tr>
<tr>
<td>9</td>
<td>To develop different methods of assessment for shower/bath adaptations</td>
<td>Disabled adults and older people</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

* The project numbers are those used in the original evaluation and have been used here in order to maintain consistency of reporting across publications.

Findings

Context
As noted above, five pilot projects were located in local authority occupational therapy services. Two were London boroughs, two were shire unitary authorities and one was a metropolitan city i.e. all single tier authorities.

Aims and forms of self-assessment
All five projects aimed to improve access to community equipment and adaptations and targeted a combination of older and disabled adults (Table 1). However, some projects had further secondary goals, such as improving the customer experience or reducing waiting lists. The way in which the different authorities conceived of and operationalised self-assessment varied markedly, with assessments variously available on paper, by telephone and electronically. Nevertheless, in all instances local authority staff played some part in the completion of the assessment and the determination of an appropriate response.

Service users
In Table 2 information about the socio-demographic characteristics, health and functioning of more than 630 people who undertook self-assessments is set alongside that of approximately 330 people who had a professional, usually face-to-face assessment. Whilst all five projects provided information about self-assessment users, information about people who received a traditional assessment was available from just three – Projects 4, 5 and 7. The number of authorities that provided information about each individual variable also varied considerably.

As Table 2 shows, the average service user undertaking a self-assessment for community equipment or adaptations in these projects was in their late 60s/early 70s, female, white and in poor or fair health, although still relatively able to undertake key daily activities of living. Only modest differences were found between the general health and functioning of people who undertook self-assessments and people who received traditional assessments, although the former group were significantly more likely to live alone and more ethnically diverse than the latter. There was also some suggestion that people who completed self-assessments were younger than people who received a traditional assessment and experienced more memory problems and low mood. However, closer examination of the data showed this
was largely due to the influence of Project 1 (which provided information about a disproportionately large number of cases and targeted a more youthful, disabled population) and was not true of other projects. Furthermore, when data from Project 1 was excluded, the general health and daily functioning of those people who completed self-assessments appeared to be rather better than that of people who had professional assessments (proportion of people in poor health 33.5% versus 50.7%; mean dependency score 1.1 versus 1.5).

Table 2 Characteristics of self and traditional assessment recipients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Self-assessment recipients</th>
<th>Traditional assessment recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>mean</td>
<td>n</td>
</tr>
<tr>
<td>Age</td>
<td>Mean years</td>
<td>68.5</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>32.2</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>67.8</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White</td>
<td>75.2</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Asian</td>
<td>16.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Black</td>
<td>6.4</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Other</td>
<td>1.9</td>
</tr>
<tr>
<td>Living situation</td>
<td>Not living alone</td>
<td>57.2</td>
</tr>
<tr>
<td>Living situation</td>
<td>Living alone</td>
<td>42.8</td>
</tr>
<tr>
<td>General health</td>
<td>Excellent</td>
<td>0.9</td>
</tr>
<tr>
<td>General health</td>
<td>Very good</td>
<td>3.6</td>
</tr>
<tr>
<td>General health</td>
<td>Good</td>
<td>12.0</td>
</tr>
<tr>
<td>General health</td>
<td>Fair</td>
<td>37.3</td>
</tr>
<tr>
<td>General health</td>
<td>Poor</td>
<td>46.2</td>
</tr>
<tr>
<td>Incontinence</td>
<td>No</td>
<td>79.8</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Yes</td>
<td>20.2</td>
</tr>
<tr>
<td>Memory problems</td>
<td>No</td>
<td>58.9</td>
</tr>
<tr>
<td>Memory problems</td>
<td>Yes</td>
<td>41.1</td>
</tr>
<tr>
<td>Low mood</td>
<td>No</td>
<td>51.5</td>
</tr>
<tr>
<td>Low mood</td>
<td>Yes</td>
<td>48.5</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>0</td>
<td>22.3</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>1</td>
<td>37.8</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>2</td>
<td>20.9</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>3</td>
<td>10.2</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>Dependency* score</td>
<td>5</td>
<td>2.6</td>
</tr>
</tbody>
</table>

* The number of activities that help is needed with: bathing, dressing, toileting, bed/chair transfer, eating and drinking.
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Service receipt

Information on the community equipment and adaptations received by people undertaking self-assessments was obtained from all five projects. However, only two projects (Projects 4 and 7) provided data about the services supplied to people receiving a traditional assessment. As the services considered suitable for provision via self-assessment varied markedly from site to site and most authorities made only a subset of services available to self-assessees, any differences between the items received by people receiving self and traditional assessments may simply reflect the different mix of services available to them. Table 3 thus focuses on the function and cost of the services supplied (or, in the case of major adaptations such as level access showers and stair lifts, recommended) by each authority as opposed to their exact description.

As can be seen, a large percentage of the equipment and adaptations provided to people who completed self-assessments in Projects 1, 4 and 9 was intended to help people bathe or shower (e.g. bath boards and bath seats). In contrast, the largest group of equipment supplied in Project 5 (e.g. calendar clocks and flashing doorbells) was designed to help people with visual or hearing impairments, whilst many of the items supplied in Project 7 (e.g. grab and stair rails) were targeted at individuals with mobility problems. The equipment and adaptations supplied to people who had a traditional assessment, appeared to relate to a wider range of needs.

Table 3 Function and cost of items supplied to self and traditional assessment (SA and TA) recipients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Items supplied to SA recipients</th>
<th>Items supplied to SA recipients</th>
<th>Items supplied to SA recipients</th>
<th>Items supplied to SA recipients</th>
<th>Items supplied to SA recipients</th>
<th>Items supplied to TA recipients Projects 4 &amp; 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of items*</td>
<td>826</td>
<td>121</td>
<td>464</td>
<td>96</td>
<td>230</td>
<td>413</td>
</tr>
<tr>
<td><strong>Function:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal preparation</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Mobility</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Transfer (bed &amp; chair)</td>
<td>13</td>
<td>28</td>
<td>16</td>
<td>49</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Dressing</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Bathing &amp; showering</td>
<td>13</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Eating &amp; drinking</td>
<td>55</td>
<td>43</td>
<td>-</td>
<td>29</td>
<td>47</td>
<td>29</td>
</tr>
<tr>
<td>Toiling</td>
<td>4</td>
<td>22</td>
<td>13</td>
<td>18</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Seeing, hearing &amp; communicating</td>
<td>-</td>
<td>44</td>
<td>-</td>
<td>&lt;1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Cost band:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (≤ £20)</td>
<td>42</td>
<td>31</td>
<td>47</td>
<td>24</td>
<td>31</td>
<td>17</td>
</tr>
<tr>
<td>Medium (≥ £20, &lt; £100)</td>
<td>32</td>
<td>54</td>
<td>53</td>
<td>56</td>
<td>35</td>
<td>57</td>
</tr>
<tr>
<td>High (≥ £100, &lt; £1,000)</td>
<td>16</td>
<td>15</td>
<td>-</td>
<td>20</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Very high (≥ £1000)</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>12</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>

* Please note that many individuals received more than one item.
Most of the equipment and adaptations supplied to people who completed self-assessments were at the lower end of the cost spectrum, with 40 and 41 per cent of items in the low (<£20) and medium (<£100) cost bands respectively. In comparison, 17 and 57 per cent of the items supplied to people who received a traditional assessment were in these cost bands. Given that one of the three arms of Project 9 focused on the provision of major adaptations enabling people to bathe/shower, the concentration of very high cost (≥£1000) items here (12%) is understandable. However, a sizeable minority of the services provided in Project 1 (11%) were also in this banding, and upon further investigation, most of these also related to recommendations for level access showers.

The timeliness of service delivery
Just two authorities (Projects 4 and 7) provided data on the timeliness of service receipt for comparable groups. In both cases the mean time between referral and completion of assessment was shorter for the self-assessment recipients than for the traditional assessment recipients. Within Project 4 this led to a shorter waiting time between referral and first service receipt (5 as opposed to 23 days). In Project 7 the shorter period between referral and assessment was counteracted by a longer wait between assessment and service receipt, such that the aggregate time from first contact to first service receipt was almost identical (56 as opposed to 55 days).

Costs
As can be seen in Table 4, some pilot projects incurred greater costs than others. In light of the variation in the quality of the data provided by different authorities, it should be reiterated that these costs are not directly comparable across sites. Nevertheless, the figures indicate that although all pilot projects incurred substantial capital costs, one produced revenue cost savings (Project 5), whilst the remainder incurred additional revenue costs. Interestingly, three projects (Projects 5, 7 and 9) saved resources in respect of the cost of the assessment itself, through the use of less professional time. However, in two instances (Projects 7 and 9) these were counterbalanced by the cost of the additional services provided.

Service user satisfaction
Completed satisfaction surveys were received from 648 people undertaking self-assessments in Projects 1, 4, 5 and 7 and 590 people receiving traditional assessments in Projects 4, 5 and 7 (an overall response rate of 55 per cent). The vast majority of both self and traditional assessment recipients in all projects found their assessment easy to complete (mean values 7.9 and 8.0, maximum possible value 9) and expressed a high degree of satisfaction with their experience (mean values 10.5 and 10.6 respectively, maximum possible value 12). Indeed, an examination of the responses to each individual question used to construct these scores identified no

Table 4 Estimated cost of self-assessment (2006/7 £s)

<table>
<thead>
<tr>
<th></th>
<th>Project 1</th>
<th>Project 4</th>
<th>Project 5</th>
<th>Project 7</th>
<th>Project 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital cost of self-assessment project</td>
<td>102,000</td>
<td>168,000</td>
<td>173,846</td>
<td>63,795</td>
<td>110,000</td>
</tr>
<tr>
<td>Revenue cost or saving (-) of self-assessment project*</td>
<td>48,138</td>
<td>1,985</td>
<td>-21,689</td>
<td>154</td>
<td>13,346</td>
</tr>
<tr>
<td>Total cost of self-assessment project</td>
<td>150,138</td>
<td>169,985</td>
<td>152,157</td>
<td>63,949</td>
<td>123,346</td>
</tr>
</tbody>
</table>

* The average incremental cost or saving of the assessment itself plus aggregate service costs;

N.B. the costs of web-based tools, where employed, were discounted over 5 years apart from Project 1 where the use of such a tool was discontinued in the project period.
statistically significant difference between self and traditional assessments. Furthermore, whilst there was considerable between-project variation in the extent to which assessments encompassed certain elements of good practice with regard to the collection and sharing of information, there was no suggestion that either self or traditional assessments were better at this per se. (mean values 2.9 and 3.1 respectively, maximum possible value 4).

Discussion

Local authority community equipment and adaptation services have been subject to ongoing criticism and reorganisation over many years. Against this backdrop, the use of self-assessment has been identified as one possible means of delivering both more effective and more person-centred care, improving access to low-level services and giving service users greater choice and control (Department of Health, 2005, 2006a & 2006b; Her Majesty’s Government, 2007). Such aspirations have been predicated upon largely untested assumptions about the relative effectiveness of different assessment approaches, however, whilst the context in which self-assessment is either legitimate or legal is itself the subject of debate (Mandelstam, 2008; Law Commission, 2011).

The material presented in this paper, which provides some of the first detailed information about the way in which self-assessment has been implemented within occupational therapy services, the people who use it, the services they receive and their satisfaction with this process was intended to facilitate an exploration of these issues. Firstly, however, it is important to note a number of methodological limitations, not least of which is that the framework for evaluation was not agreed until after the initiative commenced, by which date the selection of the research sites and the timeframe for data collection had already been decided by the Department of Health. There was, furthermore, considerable variation in the amount of funding the different authorities received, their project designs and the extent of the information they were able to provide (particularly with regard to timeliness and costs) such that the generalisability of the findings may be reduced.

Other methodological concerns relate to the nature of the samples, which cannot be regarded as true random samples of the target population. Thus whilst the traditional assessment recipients may be viewed as a ‘naturalistic’ sample of the authorities’ usual service population, the self-assessment sample is likely to have been moderated by the fact that some pilot projects targeted specific sub groups, e.g. people from ethnic minorities. The varied numbers of service users accessing assessments at different sites, and the aggregation of data across authorities, are also inherently problematic, for such composite figures can produce arbitrary grouping effects whereby the highly contextual impact of one locality creates the impression of a national phenomenon. Checks for this were made, however, whilst as noted above, comparison of our data with a large nationally representative survey suggested that the studied groups, and combinations thereof, were not dissimilar from the expected service user populations.

How might self-assessment be employed in occupational therapy services?

Whilst the classification noted earlier identified four possible functions of self-assessment, all five pilots used it to facilitate direct service access. This is in marked contrast with the situation in the NHS, where self-completed screening questionnaires have more commonly been used to identify individuals who might benefit from further professional assessment or advice (e.g. Tulloch & Moore, 1979; Bowns et al., 1991). In actual fact two of the self-assessment projects in this evaluation did identify a number of people who required a professional assessment. However, this appeared to be a chance rather than a planned event, leaving one to wonder if there might not be the potential to do this more systematically.
The fact that social services or other statutory agency staff played some part in all the assessments is also noteworthy and suggests that the term self-assessment as used in this initiative may be a little misleading, with the approach taken perhaps better conceptualised as mediated or supported assessment. Indeed, as Mandelstam (2008) has stated, it is difficult to see how self-reports alone could constitute lawful assessments under section 47 of the NHS and Community Care Act 1990, for although where a practitioner is content with a service user’s self-assessment they can adopt it as the organisation’s formal assessment of need, they cannot simply delegate this duty to the service user, but must, as recently reiterated by the Law Commission (2011), retain overall control of the assessment process.

Who is self-assessment suitable for?
In light of the push to promote greater personalisation, including a strategic shift towards early intervention and prevention (Department of Health, 2008b & 2010), the introduction of self-assessment has been advocated as one way of reaching out to people who do not normally come to the attention of social care services. To what extent does this appear to be the case? On the one hand, our data indicates that those people who completed self-assessments for community equipment and adaptations were not that dissimilar from people receiving traditional assessments, whilst on the other hand there was some suggestion that these new initiatives attracted a somewhat healthier, more able population. Furthermore, at least some projects successfully attracted a more ethnically diverse service user group than would normally be expected, suggesting that the provision of self-assessment may go some way to engaging certain previously disengaged individuals.

Just how widely might local authorities want to cast their nets? Recent years have seen the public sector increasingly urged to broaden access to support on the grounds of progressive universalism (Commission for Social Care Inspection, 2008; House of Commons Health Committee, 2010). Indeed, the most recent review of eligibility criteria reiterated that everyone, whether they are eligible for public funds or not, should receive an assessment of their care needs and access to information and advice. However, the associated survey suggested 62 per cent of respondents who did not fulfil eligibility criteria were not signposted to any alternative help (Commission for Social Care Inspection, 2008). In an increasingly cash-limited system, directing such individuals towards some form of mediated self-assessment system that enables them to both assess their need for, and access information on simple pieces of community equipment located outside the authority (perhaps in the voluntary sector?) may be one way of squaring this circle. In addition, information collected in this way might subsequently feed into Joint Strategic Needs Assessments, informing future commissioning.

What services should be provided via self-assessment?
This study found that the equipment provided via self-assessment was primarily intended to help people bathe and mobilise, assist individuals with visual and hearing impairments and promote independence and reablement. Furthermore, most of the items supplied cost less than £100. This would seem to suggest that self-assessment is compatible with a retail model of service provision (Care Services Efficiency Delivery, 2007) or a similar approach. The study also demonstrated a range of circumstances in which it may be appropriate to deliver more expensive equipment via self-assessment, notably the installation of showers. In these circumstances it is likely that the person is already known to the local authority, such that details of their dependency and living situation have already been documented and the element of self-assessment relates specifically to the adaptation required, which will be checked prior to structural work being undertaken.

These findings together demonstrate the importance of determining the range of
services which will be made available via self-assessment within the local nexus of health and social care provision, taking account of national guidance and legal requirements. Such an approach will permit local managers and commissioners to select combinations of indicators and descriptors of contextual factors which permit judgements to be made about the role and extent of self-assessment in service provision and to develop locally determined measures of outcome (Department of Health, 2006a).

What does self-assessment cost?
The need to achieve efficiencies forms the background to all recent developments in occupational therapy services. Thus the Best Value (Department of the Environment, Transport and the Regions, 1998) regime, with its requirement to demonstrate value for money and quality in specific services, was superseded by Comprehensive Performance Assessment reviews (Department of Transport, Local Government and the Regions, 2001) focusing on the delivery of councils as a whole. Of particular note is the requirement following the 2004 Comprehensive Spending Review to make Gershon (2004) efficiencies in terms of savings in ‘back office’ functions such as administration and paperwork, releasing resources to front-line services.

The data from this study were intended to evaluate the nature of any savings arising from the introduction of self-assessment through a comprehensive measurement of costs. Interestingly, the study found that the biggest potential for cost saving appeared to be in the cost of the assessment itself, with three of the five projects making savings here. These arose from the use of less professional time, with relatively more costly professional assessments replaced by (albeit mediated) self-assessments. Such savings are thus rather ‘front office’ (Chase, 1978; Tinnilä & Vepsäläinen, 1995) than ‘back office’ efficiencies in terms of what happens during the assessment process and who provides the assessment. As a related gain, at least one project used less qualified/assistant staff rather than occupational therapists to support the self-assessment process, freeing more qualified staff to focus on service users with complex needs. Little is known about the effects of such substitution on service users’ dependency levels and/or well-being, however, and further research is needed here.

In two of the three projects that incurred cost savings from changed assessment processes, these gains were offset by the cost of providing additional equipment. It is important to note that this was in keeping with these projects’ objectives, which sought to widen service access and enhance service responsiveness. This highlights the fact that such new initiatives may have multiple – sometimes conflicting – objectives. It is also important to make a distinction between the incremental costs of the individual projects (which include investment as well as revenue costs and depend on the number of service users recruited) and the additional costs (or indeed savings) of the self-assessments themselves. Indeed, it is essential that a comprehensive costing approach informs decisions about rolling out such initiatives. Thus whilst our study suggested that potential savings may be made from introducing self-assessment in this setting in terms of the assessment process itself, when investment costs were also taken into account, the overall costs of each pilot rose. However, compared to the overall expenditure on adaptations (Department for Communities and Local Government, 2007), the projects’ capital costs were relatively modest.

How satisfied are service users with self-assessment?
If managers and commissioners are understandably concerned with the need to manage budgets and achieve efficiencies, Lymbery (2000) suggests that service users are more interested in the way services are delivered and whether they meet their needs. With regard to the process of service delivery, this evaluation suggests that there is no reason to believe that the introduction of self-assessment is associated with any change to the generally very high levels of satisfaction
reported with traditional assessment processes. This mirrors the findings of the aforementioned national survey of community equipment users which identified little relationship between how respondents’ needs were discussed (in person, on the telephone or self-assessment on the internet) and how satisfied they were with their equipment/adaptation (NHS Information Centre for Health and Social Care, 2008). Moreover, a review that examined older people’s experience of self-assessment in a variety of settings including social care concluded that they found (supported) self-assessment acceptable (Griffiths et al., 2005).

Conclusion

The above findings highlight some important lessons for commissioners and providers considering the introduction of self-assessment in local authority occupational therapy departments. These include the need to:

1. Clarify what is meant by self-assessment and the roles to be played by any facilitators / mediators.
2. Be clear about the purpose of self-assessment and whether it is intended to substitute for or complement traditional professional assessment processes.
3. Provide alternative arrangements for people who will find it difficult to self-assess.
4. Critically appraise the potential costs and benefits of introducing or expanding the use of self-assessment, recognising that this may involve certain trade-offs.

Designing the service is, however, just the first step. There is then the challenge of translating the vision into practical change on the ground that will ‘make a real difference to the way individuals engage with services and support and, in so doing, make a real difference to their lives’ (Department of Health, 2008b, p.5).

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Providing community equipment and adaptations in adult social care


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