Self-Assessment Models, Practice and Tools within Disability Support Services

Prepared for -

on behalf of the Ministry of Health -

Carol MacDonald

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**Acronyms**

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<tr>
<td>CSCI</td>
<td>Commission for Social Care Inspection</td>
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<td>DSS</td>
<td>Disability Support Services</td>
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<td>FFACS</td>
<td>Fair Access to Care Services</td>
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<td>IB</td>
<td>Individual budget</td>
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<td>IBSEN</td>
<td>Individual Budgets Evaluation Network</td>
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Executive Summary

This report was compiled for NZNASCA on behalf of the Ministry of Health to inform the implementation of the new model/framework to support disabled people. It comprises three parts: a literature and document review of international self-assessment best-practice; a stock-take and analysis of self-assessment practice in New Zealand; and recommendations and on design and implementation of self-assessment for the New Zealand context.

Literature Review

The literature and document review included both published and unpublished material, where available. A challenging aspect of the review was that ‘self-assessment’ is rarely identified as a specific programme component and has seldom been explicitly studied or evaluated. References to self-assessment tend to be incidental in other published material and where self-assessment has been explicitly addressed, the discussion is largely descriptive in nature.

Because of the limitations of the available literature, much of the material used for the review was sourced from England, and includes some publications referring to groups other than those with disability, such as older people, where they are deemed relevant. A summary of key themes that emerged from the literature are presented below. Fully referenced discussion of each issue is included in the body of the report.

International Background

The use of self-assessment assessment in social care setting is most predominant in England. Three key developments pertaining to self-assessment there are summarised; Direct Payments, In Control and Individual Budgets Pilots. The developments undertaken by In Control have been particularly influential in the development of self-assessment in England.

The difficulty sourcing relevant information from Canada suggests that the use of self-assessment is either not widespread in Canada or that it is not generally addressed specifically in publications. It unclear how many of the provinces include self-assessment as part of their self-managed care programmes.

Literature from Australian sources seldom included specific reference to self-assessments. This was true even for very recent documents pertaining to the Governmental inquiry into disability care and support (Productivity Commission, 2010).

What is self-assessment?

The concept of self-assessment appears to be somewhat problematic. It has a range of meanings and limited evidence base with little work published clarifying its components and its applicability to those receiving community care services. Whilst there is a lack of agreement on the precise meaning of self-assessment key features of the variable definitions include:

• Service user and/or carer led
• Needs are self rather than professionally defined
• Individual’s rights, wishes and goals are upheld.
The preferred definition for this report is that of Qureshi (2006) - “A process in which a person uses information about their goals, circumstances and environment as a basis for decision-making about their future actions and needs for assistance.”

While self-assessment generally has been used across a wide variety of domains, published examples of self-assessment initiatives in social care settings are rare. The limited evidence suggests that, compared to other domains, self-assessment in this domain is:

- More likely to be user initiated and interpreted
- More likely to aid decision making on behalf of the user
- Substantively different from face-to-face assessment
- Relates primarily to practice and research settings
- Directed at particular groups, such as carers, older people, and people with learning difficulties
- Highly variable in its purpose, including identifying individual needs as part of a professional assessment or as an alternative to professional assessment
- Primarily located within occupational therapy services for the provision of minor equipment and adaptations, or within assessment and care management arrangements
- Predominantly paper-based, but increasingly computer or web-based.

**Self-assessment tools**

Self-assessment lies at the heart of self-directed support. Within the In Control model, the self-assessment questionnaire (SAQ) provides the basis for the Resource Allocation System (RAS) and it is this model that the majority of local authorities in England have adapted for their own purposes. While there are various versions of the In Control SAQ in use, all feature the domains: meeting personal care needs; relationships; community participation; work, leisure and learning; making decisions; staying safe from harm; complex needs and risks; family carer.

Those using the SAQs have expressed reservations about:

- Its simplicity and ‘narrow focus’
- The risk of people underestimating the nature and complexity of their needs
- Its ability to provide enough information to understand potential risks
- A focus on the ‘here and now’ without enough context and background.

Paper-based assessments have predominated but are gradually being replaced or complemented by computer or web-based. However there is some evidence to suggest that the use of information technology is not a driver for change in encouraging users to self-assess, with online assessment giving rise to less satisfaction amongst service users.

Clearly, there is a significant challenge in designing a straightforward questionnaire that is:

- In plain language, practical and easy for people to use, but provides sufficient information
- Accommodates the needs of different groups
- Strength-based through the inclusion of goals and the barriers to achieving them
- Holistic and take the needs of the person and their family into account.
Examples of SAQs can be found on numerous websites available as online only and/or paper copy for service users and carers. These range from relatively simple “check box” forms, through to those requiring a person to enter information in a number of free fields, to more lengthy and complex documents.

**What is the user experience of self-assessment?**

It is clear that no single form of self-assessment is suitable for all service users or types of need and central to the use of self-assessment is the question “Does this person have the capacity to do some or all of this?”

Self-assessment appears to be particularly challenging or problematic for certain groups:

- People with high levels of cognitive or affective disorder
- People with fluctuating conditions
- People with learning difficulties
- Vulnerable or frail service users

**What is the user experience of self-assessment?**

The limited literature concerning the measurement of user satisfaction with assessment indicates that service users view self-assessment as acceptable when they are assured of its value and if they have or can seek professional support. Generally the self-assessment forms are seen as user-centred and the processes as holistic and goal-oriented.

Results of the most comprehensive user experience survey of self-assessment show that:

- There was no difference between self or traditional assessments in terms of ease of completion, satisfaction or the collection and sharing of information
- All other factors being equal, on-line completion was the strongest predictor of dissatisfaction or difficulty with self-assessment
- Others who found self-assessment difficult included; Asian service users, people with concerns about their memories and/or individuals who rated their health low
- Males and/or people with low mood were less likely to be satisfied with their assessment (traditional or self).

With respect to carers, there are different approaches to the treatment of their needs within the main service user (self) assessment process and evidence suggests a real danger that the needs of carers can be overlooked. Many of the reported self-assessment processes do not include questions to determine what support carers provided; whether or not they were willing and able to continue providing that level of support; if they were in need of support themselves; or carers’ wishes in relation to employment, training/education and leisure activities.

**What are the outcomes and effectiveness of self-assessment?**

This review found very little research evidence about the effectiveness of self-assessment, particularly with regard to the costs and benefits. Overall, self-assessment appears to have the greatest utility when it complements existing processes rather than substituting them. In this way, it can contribute to the assessment and care planning processes, thereby linking with the personalisation agenda since it facilitates the users’ involvement in the assessment. In contrast,
requiring the user to complete the assessment process alone could be conceived as
disempowering.

In terms of cost-effectiveness, self-assessment has produced mixed results. Some initiatives
have generated greater benefit at less cost, others have been more effective in terms of
enhanced satisfaction, but were more costly, and others proved to be less costly but less
effective. There is, therefore, a trade-off in judging the cost-effectiveness of self-assessment in
policy terms, between whether efficiency savings or enhancement of the user experience is the
preferred aim. The section on implementation and sustainability details a number of factors
which have been identified as important in the implementation and sustainability of innovation
in social care, including self assessment.

**Professional roles and workforce implications**

There is growing debate about the degree to which assessment might be user initiated, user-led
and used directly as a basis for provision without professional involvement.

Self-directed assessment clearly implies significant changes for those currently undertaking
professional assessments. However at this relatively early stage of its use the exact nature of
the changes are yet to be seen. While some have speculated there will be a reduced need for
care managers, in reality authorities who have introduced self-assessment are finding that they
are still needed for a number of key tasks.

While some staff were open to the changes associated with self-assessment, generally the initial
responses were those of suspicion, concern and resistance. Some view the term “self
assessment” as misleading because in practice it usually involves some additional input from
family members, friends or other professionals, who are seen by many as providing essential
support.

A dilemma identified in the review was that requiring caseworkers to conduct assessments and
assist with planning while they are also responsible for allocating budget amounts can create a
conflict of interest that strains their relationships with clients.

It is clear from the literature that for many professionals self-assessment is a challenging
concept - there are mixed views about how it might operate and about the perceived risks
associated with its adoption presents. These concerns would seem to arise from lack of
knowledge of the operational detail of how self-assessment works, a lack of experience with
implementation and the challenge presented by the transfer of power from professional to
service user.

The primary concerns about self-assessment reflected in the literature can be summarised as:

- Individuals will make frivolous or excessive demands
- People may underestimate the nature and complexity of their needs
- People will assess their needs inappropriately and ‘misuse’ allocated resources
- Self-assessment will become a ‘token’ activity
- Service users could lose important face to face contact
- Understanding how self-assessment fits with current processes and eligibility criteria
- Self-assessment will involve balancing an increased demand with a constrained budget
Implementation and sustainability
The only published study found in this review which considered implementation and sustainability of innovation in public sector social care settings concluded that there is no single recipe for successful implementation - no ‘road map for others to follow’. However a number of factors were identified in the study as important in the implementation and sustainability of innovation in social care. These are detailed on pages 48-51.

Stock-take
Telephone interviews were conducted with 18 NASC managers and/or senior executives from 16 NASC contracted agencies (or branches) nationwide. Only one organisation reported using self-assessment, and two utilised modified processes that included elements of self-assessment. A number of others spoke about the occasional use of ‘adapted’ or ‘flexible’ approaches to assessment that incorporated components or principles of self-assessment. Some of the more commonly shared views about self-assessment included:

- Self-assessment involves a person completing their own assessment (with or without support) and providing information from their perspective
- Whilst - current assessments are face-to-face, self-assessment would be largely independent of professional input
- Self-assessment, -as part of a self directed or self managed approach is about empowering the client and giving them more choice and control
- More emphasis needs to be placed on families, networks and the opportunities that these have to provide for support
- Self-assessment needs to use a strength-based model, including strengths, what is being managed well and future goals and aspirations.

Recommendations and discussion
The recommendations and discussion report have been informed by international experience and evidence and practical knowledge of the New Zealand DSS environment. However it should be noted that the use of self-assessment in social care settings is relatively recent, it is not widespread and there is limited documented evidence about the implementation, efficacy and outcomes of self-assessment, particularly as it pertains to DSS. Seven primary recommendations are made for the implementation of self-assessment in New Zealand:

1. That self-assessment for disability support services in New Zealand is introduced in a three-phase incremental approach, as outlined in figure 1.
Phase one:
Pilot self assessment in the demonstration site, within current NASC processes, as an option for service users with low-medium need.

Phase two:
Incrementally roll-out self assessment to other sites building on the lessons learnt from the demonstration site pilot.

Phase three:
Extend the self assessment option to service users with higher, more complex needs.

Figure 1: Recommended approach to implement self assessment in New Zealand

2. - That in the demonstration site self assessment is offered to service users with low-medium need, specifically those only requiring household support, personal cares and/or minor equipment and adaptations.

3. - That preliminary to phase 1, the Ministry of Health engage with the disability community to clarify what service users are expecting self-assessment to deliver.

4. - That a self-assessment questionnaire appropriate for New Zealand is developed building on work already undertaken locally and as an integrated piece of work in the co-development of the new model involving a wide range of stakeholders, including NASC, service users and carers, providers, Maori and other ethnic groups.

5. - That the self-assessment questionnaire is developed as a standard template against the New Zealand standards and criteria to ensure that these continue to be met in the self-assessment process.

6. - That initially self-assessment would be paper-based with alternative mediums offered as tools and processes are refined and validated.

7. - That the effectiveness of self-assessment is formally evaluated in the demonstration then in each site as it is incrementally implemented.

Requirements for implementing self-assessment
Informed by the literature and overseas experience the following are suggested as requirements for implementing self-assessment in New Zealand:

- Clear policy and political mandate
- A clear and agreed understanding of the purpose of self-assessment
- Close links with existing services and relevance to the wider agenda
- A partnership, co-development approach requiring active engagement of support networks and communities
- Managing the scale and complexity of change through a graduated approach with incremental shifts in practice
- Visible and ongoing senior management support and leaders who effectively engage and support staff and the wider community
• Flexibility and adaptability
• Challenging the culture – changing staff perceptions through support and engagement
• Marketing and publicity to engage with and learn from the community and to promote a culture of self-assessment
• Appropriate access to information technology and support
• A robust, independent and ongoing evaluation.
Introduction

In May 2010, the Ministerial Committee on Disability Issues considered a Ministry of Health paper outlining a new model/framework to support disabled people. The Committee agreed to the paper’s recommendations and in June 2010 Cabinet supported the decisions taken by the Ministerial Committee. The recommendations stated that the immediate focus will be on further development of the new model, including:

a. Ongoing consultation with the disability sector on the new model to support disabled people. The Ministry of Health has already begun informal discussions with interested groups on the new model and has received significant positive feedback.
b. Ongoing development of the new model, which will include addressing the policy, operational and implementation issues that it raises. For example, consideration needs to be given to what funding can and cannot be used for.
c. Demonstrating the core elements of the new model at least one or two sites. The most significant part of the demonstration projects will be introducing Local Area Coordinators. The Ministry of Health will continue with existing initiatives to allocate funding rather than supports, expand individualised funding and improve accountability arrangements but will identify opportunities to expand or extend them in the demonstration sites.

(Cabinet Social Policy Committee, 2010)

The model comprises four key components:

a. Information and Personal Assistance, including the core element of Local Area Coordination
b. Allocation of Funding, including greater use of self-assessment and moving toward allocation of indicative funding (but not entitlements) rather than by service type and level

c. Purchasing, including the expansion of Individualised Funding and moving to contracting for more flexible supports
d. Accountability, including a new accountability framework and evaluation of the Demonstration Project.

(Cabinet Social Policy Committee, 2010)

To inform the Allocation of Funding component, the Ministry commissioned a report on self-assessment models, practice and tools within disability support services, including:

a. A literature and document review of international self-assessment best-practice
b. A stock-take and analysis of self-assessment practice in New Zealand, and
c. Recommendations on design and implementation of self-assessment (for Ministry of Health funded clients with intellectual, physical and sensory disabilities who are usually aged less than 65 years).
This report is the culmination of that work and is presented in three parts: Literature Review; Stock-take; and Recommendations.

**Part one: Literature Review**

**Background and Scope**

This review seeks to explore the use of self-assessment models, practice and tools within disability support services. As there have been few published studies of the structure, process or outcome of self-assessment in this area, it also draws on work in other domains and settings where relevant.

Internationally a large volume of work has been undertaken to create self-directed, personalised options of care and support across a range of sectors, such as health, disability and aged care. Since the 1970’s many initiatives have been implemented in variously configured models representing quite different approaches. These ‘person centred’ approaches have been central to developments in the delivery of health and social care services for people with disabilities in a number of countries including New Zealand, Australia, Canada, the United Kingdom and the USA.

Of particular relevance to the current New Zealand context and the development of the new model/framework to support disabled people, are the strategies of individualised funding (IF) and local area coordination (LAC). The Ministry of Health recently commissioned a literature review to examine the available evidence pertaining to these two strategies (Bennett & Bijoux, 2009).

It is not within the scope of the current report to review these approaches; however, the review of self-assessment models, practices and processes is closely linked to them. Any self-assessment component of these strategies is typically embedded in the larger programmatic model underpinning each strategy. As such, it is usually extremely difficult to disentangle self-assessment as a discrete item for examination (Kendrick, personal communication, 2010).

Because it is essentially part of a larger process, self-assessment is not generally singled-out as a specific programme component and has seldom been explicitly studied or evaluated. As Griffiths and colleagues (2005) note, whereas user involvement in general has been relatively well studied, self-assessment as a specific mechanism has not. Consequently references to self-assessment in the literature tend to be incidental in other published material and where self-assessment has been explicitly addressed, the discussion is frequently of a descriptive rather than analytical nature (Kendrick, personal communication, 2010).

A notable exception is the extensive evaluation study undertaken by the Personal Social Services Research Unit (PSSRU) at the University of Manchester. The PSSRU was funded by the Department of Health to evaluate the efficiency and effectiveness of self-assessment practices in adult care in 13 pilot sites in English authorities between October 2006 and November 2007. This work is represented in the review primarily by publications from Challis, Glendinning, and colleagues.
Method

A comprehensive search strategy was used to identify appropriate resources for use in this review. Documents were sourced primarily through the CCS Disability Action Information Service, Massey University Electronic Library resources and the In Control website.

Literature searches used a range of web-based databases, including:

- PubMed
- Social Care Online
- NARIC
- Clearinghouse for Home and Community Based Services
- NHS Evidence Specialist Collections
- Centre for Reviews and Dissemination – University of York
- CCS Disability Action Library Catalogue
- Massey University databases:
  - Google Scholar
  - Academic Search Premier
  - Medline

Searches used identified country specific keywords and combinations of the search terms were used for searches of material:

Search terms:

- assessment&(service delivery/disability services)
- self-assessment” disability services
- “self-assessment” AND disability support
- self-assessment questionnaire
- “user led assessment” +disability
- user defined assessment
- citizen directed support
- user conducted assessment
- consumer controlled self-assessment
- consumer directed self-assessment
- individualized funding
- self directed support/care
- “direct funding” disability assessment
- consumer directed programme
- “financing, personal” AND “disabled persons”

Searches were also guided by particular types and formats of information, including policy and procedural documents, outcomes and stories from people who have already gone through self-assessment for disability services (formal and non-formal), existing self-assessment tools, and examples of forms and questionnaires.
There were a number of organisations requiring further research, both online and with personal contacts, as they were known by the researchers to work in the disability services field. This included:

- Social Care Institute for Excellence (UK)
- Personal Social Services Research Unit (PSSRU), University of Manchester (UK)
- In Control (UK and Australia)
- Roeher Institute (Canada)
- Social Policy Research Centre, University of NSW
- Aging and Disability Resource Center (US)

Grey literature was sourced with web searches and searching references cited in key articles and reports. Grey sources of information include the FADE Library (NHS), Networked Digital Library of Theses, Quality Mall, Human Services Research Institute, National Association of State Director of Developmental Disabilities Services, Center on Human Policy, and Family Advocacy.

The literature review also considered the following when setting up the search strategy:

- Currency – documents published from 2000 onwards
- Source – a reputable and known researcher and research organisation
- Unknown sources were traced to origin and authenticity confirmed
- Reliability and relevance – all resources were reviewed by the researchers to ensure they were appropriate to the project’s purpose
- Language – English
- Coverage – Australia, UK, USA, Canada, Europe

Comments on the literature searching

- The most difficult process in reviewing results from the literature searches was that ‘self-assessment’ was not often identified as a distinct step in the process of obtaining services and where it was, was rarely investigated by researchers as a separate entity to other processes
- There was very little material on ‘self-assessment’ in the Canadian context – most assessment procedures were only allowed to be completed by professionals with little independent user comment. We could only find two programmes that used a consumer based assessment model - Ontario’s Self Managed Attendant Service Funding Programme and Manitoba’s In the Company of Friends
- Searching for “self-assessment AND disability services” in Australia and the UK leads to information resources on the self-assessment of disability services and organisation by service users.

As a consequence of these limitations in the available literature, much of the material used for this review was sourced from England, and includes some publications referring to groups other than those with disability, such as older people, where it was deemed to be relevant.
International Background

Three approaches to the assessment of need and resource allocation in consumer-directed care projects can be identified in the literature (Laragy & Naughtin, 2009). The first and most common approach is allocate funds following and according to a professionally assessed level of need. A second approach is to develop with the consumer a plan that is later costed. Self-assessment is the third approach recently trialled in England. In this literature search, few direct references to self-assessment processes were found outside of the English experience.

England

As noted above, much of the literature sourced for this review relates to developments in social care in England. Whilst it is not within the scope of this review to describe these changes in detail, a brief summary of three key initiatives provides a context for the following discussion.

Direct payments

Direct Payments were introduced in 1997 and allowed local authorities to make cash payments, or a combination of cash and services, to people eligible for social care in lieu of local authority commissioned social services. Initially this applied only to disabled people aged between 18 and 65 who were willing and able to take responsibility for their own care arrangements. From 2000, eligibility was extended to people aged over 65, and from 2001 to carers, parents of disabled children, and to 16-17 year old young people. Since 2003, there has been a duty on local authorities to offer Direct Payments to people eligible for social care (Hudson & Henwood, 2009).

In 2006-07 Direct Payments accounted for 7% of net expenditure on community services (Hudson & Henwood, 2009) and although the number of people receiving direct payments more than doubled from an estimated 15,000 in 2003 to 37,000 in 2005, direct payment users still represent only 2.5% of all adults receiving community-based social care services in England (Glendinning, et al., 2009). Take up of direct payments remains patchy both geographically and with variation between different user groups (Hudson & Henwood, 2009).

In Control

Established as a social enterprise organisation in 2003, In Control conceived and developed the concept of a “personal budget” to use within a new model of active citizenship and self-directed support. Local authorities can join In Control as members, and the vast majority have done so (122 out of 150 in 2009) (Hudson & Henwood, 2009).

The In Control approach encourages self-assessment; the allocation of resources to individuals according to relative levels of need; transparency about the resources allocated to each person; and support in planning how to use those resources to meet individual priorities (Glendinning, et al., 2009). In Control encourages flexibility and the use of a wide range of ordinary community-based services and supports and has a broad aim of redesigning social care systems towards ‘self-directed support’ (Duffy, 2004; 2005). Boxall et al. (2009) describe the In Control model as exceptional, and probably unique, among individualised funding initiatives in attempting to create a system based on early awareness of financial entitlement, with the individual budget (IB) determined at the outset on the basis of a score from self-assessment.
**Individual Budget Pilots**

In November 2005, it was announced that IBs were to be piloted in 13 sites across 11 English local authorities between 2006 and 2008 for: people with physical or sensory impairments, learning disabilities, mental health needs and older people (Glendinning et al., 2009).

Three research units collaborated to evaluate the pilots (known as the IBSEN project – the Individual Budgets Evaluation Network) – the Personal Social Services Research Unit (LSE, University of Manchester and University of Kent), the Social Care Workforce Research Unit (King’s College, London) and the Social Policy Research Unit (University of York). The central aim of the evaluation was to identify whether IBs offer a better way of supporting disabled adults and older people than conventional methods of resource allocation and service delivery; and, if so, which models work best for which groups of users (Hudson & Henwood, 2009).

Although there is some variation in how they are conceived, IBs have generally been defined as a sum of money allocated to eligible individuals for them to decide to spend as they wish in order to provide the ‘package of support’ they want (Boxall et al., 2009). Two key characteristics of IBs include that they may include funding from a range of funding streams and that through a ‘resource allocation system’ (RAS) service users very quickly know what their entitlement is.

The IB can be used to secure a flexible range of goods and services, from a wider range of providers, than was possible through either direct payments or conventional social care services. For example, an IB may be used to pay informal carers (including close relatives living in the same household), or to purchase goods or services from local authorities – opportunities not normally available to users of direct payments (Glendinning, 2008).

While ‘personal budgets’ of the type pioneered by In Control had focused on social care funding, the IB pilots attempted to bring together additional funding streams (Access to Work; Independent Living Fund; Supporting People; Disabled Facilities Grant; local Integrated Community Equipment Services) (Hudson & Henwood, 2009).

Most of the pilot sites have variants self-assessment questionnaires developed by In Control, and service users are completing the forms with help from their care manager, support worker, family or friends. Some sites, however, still regard self-assessment as too risky. (Henwood & Hudson, 2007a).

**Canada**

In Canada, home care programmes have been funded by Canadian provinces for over three decades. Home care refers to the provision of health and social services designed to support living at home for those who are ill, disabled, or dying (MacAdam, 2004). The programmes are similar across Canada in a number of features: entry to all home care services is by way of a provincially designated public or quasi-public agency, eligibility for any type of home care is based on needs as determined by a provincially uniform assessment and care planning process, all provinces offer a case management service, and all have a single provincial or regional administrative structure (MacAdam, 2004).
In 2004, seven provinces and one territory (Quebec, British Columbia, Alberta, Ontario, Manitoba, New Brunswick, Newfoundland, and the Northwest Territories) offered self-managed care models of care in addition to traditional provider models (MacAdam, 2004).

Spalding and colleagues (2006) identified 16 documented self managed home care programmes in which clients are directly funded to purchase services from providers of their choice. The programmes vary significantly in terms of the population served, degree of self determination, and funding mechanism. The range of clients using self managed home care programmes include; children and families with continuing care needs, adults with physical disabilities, adults with chronic illnesses, and adults with developmental disabilities.

However it is unclear how many of the provinces include self-assessment as part of the programmes. Spalding and colleagues (2006) noted that there was considerable variation in the process of assessing eligibility and needs. In some programmes, assessment was undertaken by professionals, in others, consumers have a more active and participatory role, but it does not appear that any of these could truly be described as self-assessment.

The Public Health Agency of Canada funded a project initiated by the Kendrick Report Coalition (KRC) to investigate best practices for two alternatives to traditional forms of disability supports: self-management and supported decision-making. The project included a literature review of programmes in Canada and internationally, and consultation within Nova Scotia (KRC, 2005). The authors commented that

A unique feature of the Ontario self-management program delivered by the Centre for Independent Living in Toronto (CILT), lies in the selection process which emphasizes self-assessment by having individuals define the types of services required, create budgets and demonstrate self-management ability (KRC, 2005, p.4).

This comment suggests that the use of self-assessment is either not widespread in Canada, or it may be that it is simply not addressed specifically in publications. In a recent report which included a review of seventeen funding models in Canada and internationally, Chopin and Findlay (2010) described programmes across the provinces, including the range of assessment practices. No mention was made, however, of self-assessment.

The CILT self-assessment for Direct Funding is not particularly user-friendly with a strong focus on budget planning and funding (http://www.cilt.ca/funding_app.aspx).

Australia

Literature from Australian sources seldom included specific reference to self-assessments. This was true even for very recent documents pertaining to the Governmental inquiry into disability care and support (Productivity Commission, 2010).

In 2010, the Australian Government asked the Productivity Commission to undertake a “public inquiry into a long-term disability care and support scheme and advise on a scheme that will cover those most in need, with a disability present at birth, or acquired through an accident or
through a health condition, but not as a result of the natural process of ageing” (Productivity Commission, p.1).

Consumer Directed Care is planned for all Australian Government funded Packaged Care Programmes. The model is an individual budget based on a needs assessment and administered on the care recipient’s behalf for an agreed percentage of the allocated budget (Department of Health and Ageing, 2010). It is questionable whether self-assessment has a role in this new model. The information document clearly states that an individual budget will be based on a “care recipient’s needs as assessed by the packaged care provider” (Department of Health and Ageing, 2010, p. 5).

The Australian Federation of Disability Organisation (AFDO) submission also suggests that self-assessment is not a common component in Australian processes. They propose that “the main goal of assessment should be letting the person with disability provide information. If the person needs assistance to do this, they should be given the choice to nominate a support person, who should be as independent as possible from the outcome, such as a friend or family member, and not a care worker or service manager. Formal assistance should also be available for those who request it” (AFDO, 2010, p.).

Even the In Control Australia submission to the Productivity Commission inquiry into disability care and support has little to say about self-assessment beyond that the eligibility for the new scheme must be assessed by a framework which has the capacity to stand as a framework for the development of self-assessment and monitoring/appeals tools (In Control Australia, 2010).

In the absence of clear evidence to the contrary, it appears that self-assessment does not have a key role in Australian disability care and support programmes.

**What is self-assessment?**

The process of assessment, is the collection of information on people’s specific needs, problems and preferences, is central to the planning and delivery of social care and health services in the widest sense (Challis et al., 2009). Ensuring that the process is personalised and accessible is “important in terms of both individuals’ experiences and resource allocation, providing the basis on which needs are identified and services are commissioned” (Challis et al., 2008b, p.4).

The “Personalisation” and ‘Self Directed Support’ agenda are progressing rapidly (Clements et al., 2009) and require new ways of assessing people in order to offer a greater degree of choice, control and individually tailored approaches to people who may require personal support or assistance (Cm 6737, 2006). The principle that people should be supported to identify their own needs is the starting point for self-directed support, and is a fundamental principle that gives practical effect to the idea of transferring power from the professional to the service user and their carers (Henwood & Hudson, 2007b). John Waters of In Control recognises this challenge, commenting that self-assessment is possible but that it requires professionalism to let go of power and control. Further, that it:

...threatens professional power and there is a cultural challenge to accept a system based on trusting disabled people. In the UK ‘assessment’ is the only legal entitlement for a citizen and duty for the govt, in relation to social care, so
without replacing these with better alternatives...there is a risk that a shift towards self-assessment erodes statutory protection (John Waters, personal communication, 2010).

Although self-assessment has been identified as a key mechanism to achieve greater involvement of service users as active participants in health and social care (Griffiths et al, 2005), little agreement on the precise meaning of the term emerges from the literature. Occasionally used to simply refer to self-report, self-assessment has been variously defined as:

- Service users and carers undertaking the assessment, usually applying predetermined processes and criteria (Whittington, 2007)
- Assessment that is completed by the subject of the assessment without the immediate involvement of professionals’ (Griffiths et al, 2005)
- The idea that an individual controls the assessment of their need for social care support (Clements, 2008)
- Locating the individual at the heart of their assessment with their rights, wishes and goals upheld, with a notion that needs are self rather than professionally defined (Clarkson et al., 2010)
- Assessment undertaken by disabled people of their own needs. The principle underlying this process is that disabled people understand their own needs better than social workers (Renshaw, 2008)

The following definition is preferred for the purposes of this report:

A process in which a person uses information about their goals, circumstances and environment as a basis for decision-making about their future actions and needs for assistance (Qureshi, 2006, p1.)

As Challis et al. (2008c) note, this definition contains both the perceived potential benefits of self-assessment, that it may help in assisting the person to clarify goals that are important to them, and also the difficulties and complexities, that the decision-making function of assessment leads to challenges in terms of who is required to make the decisions regarding resource allocation.

The concept of self-assessment appears to be somewhat problematic. It has a range of meanings and limited evidence base with little work published clarifying its components and its applicability to those receiving community care services (Griffiths et al., 2005; Qureshi, 2006).

Self-assessment generally has been used across a wide variety of domains and for a number of purposes ranging from targeted screening for specific medical disorders through to approaches designed to help individual decision-making in relation to major life events such as changing accommodation (Griffith, 2005). However much of the literature has focussed on the use of case-finding in general practice and has been undertaken within the tradition of research enquiry (Challis et al., 2010).

Self-assessments can be categorised according to their content in relation to health and social care and according to the extent to which they focussed on single or multiple problems. They can be located at various points in the assessment process (Challis et al. 2008b) and potentially
might directly substitute for, prepare for, be a part of, or be subsumed into, professional assessment (Qureshi, 2006).

In their review of the use of self-assessment Griffiths et al. (2005) found that in the majority of focussed health related assessments, self-assessment substituted for professional assessment, and in most cases was simply a mode of administering a screening test without having face-to-face contact. Most self-assessments in health were professionally initiated and interpreted (Griffiths, et al., 2005).

Although fewer in number, there is more variety in the general health assessments identified by Griffiths et al. (2005). Examples include paper and pencil questionnaires, self-assessment algorithms and web-based systems with feedback. There was more autonomy in the use of the assessments, with some examples being entirely user directed from initiation to action. Frequently the goal was to improve management of healthcare in general and to mediate relationships with professionals (Griffiths, et al., 2005).

While published examples of self-assessment initiatives in social care settings are rare, Challis et al. (2008c) identified a number of recurrent themes within the emerging literature. They found more variety and reported that many of the examples identified were substantively different from face-to-face assessment. They found that self-assessments in this domain are more likely to be user initiated and interpreted and to aid decision making on behalf of the user.

The use of self-assessment in social care settings relates primarily to practice and research settings and has been directed at particular groups. The focus of interest has been on carers, older people as part of the Single Assessment Process (SAP) (Griffiths et al., 2005) and people with learning difficulties through the In Control programme of self-directed support (Duffy, 2004; 2005).

The function of self-assessments varies, with a number related to the carer role, such as to assess carers’ needs, help practitioners support carers, identify carers requiring professional assessment and to help carers prepare for professional assessment (Challis et al., 2008c). The purpose of most self-assessment within SAP was to identify individual needs as part of a professional assessment. Other tools, such as EASY-care (Philp, 2000 as cited in Challis et al., 2008c) and the Cambridgeshire Assessment Tool (Purdie, 2003 as cited in Challis et al., 2008c) were piloted as alternatives to professional assessment. The Knowsley Overview Assessment was designed to be wholly self completed (Moss, 2003, as cited in Challis et al., 2008c). In each of these cases, it is the professional who initiates, interprets and acts upon the assessments (Challis et al., 2008c). In contrast, the developing models of self directed support for disabled people enable people to both assess their own needs and develop their own support plans (Challis et al., 2008c).

The location of self-assessment also varies. Within SAP and self-directed support initiatives, self-assessments sit within assessment and care management arrangements, others are located within occupational therapy services. Indeed as Challis et al. (2008c) point out, the use of self-assessment in the provision of minor equipment and adaptations has attracted considerable attention and a number of councils offer a restricted range of services on this basis.
Internationally this is probably the most common use for self-assessment in the social care domain.

Paper-based assessments have predominated but are gradually being replaced or complemented by computer or web-based approaches (Challis et al., 2008c; Whittington, 2007). There are two internationally recognised online assessment systems, the Self-assessment Rapid Access (SARA: AskSara website) and the ADL Smartcare (ADL Smartcare website). Through both systems individuals are able to assess their need, and access information on simple pieces of equipment, initiating, completing and acting upon the assessment themselves. Both are discussed in more detail later in the report.

The potential benefits of user self-assessment have also been noted in the literature. Whittington (2007) suggests the following possible gains:

- Recognising and using the expertise of service users and carers
- Challenging cultural values about the dependency of particular groups
- Guiding people to sources of help and clarifying eligibility
- Where online methods are used, providing 24-hour access to assessment
- Providing an early alert to need
- Speeding up provision by removing the wait for professional assessment
- Enabling service users to prepare for professionally conducted assessment
- Obtaining an evaluative check on services currently being used.

(Whittington, 2007, p.48)

Similarly, Qureshi (2006) maintains that self-assessment recognises and makes use of the expertise of service users, and, sometimes, family carers and that where a person is receiving, or may need, services, self-assessment has the potential to:

- Direct people to suitable/appropriate sources of assistance and give them information about eligibility
- Bypass the need for professional assessment and thus speed up provision
- Enable service users to prepare for a professional assessment, potentially thus increasing their level of involvement and influence
- Enable service users to evaluate the outcomes and process of their existing services.

(Qureshi, 2006, p.1)

**Self-assessment tools**

The way in which potential users are assessed for support is an important influence on self-determination. It is a complex issue and is central to the debate on user control and empowerment.

Self-assessment lies at the heart of self-directed support and, within the In Control model, the self-assessment questionnaire (SAQ) provides the basis for the RAS (Henwood & Hudson, 2007b). In Control created a prototype SAQ that they made available for authorities to adapt for their own purposes. Whilst most authorities start with a different SAQ for different groups, the aim is to get a single self-assessment system that does not distinguish between groups (Browning, 2007).
Within the IB pilots, different models are being trialled and there are various SAQs in use, but all feature a number of ‘domains’ or areas of life. Each domain is then divided into ‘fields’, which reflect different abilities within each domain. Each field is scored, and the greater the need, the higher the number of points allocated (Browning, 2007). The In Control Fact Sheet describes the domains as:

- Meeting personal care needs – looking after yourself: for example, eating, washing, dressing, shopping
- Relationships – family, friends, people you know
- Being part of the community – for example, using local shops, the library, clubs, community centre, church or other place of worship, helping neighbours, being involved in local organisations
- Work, leisure and learning – having a job, learning new things and enjoying life
- Making decisions – who decides important things like where you live, who supports you, who looks after your money
- Staying safe from harm – for example, when you’re going out on a bus, using a gas cooker, or going down stairs
- Complex needs and risks – can your behaviour be dangerous for you or other people?
- Family carer – if someone in your family supports you, what effect does supporting you have on them?

(In Control Fact Sheet 3)

The experience of three localities is described by Henwood and Hudson (2007b) who undertook in-depth qualitative case studies to investigate the progress of implementing self-directed support (SDS). SAQs went through various iterations and were tested out in desktop exercises and planning live sessions. In the IB pilot site, in line with the requirements of the IB evaluation, people were allocated to IBs on a randomised basis, elsewhere the new approach to SDS was being phased in, starting with clients being reviewed but with an expectation of subsequently rolling the system out to new people entering the social care system (Henwood & Hudson, 2007b).

Evidence suggests that funders and service providers struggle with developing and implementing an assessment process for IF (Lord Hutchison, 2003). In a study of five of the English councils, Henwood and Hudson (2009) found that none had a settled approach to the SAQ and most expressed reservations about the accuracy of such assessments. One council, using a very early version of SAQ as part of an In Control pilot, concluded that the exercise had not generated a clear understanding of needs. Specifically, the evaluation of this pilot found that the SAQ:

- Did not provide enough information about the person, leading to difficulties in reconciling the SAQ with Fair Access to Care Services (FACS) criteria
- Did not provide enough information to understand potential risks, thereby compromising the ‘duty to care’
- Focused on the ‘here and now’ without giving context and background.

(Henwood & Hudson, 2009)
Those using more recent versions of SAQ also had reservations, especially professionals who often compared it unfavourably with their own professionally led procedures. A particular concern was that people using services would underestimate the nature and complexity of their needs. Others thought the main problem with the SAQ was its simplicity, especially in responding to people with more complex needs. Service users in the study expressed concerns about the “narrow focus” of the SAQ and felt that it had been “lifted from the learning disability field” (Henwood & Hudson, 2009).

“I’m not happy with the assessment form. It’s lifted from the learning disability field so there’s a lot of stuff around supervision, monitoring, safety issues and questions around that. There aren’t actually that many questions around other things.” (Person using services) (Henwood & Hudson, 2009).

The potential for increased internet access to facilitate user involvement in assessment has been recognised, however, Loader et al. (2007) suggest that this could further privilege already advantaged service users. In user-centred services increasingly driven by technology and the ability to understand and navigate information systems, there could be an uneven distribution of provision based upon technological access and confidence rather than assessed need.

Within the self-assessment projects overall, the use of information technology was not as successful or important as had initially been anticipated. 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. In fact, people accessing online 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 (Challis et al., 2008b).

Clearly there is a significant challenge in designing a straightforward questionnaire that is easy for people to use, but provides sufficient information; and accommodates the needs of different groups. A key learning from In Control was to “keep the whole thing simple so people can understand it and the assessment is viewed as fair by the person their family” (Waters, Personal communication). The In Control SDS fact sheet states that the self-assessment form:

• Should be practical and easy to answer
• Must take the needs of the person and their family into account
• Should make clear what outcomes the local authority expects you to achieve if you have the right support
• Should tell you if you are entitled to other kinds of funding
• Should trigger a benefit check, so you can make sure you are getting everything you are entitled to.

(In Control Fact Sheet 3)

Similarly, community consultation in Nova Scotia (Wallace, 2005) indicated that people want assessments that are; in plain language, individualised and based on wants and needs, holistic (focused on all aspects of a person’s life), and used to inform the provision of flexible services, and seamless supports between life transitions.
Further more, Browning (2007) suggests that different scoring systems may be needed for different groups (people with mental health problems, and people with physical or learning disabilities) as issues that may be important for one group may be less so for another. Whether there should be different versions of SAQs to address different client groups is, however, a matter of on-going debate. Henwood and Hudson (2007b) found that even if it was decided to use a unified SAQ, this did not necessarily lead to comparable allocations under the RAS, which raises major questions about equity between different needs.

**Examples of Self-Assessment Questionnaires**

Examples of SAQs or SSAQs (supported self-assessment questionnaires) can be found on numerous websites. Some SAQs are available online only, some as paper copy only and others as both. In a number of instances, websites also provide carers SAQs. The assessment tools range from relatively simple ‘check box’ forms, to those requiring a person to enter information in a number of free fields, through to more lengthy and complex documents, such as the 40 page Tennessee Personal Assistant Supports and Services Self-Assessment Tool used in the needs assessment process for people requiring the support of a personal assistant to remain in their home (PASS, 2004).

The following are selected examples representing the types of SAQs currently in use. Whilst most will contain questions that may not be appropriate for the New Zealand context, they do provide useful options for review. The accompanying website links were correct at the time of this report going to print. Sample extracts are provided for some of the questionnaires, others are presented in full as appendices.

Online assessments for equipment and/or advice can be found on various English council websites, including a number utilising the AskSARA website. To date at least 11 Local Authorities in England have licensed AskSARA to use in their area, primarily in occupational therapy services. The London Borough of Croydon, for example, uses a customised versions of SARA “that asks a series of questions about your daily life and the difficulties you are having, and gives you tips and information on equipment and minor adaptations to your home” ([http://www.croydon.gov.uk/healthsocial/disabilities/equip/sara](http://www.croydon.gov.uk/healthsocial/disabilities/equip/sara)).

AskSARA is designed primarily for individuals whose situation is not complicated and disability not severe. In Croydon, council services such as meals on wheels, home care, day services or short breaks are not covered by the self-assessment. AskSARA is a simple, highly visual online tool which steps the user through a series of screens under three main headings: Your health, Your Home, and Daily activities. Through a personalised report based on an individual’s responses to the questions, product information and advice is provided to help individuals independently manage their disability needs. The website gives the example -“if having a handrail by your front door would be helpful, or if you are having difficulty getting in or out of the bath, the assessment will generate tips and information on where you can see, try and buy suitable equipment.”

The estimated time for completion is about 30 minutes for most users. Those who wish to complete the online SARA self-assessment but are unfamiliar with computers or who have difficulty accessing the internet (including those for whom English is not the first language and for people with dyslexia) are provided with assistance through Age Concern Croydon.
The following screen samples illustrate the simplicity and highly visual nature of the tool. Starting from the home screen, “Preparing meals, eating and drinking” was selected then “Opening jars, tins, packages or bottles.” In this manner individuals identify the tasks and activities with which they need assistance. The report is then generated to provide information and advice specific to those issues.
Like Croydon, the London borough of Kingston is one of 11 self-assessment pilot sites for people with long-term social care and health needs. Kingston offers disabled and older people the chance to assess themselves for small items of daily living equipment through the online SmartAssist self-assessment tool (ADL Smartcare website). Kingston Council introduced the online self-assessment service as an additional point of access for local services, rather than as a replacement for traditional ways of accessing services.

SmartAssist is primarily equipment related and gives individuals the ability to self-assess for aids to daily living, such as raised toilet seats, bath boards, tap turners etc. Individuals can assess a number of problems by answering three areas of questions and receiving detailed product information matching their specific requirements. Details of where to order/purchase the products are also given.

A number of councils use SmartAssist which is accessed through a common portal - http://www.self-assess.co.uk/saportal. Users must be resident in the council concerned and have to register on the website before progressing through the self-assessment. This is likely to be a deterrent for some people. Whilst this is also a highly visual and relatively simple tool, it is more difficult to navigate than AskSara and appears to have a narrower focus.
In a similar vein, Kent County Council’s website offers two types of self-assessment online; a General Needs assessment for adults who are finding it difficult to manage everyday activities, and a carer assessment to enable a person to assess their needs as a carer.

www.kent.gov.uk/adult_social_services/your_social_services/advice_and_guidance/assess_your_needs_online.aspx

The general self-assessment allows people to determine their eligibility for support, and if eligible, to select from a range of equipment matched to their needs.

http://www.sa.kent.gov.uk/ufs/ufsmain?esessionid=1&RG=GR1112&formid=SAP&esessionid=1

The questionnaire starts with an indication of the key domains people may be having difficulty with then progresses through series of screens asking for greater detail, including general health questions. On the basis of the responses given, a report is produced which details the services and/or equipment the individual may be entitled to.
What are the situations where you think you may need help?

Below we have listed some areas where, if assistance is needed and is eligible, we can provide equipment or services to help you. You can tick as many categories as you find necessary, so please tick all that apply to you. We will then ask some questions. There are no right or wrong answers. To help us plan your package, here is a list of details of what is needed in the categories:

**Getting in to and around the home** - If moving around your home is difficult please choose this category.
- Using the stairs
- Using the toilet
- Using the bathroom
- Getting in or out of bed
- Getting in or out of the car
- Using the telephone

**Using the kitchen** - If you find it difficult to prepare food and eat meals please choose this category.
- Using the microwave
- Using the refrigerator
- Using the oven
- Using the toaster
- Using the kettle

**Using the bathroom** - If you have difficulty getting in and out of the bath or toilet please choose this category.
- Using the step
- Using the grab stick
- Using the sink

Reminder to tick all the categories that apply to you.

<table>
<thead>
<tr>
<th>Category</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting in and around the home</td>
<td></td>
</tr>
<tr>
<td>Using the stairs</td>
<td></td>
</tr>
<tr>
<td>Using the toilet</td>
<td></td>
</tr>
<tr>
<td>Using the bathroom</td>
<td></td>
</tr>
<tr>
<td>Getting in or out of bed</td>
<td></td>
</tr>
<tr>
<td>Getting in or out of the car</td>
<td></td>
</tr>
<tr>
<td>Using the telephone</td>
<td></td>
</tr>
<tr>
<td>Using the kitchen</td>
<td></td>
</tr>
<tr>
<td>Using the microwave</td>
<td></td>
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<tr>
<td>Using the refrigerator</td>
<td></td>
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<tr>
<td>Using the oven</td>
<td></td>
</tr>
<tr>
<td>Using the toaster</td>
<td></td>
</tr>
<tr>
<td>Using the kettle</td>
<td></td>
</tr>
</tbody>
</table>

Using the kitchen

Are you able to prepare a meal for yourself? *

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to prepare a meal</td>
<td></td>
</tr>
<tr>
<td>I find it difficult and have trouble STANDING when preparing food or drink</td>
<td></td>
</tr>
<tr>
<td>I find it difficult or I can't for another reason that I have explained below</td>
<td></td>
</tr>
</tbody>
</table>

You can use this box to give us more information.

<< BACK  NEXT >>
Kent County Council’s carer self-assessment is very similar to that for service users. Through a series of screens, the carer is asked questions about the person or persons they care for, the type of care provided, and if they feel that they can continue to provide it. As the following sample screens illustrate, the carer selects the answer that most describes their situation and can, in some instances, provide more detail in a free text box.
As noted above, the majority of local authorities in England have developed variants of the
generic In Control self-assessment questionnaire. In Control SAQs provide the basis for the RAS
covering eight key domains: meeting personal care needs; relationships; community
participation; work, leisure and learning; making decisions; staying safe from harm; complex
needs and risks; family carer.

The format is relatively straightforward with multiple choice type questions for each domain.
The following extract is from the “Making Decisions” section of the In Control model SAQ (a
copy of the full SAQ is attached as Appendix 1).
(http://217.154.230.218/NR/rdonlyres/D7EB7F27-65FE-4A80-98CC-
8634AF604A08/0/SS_HSelfAssessmentQuestionnaireSAQ.pdf)

5 Making Decisions
This part is about who decides important things in my life – things like where I live, who supports me, who looks after my
money.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>To take more decisions about things important to me.</td>
</tr>
<tr>
<td>2</td>
<td>To take the decisions that are important to me.</td>
</tr>
<tr>
<td>1</td>
<td>To carry on making decisions with good advice.</td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

The version being used by Hartlepool Borough Council to help them allocate personal budgets is -
considered to be “one of the best and most used self-assessment questionnaires in the country” -
(In Control website; John Waters, personal communication). The Hartlepool SAQ is a more extensive (18 page) document that builds on the In Control model SAQ. It is the means by which people begin to define and plot out a profile of their needs and begin to think in a systematic way about what it is that they want from life and how they might take control (Tyson, 2010).

The similarity to the original In Control model SAQ can be seen in the first extract below. The second and third extracts illustrate two of a number of additional questions which have been added to the Hartlepool SAQ, including sections covering: Eligibility Criteria, Current Support, Income and Accommodation. A copy of the full questionnaire is attached as Appendix 2. (www.in-control.org.uk/DocumentDownload.axd?documentresourceid=756)

5. Making important decisions about life

This part is about who decides important things in my life – things like where I live and who supports me.

Tick the box that fits you best

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need any support in this area.</td>
</tr>
<tr>
<td>I need support to make decisions but I have full control over all day-to-day and life changing decisions.</td>
</tr>
<tr>
<td>To maintain opportunities to make supported decisions.</td>
</tr>
<tr>
<td>I need support to make decisions. I have control over most day-to-day decisions but less say in life changing decisions.</td>
</tr>
<tr>
<td>To have control over life changing decisions.</td>
</tr>
<tr>
<td>I need support to make decisions about my life, but most day-to-day decisions are taken by other on my behalf.</td>
</tr>
<tr>
<td>To take more control over day-to-day decisions.</td>
</tr>
</tbody>
</table>

Additional Information
The Reading Borough Council online Self-Assessment/Self-Referral Form is for disabled adults and older people. It is not available in hard copy. [https://secure.reading.gov.uk/forms/ShowForm.asp?fm_fid=324](https://secure.reading.gov.uk/forms/ShowForm.asp?fm_fid=324)

Individuals are given the choice to either apply for a full assessment directly without going through the self-assessment process, or “follow the self-assessment process to see instantly if you (or someone you are concerned about) could be eligible for help from Community Care Services and then apply online if you want to.” As the following extracts illustrate, this is a relatively simple form which asks a series of basic questions about an individual’s health and abilities. The assessment is relatively comprehensive covering a number of key domains. [http://www.reading.gov.uk/healthandsocialcare/communitycareservices/learningdisability/General.asp?id=SX9452-A7814FA2](http://www.reading.gov.uk/healthandsocialcare/communitycareservices/learningdisability/General.asp?id=SX9452-A7814FA2)

### Quality Of Life Questions

This information needs to be collected so that we can find out what the benefits are in taking up Self Directed Support.

You can complete this section yourself or it can be filled in by someone else such as a Care Manager.

Please answer ALL questions by ticking the relevant boxes:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the past year, would you say your health has been:</td>
<td>Very good, Fairly good, Not good</td>
</tr>
<tr>
<td>2. Do you feel safe when you are at home?</td>
<td>Very safe, Fairly safe, Fairly unsafe, Very unsafe</td>
</tr>
<tr>
<td>3. Do you have enough money to lead the life you want?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough</td>
</tr>
<tr>
<td>4. Do you have the right amount of control over your life?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough, Don’t know</td>
</tr>
<tr>
<td>5. Do you have the chance to be with the people you like being with?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough</td>
</tr>
<tr>
<td>6. Thinking of your whole life, would you say that you are:</td>
<td>Very happy, Fairly happy, Fairly unhappy, Unhappy</td>
</tr>
</tbody>
</table>
Similarly, Islington Council provides adults who are finding it difficult to manage everyday activities with the option of initiating a needs assessment process online. - http://www.islington.gov.uk/eFormASSD/MainForm.aspx. This is also a relatively-
straightforward form that progresses through a series of questions to which respondents select one of five responses to indicate their current circumstances:

- I cannot do this
- I can do this on my own
- I need help with this
- A carer (friend/relative) helps me with this
- I already have help from the Social Services with this

The London Borough of Sutton SAQ is also used to initiate the assessment process and is followed up by phone contact and/or a visit. This SAQ is typical of many others using the multiple choice style format. The questionnaire asks the person to select the answer to each question that best describes their circumstances and has a section on each page for them to add more comments if they wish. Where it differs from many other forms, is that it provides an opportunity for an unpaid carer (family or friend) to give a response to each question and has a third space is for a final score “agreed” between the parties, including the professional assessor. This variation from the In Control model SAQ can be seen in the following extract, also from the “Making Decisions” domain.

https://spocc.sutton.gov.uk/LBSPORTAL/Downloads/Sutton%20Supported%20Self%20Assessment%20Questionnaire.PDF
The Sutton SAQ has a separate, comprehensive guidance document that is sent with the DSAQ explaining what each question is about. The section corresponding to the “Making Decisions” domain is presented below.

What is the user experience of self-assessment?

Clarkson et al. (2010) note that whilst arguments have been put forward as to the broad benefits to users of a more participatory model of assessment, particularly self-determination and self control, data on these aspects are difficult to collect. Consequently the literature concerning the measurement of user satisfaction with assessment is sparse, and particularly so for self-assessment in social care and life skills (Challis et al., 2008c; Griffiths et al., 2005). A review of the literature led Challis et al. (2009) to conclude that:

The measurement of user satisfaction poses some rather contradictory challenges: it is methodologically straightforward and very easily implemented, but its tools nevertheless require cautious interpretation; it is widely propagated as desirable and therefore has become an omnipresent feature of service delivery, yet it is also hotly debated and often derided for its naivety (Challis et al., 2009, p.5).

These difficulties notwithstanding, there are some lessons to be gleaned from the limited literature. In two reviews which focused on people’s experiences of self-assessment in a variety of settings including social care, people considered self-assessment acceptable when they had direct support from a health professional (Griffiths et al., 2005) and when they were assured of its value and if they could seek additional professional help (Harris et al., 2006).

In a study of early IB users, Rabiee and colleagues (2008) reported that most interviewees found the self-assessment forms to be user-centred. Previous experiences of assessments, in which professionals decided what they needed, were reported to focus on what they could not do; but IB self-assessment and support planning were felt to be more about what they could and wanted to do. The processes were also felt to be holistic and encouraged people to think creatively about what they wanted to achieve.

Although some interviewees found the IB self-assessment form simpler than other self-assessments, several reported difficulties in completing it. These included questions that were difficult to understand, concepts that were subjective and open to interpretation and questions to which more than one answer applied. Some interviewees were also very concerned that giving wrong answers could have implications for the level of their IB (Rabiee et al., 2008).

The most comprehensive user experience survey was conducted in nine of the self-assessment pilot sites as part of the PSSRU study (Challis et al., 2009). It included more than 1,800, people accessing occupational therapy and preventive, assessment and care management services. The key findings of the study are summarised below:

- The majority of self and traditional assessment recipients found their assessment easy to complete and expressed a high degree of satisfaction with their experience
- Whilst there was considerable variation between pilots in the collection and sharing of information, there was no suggestion that either self or traditional assessments are better at this per se
- Users of online self-assessment found their assessment more difficult and less satisfying than did respondents participating in other forms of self or traditional assessment. All
other factors being equal, those completing on-line assessments were predicted to be six times more likely to find the assessment difficult and five times more likely to be dissatisfied.

- Socio-demographic and contextual variables predicted little of the variation in users’ satisfaction, however
  - the completion of an on-line self-assessment was the strongest predictor of dissatisfaction or difficulty with self-assessment. Challis et al. (2009) suggest a possible explanation for this finding may be that the tools trialled were suboptimal for the service users they were tested on.
  - Asian service users, people with concerns about their memories and/or individuals who rated their health in the lower three categories also found it more difficult to self-assess
  - males and/or people with low mood were less likely to be satisfied with their assessment (self or traditional).

The authors conclude that the main lesson to be learnt from these findings is that:

Self-assessment, while undoubtedly widely applicable, may ultimately not be for everyone. In their wish to drive forward the personalisation agenda, the policymaker must still leave some room for selectivity. Some user groups are likely to have legitimate reasons for needing extra help during the assessment process, or for having tools tailored to their needs, or indeed for being exempted from self-assessment. Insisting in such cases on unassisted forms of self-assessment would turn the very logic of the personalisation agenda on its head, emasculating rather than empowering service users in the process (Challis et al., 2009, p. 16).

**Is self-assessment for everyone?**

No single form of self-assessment is suitable for all service users or types of need. Some service users and carers may prefer an autonomous self-assessment, others peer-supported self-assessment while still others may seek professionally supported self-assessment or assessment led by a professional (Whittington, 2007).

Central to the use of self-assessment is the question “Does this person have the capacity to do some or all of this?” (Brewis, 2007). As Henwood & Hudson (2009) point out, the true test of the “personalisation” model is whether it

Can work for people whose support needs are straightforward and stable, but whether it can also do so for people with complex, unstable, unpredictable needs, and where their capacity to indicate preferences may be limited (p.7).

Challis and colleagues (2008b) doubt the utility of self-assessment in groups with high levels of cognitive or affective disorder and suggest that existing assessment processes will continue to be required for frail service users. Findings from their study show that those who avail themselves of the opportunity to self-assess are atypical of those who hitherto have comprised social service user groups: they are healthier.

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 self-assessing and this was compounded if the assessment was electronic (Challis et al., 2008b, p.19).

A further concern is that people who self-assess may under-report their needs because of their fear of seeming demanding, low expectations or communication problems (Challis et al., 2008c). Challis and colleagues more cautiously (single site and single group data) warn that the difficulties of completing online self-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 (Challis et al., 2008b).

People with fluctuating conditions have reported problems with both self-assessment and planning their support arrangements, because they found it difficult to predict the level of support they would need at any given time. As their condition changed, sometimes quite unexpectedly, so their support needs could change significantly too (Rabiee et al., 2008)

Carers of people with learning difficulties have argued that it was essential to have an advocate involved in assessment and support planning, to explain the self-assessment form; ensure that the individual’s views were correctly represented; and challenge users’ low expectations. This reflects findings that people with learning difficulties may have difficulty imagining alternative arrangements beyond their current situations. Independent advocates therefore appear essential to ensure meaningful and equal participation in assessment and support planning by people with restricted cognitive abilities (Rabiee et al., 2008).

Similarly, Foster and colleagues (2006) argue that, given self-assessment may be problematic for some groups of people with disabilities unless they also have access to high-quality, well-funded, independent advocacy services, it is essential to understand the conduct of assessments, who they are carried out by and the organisational, financial and managerial frameworks that shape the environments within which assessments are conducted.

Henwood and Hudson (2009) found that the major challenges to the operation of RAS were identified in accommodating high cost cases associated with complex needs; problems arising from cost ceilings on support for older people relative to other care groups; and uncertainty over how best to reflect the contribution of carers.

Some people can just fill in the SAQ and we can add up the points, but when you get into the complex packages it’s going to take a long time. You really have to get to know the person (Senior manager) (Henwood & Hudson, 2009, p. 66).

Form their evaluation of self-assessment pilots, Challis and colleagues (2008b) conclude that whilst the standardisation of service receipt consequent on self-assessment may be appropriate for some is not appropriate for all. Their study indicates that for vulnerable 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 the 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 (Challis et al., 2008b, p.21).

The experience of carers

The IBSEN study concluded that there was a danger that carers’ needs for support could be overlooked in the (self-) assessment for service users (Glendinning et al., 2009). With the exception of the one IB pilot site that had developed a separate carer RAS, sites had adopted different approaches to the treatment of carers’ needs within the main service user (self-) assessment process and RAS (Glendinning et al., 2009).

A handful of sites had included a set of questions in the user’s self-assessment aimed at determining what support carers provided; whether or not they were willing and able to continue providing that level of support; and if they were in need of support themselves. Fewer still had included questions in the main service user self-assessment form that specifically addressed carers’ wishes in relation to employment, training/education and leisure activities, as legally required (Glendinning et al., 2009).

There were also reported differences between sites in the approaches to linking service user (self-) assessments for IBs and carers’ assessments. Carer lead officers raised a range of concerns about IB service user assessments:

- Self-assessment forms not including ‘trigger points’ to prompt service users and/or social services practitioners to think about carers’ needs. This risked the latter being overlooked, and/or, in the words of one interviewee, carers’ support needs somehow ‘popping out of the resource allocation machine’
- Carers’ support being treated as an additional service for the service user, rather than services aimed specifically at the carer
- Not enough emphasis in the IB process to the 1990 NHS and Community Care Act and Fair Access to Care criteria, with the risk that councils might begin providing support for carers who, strictly speaking, did not meet local eligibility criteria, with subsequent large financial implications for the council
- Carers’ needs and rights to help in relation to education, training, leisure and work being much more difficult to address within the service user RAS compared with carer breaks.

(Glendinning et al., 2009, p.30).

To address these concerns, a number of carers’ lead officers considered there was a need to develop a separate RAS for carers. A key concern was to ensure that the impact of care-giving on a carer, and carers’ commitments and aspirations relating to employment or training, for example, were made far more explicit than they were within a carer section of the service user RAS. In 2009, some pilot sites had already made a start on this, with carers’ lead officers helping to develop self-assessment forms for carers (Glendinning et al., 2009).

As far as the processes of undertaking carers’ assessments were concerned, the interviews with carers’ leads suggested that the introduction of IBs had prompted some changes. These included: triggering a self-assessment process for carers, in addition to the standard face-to-face carer’s assessment; and increased attention to the details of carers’ roles within the service
user’s support plan. It was also suggested that there was potential for greater breadth in capturing carers’ care-giving activities and consequent needs for support, but to date there was no evidence that this change had actually happened (Glendinning et al., 2009).

In a recent paper, Clements and colleagues (2009) consider progress in implementing IBs with particular reference to their relevance for carers. They report considerable variability in the approach by Councils in addressing carers’ needs and provide examples of Local Authority Self-assessment and Supported Self-assessment Forms with significant apparent defects:

- One form describes what the social worker / disabled person consider to be the amount of ‘informal care’ that is provided - but does not have a column for the carer to give his or her view of this
- Although carers have a right to a separate 'private' assessment, this is in some cases negated by the fact that his or her views have to be set out on the same form as for the service user
- One form left no scope for saying that the carer simply does not choose to care
- Several councils’ forms fail to identify whether there are children or young people under the age of 18 (required by FACS and guidance for the Carers Acts). It will be difficult to identify young carers if this question is not asked
- Some councils appear to be asking carers to self-assess the level of carers needs in isolation from a carers assessment
- Many councils are developing a carers RAS but in some cases this appears to be in lieu of the carers assessment influencing the main RAS (a requirement arising from the Carers Recognition and Services Act 1995).

(Clements et al., 2009, p. 15)

However, they also provide examples of where councils are endeavouring to embed carers’ rights within new processes and this has included:

- Eligibility decisions (to access SDS) address risk to carers as well as people who use services
- Carers Assessments being embedded so that carers needs taken into account as part of the main assessment and not seen as an optional addition
- No automatic reduction being made to the resource allocation for the service user as a result of the carer being present
- Carers are specifically asked if they are able and willing to continue to provide the level of care they currently deliver
- The resource allocation is broken down and, among other things indicates how much should be deployed to reduce the carers input if this was indicated as a need in the assessment
- Carers’ needs that are over and above those to directly support their caring role can be met through resources outside the service users RAS and a carers RAS designed to assist here
- The needs of young carers identified as part of the core process.

(Clements et al., 2009, p. 15)

Clements and colleagues (2009) argue that local authorities should involve carers in the development and evaluation of new systems for allocating individual budgets and explore
whether the legal requirements described above are being effectively delivered and experienced by carers as positive outcomes. Furthermore, that there is a need for a clear Department of Health statement that personalisation procedure must address these vital (and legally obligatory) questions, not least:

- For carers to be asked directly whether or not they are willing to provide care (or the same level of care) regardless of the whether the current level of caring is onerous
- For carers to be told that the expectation is that they will have a carers assessment in private – ie that the information they provide may be given in confidence
- For carers to be asked about their wishes in relation to employment, training, education and leisure opportunities and signposting (at the very least) provided to support them in this respect
- To identify whether there are children or young people in the household and if so do they have caring responsibilities.

(Clements et al., 2009, p. 6)

What are the outcomes and effectiveness of self-assessment?

Given the use of self-assessment in social care settings is relatively recent, it is not surprising that this review has found very little research evidence about the effectiveness of self-assessment. This is consistent with previous reviews reporting a dearth of material and which have shown that where studies have examined the reliably of self-assessment in determining health need, results have been equivocal (Challis et al. 2008c; Griffith’s et al., 2005).

As Challis et al. (2008c) note, unless self-assessment leads to different actions on behalf of the individual it would seem unlikely to lead to different outcomes from professional assessments, however professional interpretation and actions remains the norm. Indeed, they argue, this is one of the issues that self-directed models of support aim to address (Duffy 2005) and there is some suggestion that when individuals make decisions about their support needs, they select different services from those traditionally supplied by professionals (Challis et al., 2008c).

With regard to the particular concern that services users who self-assess may request more support that has been previous provided (Hancock et al., 2003), most of the limited available evidence relates to equipment. The early evidence from the implementation of self-directed support programmes suggests that people do not make frivolous or excessive demands (Henwood & Hudson, 2007).

Overall, self-assessment appears to have the greatest utility when it complements existing processes rather than substituting them (Challis et al., 2008b). In this way, it can contribute to the assessment and care planning processes, thereby linking with the personalisation agenda since it facilitates the users’ involvement in the assessment. In contrast, requiring the user to complete the assessment process alone could be conceived 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 (Challis et al., 2008b, p.19).
**Is self-assessment cost effective?**

While the literature around costs and cost evaluation in health care is voluminous, in social care the material is less extensive (Challis et al., 2008c) and there are few empirical investigations of the costs and benefits of self-assessment (Clarkson et al., 2010).

Self-assessment has been seen as a potential way of saving resources, particularly around ‘back office’ functions such as administration and paperwork and of freeing up professional staff to concentrate on the assessment of more complex cases. However, although the approach is discussed freely in academic and policy debate, there are few empirical referents as to its costs and benefits (Clarkson et al., 2010). A notable exception to the lack of empirical evidence in this area is the PSSRU evaluation of the Self-assessment Pilot Projects that provides useful material for this review.

Whilst the 13 pilot projects included in the evaluation were all defined by their promotion of self-assessment, they differed in a number of ways. A number related to innovations in occupational therapy services, others contributed to assessments within care management, whilst a third group focused on preventative services. The projects also varied as to whether they were designed to deliver direct access, to screen for further professional involvement, to identify a range of needs or to contribute to service planning (Challis et al., 2008a)

Challis and colleagues (2008c) addressed the question: *What kind of efficiency savings are thought to be generated by implementing self-assessment procedures?* In doing so, they found it useful to make a distinction between ‘back office’ and ‘front office’ costs. Back office refers to costs associated with functions that support the delivery of frontline services in contrast to those associated with the delivery of the service itself. Back office functions may include, for example, finance, human resources, facilities management and communication. In the community care setting, back office costs could include administration costs associated with assessments, technology support and staff dealing with telephone enquiries. Front office costs are those costs directly associated with the professional task, such as time spent in face-to-face assessment (Challis et al., 2008c). The key findings of this study are summarised below:

- The range of costs introducing self-assessment across the pilot projects reflected the different ways of administering self-assessment processes. The range of capital and revenue expenditure across projects was large. For revenue costs (including the cost of the assessment itself and service costs), seven projects produced cost savings and five incurred additional expenditure. The greatest expenditure was in occupational therapy services, followed by projects located within assessment and care management arrangements and preventative services
- In terms of the self-assessment process itself, most of the projects brought about cost savings in terms of the time of professional staff. One project was cost neutral, through employing self-assessment with an already existing facility. Four projects incurred cost savings wholly, or in part, from the use of workers in the voluntary sector
- For five projects where comparative data were available, two operated a self-assessment approach whereby service costs were significantly lower than that arising as a consequence of traditional, professional assessment
• In a case study of self-assessment and care management costs were lower than traditional assessment for: the assessment itself, in terms of staff time, and some services usually commissioned. Although self-assessed cases were offered more advice as to a wider range of preventative services (in line with the aim of the project), which generated greater costs, total costs were lower for this group. This cost saving arose from the use of staff with a lower unit cost who also spent time on administrative duties and gathering information.

• In terms of cost savings from ‘back office’ functions such as savings in administration and paperwork, 12 of the 13 projects generated ‘front office’ savings, in terms of what happens during the assessment process and who provides assessment.

• For a selection of seven projects where relevant data were available, self-assessment was found to be definitely cost-effective for two. These two projects were located within assessment and care management arrangements and generated greater benefit at less cost. Two projects (within care management and occupational therapy services) were more effective in terms of enhanced satisfaction, but were also more costly. Three projects (two within occupational therapy services and one within preventative services) were less costly but less effective.

  o There is, therefore, a trade-off in judging the cost-effectiveness of self-assessment in policy terms, between whether efficiency savings or enhancement of the user experience is the preferred aim.

(Challis et al., 2008c)

Clarkson and colleagues (2010) reported on a pilot project that attempted to link access to assessment for older people with lower-level needs to the provision of a range of preventative services, through a self-assessment approach developed by one local authority. The study, undertaken as part of the larger PSSRU pilot site evaluation, evaluated the costs and benefits of the project. Although self-assessed cases were offered more advice as to a wider range of preventative services, which generated greater costs, total costs were lower for this group. This cost saving arose from the use of staff (self-assessment facilitators) with a lower unit cost who also spent less time on administrative duties and gathering information associated with the self-assessment (Clarkson et al., 2010).

Overall, the findings of the study indicated resource savings in terms of both ‘back office’ costs, such as savings of time on paperwork and gathering information, and also ‘front office’ costs, in terms of what happens in the assessment and who provides it. These findings read in conjunction with the finding that satisfaction with self-assessment was comparable to a professional assessment, suggests that self-assessment may be a “cost-effective approach in seeking to target assessment resources on a group traditionally neglected by the usual social services response” (Clarkson et al., 2010, p. 15).

Qureshi (2006) refers to this issue as the “time-saving and low bureaucracy versus risk.” She argues that if the purpose of self-assessment is to decide on eligibility for statutory services then the authority is responsible for the outcome of provision, even if it plays no part in the assessment. The risk that people might receive inadequate or dangerous provision, or miss out on a wider assessment, has to be balanced against the benefits of swifter provision and lower bureaucracy. This tension can be resolved, she maintains, through safeguards built into the
scheme and careful consideration of what should be provided in this way, together with periodic checking of outcomes.

Professional roles and workforce implications

There is growing debate about the degree to which assessment might be user initiated, user-led and used directly as a basis for provision without professional involvement (Qureshi, 2006).

Rabiee and colleagues (2008) reported on the experiences and outcomes of early IB users. In three of the sites (two of which also had In Control schemes), interviewees’ self-assessments had been completed and support plans devised with the help of friends, family, social workers, care managers or inclusion workers. Interviewees valued the involvement of other people and several people felt that without this support potential IB holders risked under-estimating their support needs because they wanted to minimise their impairment; did not think certain things were important; or, in the case of fluctuating conditions, did not want to acknowledge that their condition could sometimes get worse (Rabiee et al., 2008).

The fourth site had run a series of workshops about support planning, involving representatives from most of the organizations involved with IBs. The interviewees from this site reported that the workshops were very useful, and that they felt adequately supported. In contrast, many interviewees in the other sites said that they would have liked more help with assessment and support planning (Rabiee et al., 2008).

All interviewees emphasised the importance of professional support during the assessment and support planning processes. While they all valued the freedom to think ‘outside the box’, some had found this a difficult task; in the past, they had been told by the professionals what they could and could not have and now needed help to learn how to plan their own support. A few people highlighted the importance of one-to-one mentoring from people who had already been through the assessment and support planning processes and the opportunity of learning from these first-hand experiences (Rabiee et al., 2008).

These results were confirmed in the full IBSEN study, with many care co-ordinators reporting that self-assessment usually involved some additional input from family members, friends or other professionals, who were seen by many as providing essential support, for example where service users could not fully understand the range of potential options. The types of individuals or organisations to whom service users could turn for support differed between pilot sites and, to a lesser degree, between user groups within the same site, but generally included family members, friends, advocates, voluntary organisations, brokers, support planners, peers, user and carer groups/organisations, in addition to care co-ordinators. People with learning disabilities or with severe and enduring mental health needs, and older people were all specifically identified by IB lead officers as needing different kinds of support, which related to their social networks, overall mental health or level of understanding (Glendinning et al., 2008).

Henwood and Hudson (2007c) contend that self-assessment is a challenging concept, and supporting people in completing a self-assessment questionnaire (SAQ), at least in these early stages, requires considerable care management input. Confirming this view, the IBSEN study also found that in all 11 sites where some form of self-assessment had been introduced, IB lead
officers reported that most of these assessments also involved an element of support or checking by care co-ordinators. In contrast, two sites had not established any self-assessment process and reported that the assessment process was care co-ordinator-led, but was a collaborative endeavour, in which service users and carers were fully involved (Glendinning et al., 2008). In some cases, both the user and the care manager are completing separate assessments and then comparing the outcomes (Henwood & Hudson, 2007a).

In the Henwood and Hudson (2009) study on personalisation and complex needs, self-assessment was widely viewed as a misleading term. In practice self-assessment entailed intensive support from care managers working together with people to identify their needs and aspirations. Where this worked well it was viewed by care managers as a superior outcome to that attained by conventional assessment; however, it was more demanding of staff time and skills than traditional professional assessment (Henwood & Hudson, 2009).

As Browning (2007) notes, some of this extra time is spent because authorities are being cautious and tending to run care management assessments in parallel with self-assessments. This practice may be relaxed as experience and confidence are gained, allowing more streamlined processes.

Some studies have shown that individuals report less, or different needs from staff or carers who know them, and such work has been used to support the case for a professional assessment that probes beneath the presenting problem to identify ‘actual’ need, particularly where people have impairment and/or lack of insight (Challis et al., 2008c).

An alternative argument is that different stakeholders have different perceptions of need and that self-assessment allows user’s views to take precedence (Richards, 2000). There may also be scope for family members to take over assessments completed without the presence of a third party (Griffiths et al., 2005).

It may be that a professional assessment is still appropriate when it clarifies the nature of problems, assists in developing responses to them and advises on likely alternatives (Clarkson et al., 2010). The central question, then, is for whom and under what circumstances particular types of assessment are likely to be beneficial? Clarkson and colleagues (2010) conclude that a self-assessment approach may be for those with ‘low-level’ needs but, as difficulties become more complex or, importantly, if they require statutory powers to be invoked, then a professional assessment becomes justified.

Workforce implications

Self-directed assessment clearly implies significant changes for those currently undertaking professional assessments (Henwood & Hudson, 2007a). The change to a system of personalisation and supporting people in assessing their own needs and making appropriate support plans could be very challenging for staff and may require them to think much more flexibly and laterally than they have been trained to do (Henwood & Hudson, 2007b). A senior manager in Hartlepool Council commented:

The current care management model of support is being radically transformed into a model of Self-Directed Support that focuses on the personalisation of social
care. In the traditional model, social workers are care managers who assess, plan, monitor and review care packages for people. With the SDS model, people complete a self-assessment form, they are allocated a budget and they then draw up a support plan to meet their perceived needs. People may or may not choose to use social workers to assist this process (cited in Tyson, 2010, p. 21).

As others have noted, it remains to be seen what the consequences of these changes are for the workers who, arguably, have the most change to embrace (Browning, 2007; Huxley et al., 2006). Indeed, others suggest that the pace at which self-assessment can be introduced within social care is likely to depend, at least in part, on the willingness and enthusiasm of staff (Challis et al., 2008c; Henwood & Hudson, 2007b).

However, as Henwood and Hudson (2007b) found in their evaluation of self-directed support, front line staff and their managers were particularly critical to the prospects of SDS development, including self-assessment. They were able to characterise a continuum of conceptualisations and judgements about SDS ranging from outright support, through qualified support, to qualified opposition and actual hostility. While people support the underlying principles, there are often substantial reservations about the practicalities of implementation.

Similarly, Challis et al. (2008a) reported that while some staff were open to the planned changes associated with self-assessment, by and large the initial responses were those of suspicion, concern and resistance. They were anxious about loss of role and status and also the safety of vulnerable service users. All of the managers in the pilots saw the projects as an opportunity to challenge entrenched professional approaches which they regarded out-dated and at odds with the agendas of personalisation, independence and choice (Challis et al., 2008a).

Henwood and Hudson (2007b) identified a number of ideological obstacles to the paradigm of SDS, including

- The ‘giving and doing’ tradition: whereby social workers do as much as they can for service users and secure them the most support possible (often running counter to the requirements of the FACs criteria)
- The loss of collectivism: where there is an apparent tension between the emphasis on the individual rather than on collective objectives
- The conflation of needs and wants: in all our authorities, but particularly in the one that has had least engagement with SDS, there is a view that personalisation addresses people’s extravagant wants rather than their needs
- And the mistrust of service users: both explicitly and implicitly there is widespread mistrust of service users and suspicion that people will seek to get as much out of the system as they can, while the professional has a responsibility to protect inappropriate demands on public funds.

(Henwood & Hudson, 2007b, p.ii)

The Commission for Social Care Inspection (CSCI) review highlighted some fundamental problems about how local systems respond to people seeking support and recommended that assessors, or those supporting self-assessments, should be skilled in understanding people with a range of needs so that specific groups of people are not marginalised (CSCI, 2008).
It is difficult to predict what effect the changes in social care will have on existing workforces. The current role of the care manager as assessor, rationer and prescriber of support services is challenged by the emphasis on ‘self-assessment’ and on the individual being able to have their own ‘personal’ or ‘individual’ budget and support package (Beresford, 2009). Renshaw (2008) argues that both self-assessment and self-directed support undermine traditional social work and that social workers need to begin to work alongside disabled people, rather than ‘for’ disabled people, in order to achieve substantial system change (Renshaw, 2008).

Browning (2007) notes that while some have speculated that there will be a reduced need for care managers in due course, pilot sites are yet to report any reduction in demand on care management time. He also reports that, while it might appear, at first sight, that care managers may no longer be needed, in reality authorities are finding that they are needed for a number of key tasks:

- Helping people to complete the questionnaires. While many people can do this for themselves, some may need a great deal of help. Frail older people in particular are reported to ask for a lot of help
- Ensuring that people have filled them in correctly, and not under or over-estimated their needs
- Helping people to identify the outcomes they wish to achieve
- Checking that these outcomes cover all the necessary issues – and in particular that any risks are identified and addressed satisfactorily. This is a particularly important aspect, if people are to be kept safe and well, as many people may not recognise some of the risks they face. By doing this, their local authority is also able to discharge its duty of care. This does not mean that risks are avoided, but that they are identified and managed
- Gathering intelligence to help commission new services to meet emerging needs;
- Providing social work support, with many people benefiting as significantly from the care, attention and support provided – the feeling that somebody is interested in them and cares - as from the resulting services.

(Browning, 2007, p.13).

Similarly, Griffiths and colleagues (2005) write that “even the most innovative self-assessments require appropriate action by professionals” and Qureshi (2006) remarks that “it is generally still for professionals to make the final decision about allocation of public resources.” However a tension implicit in the self-directed funding model has been identified, with several individual programme evaluations and larger reviews underlining the importance of separating the planning process from decisions about funding allocations. Requiring caseworkers to conduct assessments and assist with planning while they are also responsible for allocating budget amounts may create a conflict of interest that strains their relationships with clients (Chopin & Findlay, 2010).

As noted elsewhere, the workforce can no longer be described simply in terms of local authority or independent sector, but must also include family carers, volunteers, advocates and brokers (Hudson & Henwood, 2009). The self-assessment pilot projects provide some limited evidence of the widening role of the third sector. 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 (Challis et al., 2008).

It is well established that service users particularly value turning to people with shared experience for support and guidance. Service users’ own user-controlled local organisations have pioneered models and roles to support self-assessment through providing advocacy, information and technical backup and there is evidence that services, run by such organisations, are particularly valued by service users and are effective (Beresford, 2009). By developing training and roles for people with experience as service users, two issues can be addressed: making self-directed support more accessible for all; and providing valuable skills training and job opportunities for service users (Beresford, 2009).

**Issues and concerns**

It is clear from the literature that for many professionals, self-assessment is a challenging concept - there are mixed views about how it might operate and about the perceived risks associated with its adoption presents. These concerns would seem to arise from lack of knowledge of the operational detail of how self-assessment works, a lack of experience with implementation and the challenge presented by the transfer of power from professional to service user.

The primary concerns about self-assessment reported in the literature (Browning, 2007; Glendinning et al., 2008; Henwood & Hudson, 2007b; 2009; Newman & Hughes, 2007), can be summarised as:

- Individuals will make frivolous or excessive demands
- People may underestimate the nature and complexity of their needs
- People will assess their needs inappropriately and ‘misuse’ the resources they are allocated
- Self-assessment will become a ‘token’ activity
- Service users could lose important face to face contact
- Understanding how self-assessment fits with current processes and eligibility criteria
- Self-assessment will involve balancing an increased demand with a constrained budget.

Evaluating the implementation of self-directed support, Henwood and Hudson (2007b) found that the idea of self-assessment was the focus of considerable uncertainty and some anxiety. Whilst respondents may have been comfortable with the concept of ‘putting the person at the centre’, it was another matter to accept that this should mean self-assessment. Most were concerned about needs and wants becoming confused and were concerned about how to protect limited resources from potentially unlimited demand (Henwood & Hudson, 2007b).

It was also apparent that for some respondents the discomfort with self-assessment reflected a mistaken belief there would be a ‘free for all’ where people could demand – and receive – anything they wanted. Conversely, there are concerns that users engaging in self-assessment may under-assess their needs and that take-up will be uneven between user groups (Henwood & Hudson, 2007a; Glendinning et al., 2008; Newman & Hughes, 2007)
Some respondents in the Henwood and Hudson study (2007b) feared that service users could potentially lose important face to face contact and the benefits that arise from that. Some struggled to understand how self-assessment would be operationalised – what it would mean in practice. In addition, many people struggled to understand what self-assessment was all about and whether it would mean, for example, that FACs principles were abandoned and eligibility would cease to be relevant (Henwood & Hudson, 2007b).

Emerging evidence suggests that the reality is often less challenging than had been anticipated and people’s demands are relatively modest. It is not the case that people – when given the opportunity to specify their own needs – all demand services that others might deem frivolous or excessive. Rather, people may define their needs differently to the standard services that have long been offered (Henwood & Hudson, 2007b).

Similarly, in the IBSEN study a number of the pilot sites had experienced people with mental health problems and older people in particular under-assessing their own needs, however, people with physical disabilities, sensory impairments or learning disabilities were more likely to over-assess their needs (Glendinning et al., 2008). These findings were attributed, in part, to older people having low expectations, and of people with mental health problems being in denial about their needs, or not perceiving their actions or behaviours to be anything unusual. Henwood and Hudson (2009) also reported that the risks of people underestimating their needs in the self-assessment process were widely recognised.

In contrast, several IB lead officers reported that care co-ordinators tended to over-assess people’s needs; and that there was a culture of care co-ordinators trying to get the ‘best deals’ for the people they worked with, particularly perhaps for those who were the most difficult cases and/or were the most likely to complain. The RAS was considered by some to be much more objective as systems were in place for each decision to be justified and the path from assessment to allocation was expected to be more transparent. (Glendinning et al., 2008).

Implementation and sustainability

In Volume III of the self-assessment pilot evaluation study the authors considered the implementation and sustainability of innovation in public sector social care settings (Challis et al., 2008a). Overall the findings show that the implementation of innovation is a Complex matter comprising a variety of attributes concerning the innovation itself, its host organisation and its situational context, none of which are uniform to all but individually, even uniquely, combined (Challis et al., 2008a, p. 64).

The evaluation incorporated a wide ranging review of literature which highlighted key factors influencing these aspects of innovation. Although the authors concluded that there is no single recipe for successful implementation no ‘road map for others to follow” (p 69) the findings hold useful lessons for other innovation implementation (Challis et al., 2008a). A summary of key findings from this report follows:

- **Level of political mandate** is an important attribute in relation to the sustainability of new initiatives
• **Links with existing services** - the more closely an innovation is related to existing services the more likely it is to be maintained long-term. Relevance to the wider agenda is no guarantee of sustainability, but it is a necessary foundation to achieving this
  o This was reflected in the pilot projects by such things as how funding was used, whether processes were embedded in existing administrative systems or additional to them, or by the day-to-day management of the projects
  o Making real/operational connections between the pilot work and other development in the department was also an important aspect of sustainability

• **Partnerships** – the involvement of more than one organisation increases the complexities of implementation
  o Misunderstandings can emerge from the lack of shared language and understanding between partners, especially when this involves partnerships between professional and voluntary agencies
  o Partnerships are particularly important in dealing with cultural and ethnic diversity

• **Sufficient finance** is important for the successful implementation of innovation, however the use made of funding may be more significant than the amount
  o Projects that had used funds to finance additional staff and/or for web tool licences were likely to require further funding to continue to operate beyond the pilot
  o The expense and effort to sustain projects was likely to be less for projects which operated alongside existing systems compared to those which were outside mainstream practice or only operated in part of the authority

• **Scale and complexity of change** – it appears that it may be easier for new initiatives to be accepted into mainstream practice if they reflect an incremental rather than model shift in practice. The more complex the new process the more difficult it is to implement

• **Clarity of purpose** - .a clear understanding of the purpose of the innovation is important to its implementation. To be successfully implemented, an innovation must be seen to provide an effective response to the problems it was intended to deal with

• **Adaptability** - flexibility and the ability to adapt to unforeseen circumstances is more likely to lead to successful implementation in the long term

• **Management and leadership** – managers and ‘change agents’ can not produce change in a vacuum, however they do play an important role in stimulating and championing new systems
  o Visible and ongoing senior management support is important for sustainability
  o Change agents can come from within or outside an organisation, but must have credibility amongst those who are engaged in implementing innovation
  o The literature is equivocal about whether innovations are best implemented as ‘top down’ or ‘bottom up’ initiatives
  o The top down diffusion of innovation from ‘expert’ to users is a centralised approach that utilizes the influence of those in positions of authority
  o ‘Bottom up’ approaches that encourage the participation and engagement of those affected by the change are believed to lead to more successful innovation
• **Use of information technology** is clearly central to the future delivery of social care, including assessment and service delivery. The ability to obtain appropriate IT systems and support is an important factor in the promotion of implementation
  - In most of the pilot sites, the role of technology was in the form of access only with forms accessed via websites and printed for manual completion. In others, online completion of SAQs was possible and in four sites the web tool was capable of determining service receipt
  - The take-up of web based assessment and/or an information service varied between projects, but was most successful where support was available
• **Challenging the culture – changing staff perceptions** - organisational culture is a force that can hold back change as the customs, practices, and support or resistance of staff can have a major impact on implementation. It is better if innovations are in tune with existing culture
  - The self-assessment projects were largely seen as challenging the prevailing culture and all faced challenges from staff resistant to the changes. Dealing with these issues took time and resources and slowed down the pace of innovation
  - Staff can be supported through a variety of means, but it is important to keep them informed of the changes and provide opportunities for them to voice their concerns
  - Training and involving staff directly in developing new processes can facilitate engagement in the project
  - A number of the pilot projects successfully utilised ‘change champions’ to lead the way in the change process
• **Marketing and publicity** are now accepted as having a role in public sector services as a means of learning about the public’s experiences, perceptions and concerns about current services and to tailor future services to better meet the needs of service users
  - Managers in the pilot sites were concerned that publicising new services might overload a system already under pressure and raise expectations that would not be met if the ‘pilot’ was not continued.

Others have also highlighted the need to promote a culture of self-assessment amongst its users and within self-assessment projects (Henwood & Hudson, 2007a; Qureshi, 2006) and a number of ways to achieve this have been suggested:

- Mechanisms should be in place to ensure that attention is given to the information from self-assessment, and that some action follows based on it
- The purpose of self-assessment should be clear
- People should have choice about the stage at which they would like professional involvement, and/or assistance from advocates
- Work is needed on the development and testing of self-assessment materials, both the tools per se and their use in operational contexts.
  
  (Qureshi, 2006)

Whilst it is clear from the findings above that a number of factors are important in the implementation and sustainability of innovation in social care, according to Challis and colleagues (2008a), their study holds a key message, above and beyond those which match the
findings already present in the literature – that is how ‘embedded’ a project has become by the end of the pilot. The concept of an embedded service or process relates to:

The position of the project manager; the use of funding and whether or not additional monies are required for its continuation; the ability of the project to use existing structures and resources; of being regarded as in tune with other practices and developments; and of having a broad strategic fit (Challis et al., 2008a, p. 65).

Whilst the means adopted to achieve ‘embedded-ness’ varied, the attributes which appeared to be significant included:

• 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 to 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. (Challis et al., 2008b).

Well experienced with self-assessment, John Waters from In Control recommends “keeping it simple.” In a personal communication (2010), he offered these key summary lessons from the In control experience:

• Self-assessment is possible but it requires professionalism, to let go of power and control
• It threatens professional power and there is a cultural challenge to accept a system based on trusting disabled people. In UK ‘assessment’ is the only legal entitlement for a citizen and duty for the govt, in relation to social care, so without replacing these with better alternatives, i.e. right to certain outcomes, or a duty to act reasonable to ensure well-being there is a risk that a shift towards self-assessment erodes statutory protection
• Keep the whole thing simple so people can understand it and the assessment is viewed as fair by the person their family and the state
• Separate the measurement of level of need and social support (that informs allocation of money) from information on individual wishes preferences aspirations (that shape the support and the planning)
• Set the out come as part of the allocation decision, so choice and control over the use of the allocation rest with the individual, but is constrained by reasonable parameters.
Part two: Stock-take

Method

Telephone interviews were conducted with 18 NASC managers and/or senior executives from 16 NASC contracted agencies (or branches) nationwide.

The interviews followed a standard format using a brief interview schedule (Appendix 3) and were conducted by Dr MacDonald. A record of each interview was compiled and sent to the interviewees for verification and amendment where necessary. A full list of those who participated in the interviews is attached as Appendix 4.

Results

Use of self-assessment

Of the 16 agencies that provided information for the stock-take, only one reported using self-assessment, and two utilised modified processes which included elements of self-assessment. A number of others spoke about the occasional use of ‘adapted or ‘flexible’ approaches to assessment that incorporated components or principles of self-assessment.

FOCUS (Wairarapa) created a telephone-based assessment tool that they use with those needing household management only. These are mostly older service users (over 65) DHB clients but also some low need service users who do not meet Ministry of Health requirements.

The FOCUS referral forms have a check box for “needs house work only” which, when ticked indicates that the client has determined that they need help. In response, the “self-assessment” occurs by telephone with FOCUS staff completing an electronic form to determine eligibility to service.

The tool was developed in-house about 3 years ago with involvement from consumers and providers. Implementation involved initial testing by the manager then training of a “super user” before being rolled out to remaining staff. The FOCUS manager reported some initial barriers with staff who “didn’t believe that they could do it without seeing the consumer.”

FOCUS report positive feedback from both consumers and providers. As a result of the initiative the waiting list has been reduced from 8 weeks to 1 week and “coordinators are triaging more rather than using a blanket approach.”

In Northland, NorthAble do not formally have self-assessment in place but they have adapted the national assessment incorporating a “navigator” model of support in a broad outcome focused role. Navigators, purposefully matched to families, use a range of tools as they see appropriate in assessments and “empower the families to recognise what they need and to get back their resilience.” NorthAble report that they have had very positive feedback about these roles in which families are empowered and feel that they learn to navigate for themselves. They are now looking at children’s assessment.
LIFE Unlimited (Petone and Hamilton) have developed the following self-assessment process: a referral is received; once eligibility is determined the referral is received by the “Integrated assessment facilitator” (a new established role). The facilitator makes an initial telephone contact and explains “who we are, what we do, the process etc. Those with low need are offered four options for assessment, each with a slightly different format:

1. Self-assessment using a mailed printed form
2. Self-assessment using an emailed printable form
3. Face-to-face in the home or office
4. Via telephone

The self-assessment is a three-step process: the initial “front end” telephone conversation; completion of the self-assessment; a follow-up telephone conversation which provides an opportunity to clarify detail, probe for further information if required and explain what will happen next.

Handwritten assessments are entered electronically (unedited) with any additional information added below to ensure it is clear who the author of all the information is. The assessment is returned to the service user for their verification/amendment.

LIFE Unlimited started work on self-assessment in August 2009 and note that it has been a slow process to get to where they are now. In the first nine months of 2010, 30 people had used self-assessment (40% of those who were offered the option). These were mostly (70-80%) parents of children with disabilities such as ASD and ID. They deliberately started with people at the low end of need “because these are usually straight forward.” The process and forms were developed in house through repeated testing and refinement, including client feedback. “Our self-assessments reflect New Zealand culture, disability culture, language and experience of being Kiwi.”

LIFE Unlimited report that feedback from clients and others has been very positive and that no one has struggled with the form. The value, they see, is that self-assessment can happen at a time that suits the person and family, such as at the weekend when other family members can be present. They also report that what is also valuable is that other information can be added, such as a paediatrician’s report which means “parents can talk about impact rather than medical/disability detail which is provided in the report.”

The interviewee commented that there is a sector myth that people can not do assessments, that they do not have the skills or ability. LIFE Unlimited report that this is not the case, rather that it “has been a revelation; some people do a great job.” Their plans for the future include:

- Creation of a pack including essential information and some fun things (pen, jelly beans, coffee – a “survival kit”) to make the experience less daunting.
- “Market” to support groups, such as IHC, MS so that they are knowledgeable about the self-assessment option.
- Investigate putting it on the website and look at Skype.
- Independent research to validate what we think we know and understand
• Consider moving this option to people with high and complex need -

Views of self-assessment:

A number of respondents said that they had not really thought about self-assessment until they received the request to participate in this stock-take, and that this has stimulated their interest, with some then searching for more information on the topic. Most were positive, if somewhat cautiously, about the future role of self-assessment in the New Zealand context.

There was a general consensus among the interviewees that self-assessment involves a person completing their own assessment (with or without support) and providing information from their perspective. The key difference for most was that whilst current assessments are face-to-face, self-assessment would be largely independent of professional input.

Most interviewees spoke about self-assessment as part of a self directed or self managed approach – empowering the client and giving them more choice and control:

To empower a person to give information which they choose to give, including their strengths as well as disability, the aspects they are managing well and future goals

Seven of the interviewees referred to cost-effectiveness, of streamlining work allowing more time to be spent with those of higher need and/or providing a quicker, less invasive service.

The question, under what conditions, and for whom, is self-assessment most appropriate? was perhaps the most challenging for respondents. It raises the dilemma of not wishing to exclude anyone, but recognising that self-assessment depends on the ability of the person to complete it or to articulate their thoughts to someone assisting them to complete it.

Some (6) interviewees felt that all people should be offered the choice, even though some people may need more support/assistance than others. Several (7) thought that self-assessment would be inappropriate for people with high and complex needs, that it would be more appropriate for those able to engage in conversation, to advocate for themselves and to communicate their views.

People with physical and sensory disabilities may be able to do it more easily than say, those with intellectual disability who may need more support – it depends on what they can do.

It would need to be someone with very good understanding and able to articulate and communicate their views. It depends on the level of these. For example, it would not be appropriate for the intellectually disabled or those with dementia or otherwise cognitively impaired.

There was a general consensus that self-assessment would be appropriate for those with low need, such as those who only want a few hours of household management.
There are current clients in the system with low service provision who have to have an assessment every 3 years. This is an unnecessary intrusion. Self-assessment would be good for them.

However, there was also concern expressed that people do not always know what they need, that they may think their need is low but through the facilitated assessment it is clear that they need more:

They may only think they need a few hours of household management help but may actually need more.

When discussing the key domains for assessment, interviewees recognised that the self-assessment needs to furnish

Enough information to cover off everything, to make sure you don’t miss anything, to have enough information to determine resource allocation.

However there was a sense that the current approach was lacking, that self-assessment needed to use a strength-based rather than a ‘deficit’ approach and that more emphasis needs to be placed on families, networks and the opportunities that these have to provide for support.

It needs a different emphasis – the current tool focuses on what they can’t do, rather than on what they can do. It needs to be vision/goal oriented and look at the barriers and a plan to achieving the goals.

In addition to those already mentioned above, a number of other issues or concerns were expressed about self-assessment, including

- The challenge of tracking the economic impact of self-assessment
- The risk that self-assessment could create an even more convoluted process because of the need to go back for more information
- It requires a nation-wide approach with clear criteria such as with InterRAI where you could come up with a points allocation
- A self-assessment tool, whether or not it is facilitated, needs to be part of a complete process which incorporates a flexible range of communication vehicles through which assessment can occur
- How do we mitigate against risk for vulnerable people?
- We must be mindful that the assessment should be based around clients needs – not what the family wants
- Wants and expectations do not necessarily equate with need
- A risk with self-assessment is that it does not facilitate a holistic approach
- There is a risk that the group of service users who know what they want and can well articulate and communicate this, will be the ones to get the resources when others do not. The self-assessment process could end up going down the entitlement path with a risk of pre-conceived expectations/entitlement.
Part three: Recommendations and discussion

Design options for process, tools and implementation pathways

The following recommendations and discussion have been informed by international experience and evidence and practical knowledge of the New Zealand disability support services environment. However it should be noted that the use of self-assessment in social care settings is relatively recent, it is not widespread and there is limited documented evidence about the implementation, efficacy and outcomes of self-assessment, particularly as it pertains to DSS.

It must be noted that for the purposes of this review and report, self-assessment has been regarded largely as a separate or clearly identifiable entity. In reality self-assessment is one component of larger, complex processes and models of service delivery. In the In Control model, for example, self-assessment is an integral part of the RAS. Until there is a clear understanding of how the IF and RAS will work in New Zealand, it is not possible to make definitive recommendations about self-assessment in that context. These processes, should however, be developed concurrently.

It is also important to be clear that self-assessment is not about assuming any predetermined allocation of resources. However it does align with the recommendations in the DeLoittes report to allow service users to self prioritise their support needs (DeLoittes, 2010)

A particular challenge has been to develop recommendations with respect to self-assessment in relative isolation to the ongoing work related to the new model/framework to support disabled people. How the implementation of the model evolves in the demonstration site will undoubtedly impact on the development and implementation of self-assessment in New Zealand. At this point in time it is not possible to determine what impact that may be, but as the model evolves phases 2 and 3 in the following recommendation may be quite different than what is suggested here.

The following recommendation on overall approach is made on the basis of the findings of this review, local knowledge, and well accepted principles of change management:

**Recommendation 1:** that self-assessment for disability support services in New Zealand is introduced in a three-phase incremental approach, as outlined in figure 1.
**Phase one:** Pilot self assessment in the demonstration site, within current NASC processes, as an option for service users with low-medium need.

**Phase two:** Incrementally roll-out self assessment to other sites building on the lessons learnt from the demonstration site pilot.

**Phase three:** Extend the self assessment option to service users with higher, more complex needs.

*Figure 1:* Recommended approach to implement self assessment in New Zealand

Through the three-phase incremental approach it will be possible to:

- **M** inimise risk by testing self assessment in the demonstration site before an incremental implementation nationwide.
- **B**uild on work already undertaken locally.
- **E**nable the testing, refinement and validation of self-assessment tools and processes on a small scale with lower risk service users in the first instance.
- **I**ntroduce self-assessment with the least disruption to existing processes and workforce configurations.
- **E**ngage stakeholders in the co-development of self-assessment tools and processes that are relevant to the New Zealand context, thereby -
- **E**nhance the partnership approach in the current NASC framework and standards.
- **A**llow for a comparative analysis against the existing model.
- **E**nsure that the ongoing development of self-assessment is aligned with the evolving development and implementation of the new model/framework, in particular the work in the demonstration site.

**Phase one:** Pilot self assessment in the demonstration site, within current NASC processes, as an option for service users with low-medium needs, specifically

The purpose of the first phase is to pilot self-assessment in a controlled manner within the demonstration site to manage risk. Whilst it is accepted that, in the long-term, it is preferable to avoid the ‘exclusion’ of any groups, the literature clearly indicates that self-assessment is not desired by everyone and that for some groups it is especially problematic.
It is recommended that the pilot includes only service users with low-medium need. Given the research evidence it would not be advisable to implement self-assessment for those with high-complex needs until the tools and processes have been fully developed, tested, and validated. The extension of self-assessment to the later group should be left until the third phase, by which time the new model/framework should be more fully developed and understood. It is also recommended that self assessment for children, or others who can not communicate or respond on their own behalf, is not included until the third phase.

It is important to clearly define the low-medium client group or cohort for whom the self-assessment option will be made available. Because of the difficulty associated with defining level of need prior to an assessment, it is advisable to focus on needs that can be more readily objectively defined. These are likely to be more the task-oriented domains of household support, and personal cares. A similar approach is used by FOCUS for requiring assistance with housework only. International literature also shows that self assessment has been successfully utilised for the provision of minor equipment and adaptations.

The work of already undertaken by LIFE Unlimited in developing a self-assessment process and associated tools could form the basis of the initial development work in the demonstration site. There may be intellectual property and commercial sensitivity issues that will need to be negotiated to enable this.

**Recommendation 2:** that in the demonstration site self assessment is offered to service users with low-medium need, specifically those only requiring household support, personal cares and/or minor equipment and adaptations.

Whilst it is acknowledged that in current NASC practice level of need is determined by the assessment and that assessments are not made to predetermined outcomes or services, for the purposes of the pilot, the determination to offer self-assessment would be made at triage.

Anecdotal reports and some literature suggest that there is a degree of confusion amongst service users as to what self-assessment is and what it does. It appears that some are not making a clear distinction between self-assessment and self determination or individual funding. As this confusion poses a significant risk to the successful implementation and utilisation of self-assessment the following action is recommended.

**Recommendation 3:** that preliminary to phase 1, the Ministry of Health engage with the disability community to clarify what service users are expecting self-assessment to deliver.

Within the literature review self-assessment was investigated as a specific, identifiable component of wider processes – in reality this is difficult to do as it is just one part of a much larger whole and needs to be considered within the wider context. The form and function of self-assessment tools and process are dependent on how the outcomes of self-assessment are going to be ratified and provided. The self-assessment tool would be developed as part of phase 1 work and would ideally build on the work already undertaken locally.

**Recommendation 4:** that a self-assessment questionnaire appropriate for New Zealand is developed building on work already undertaken locally and as an
integrated piece of work in the co-development of the new model involving a wide range of stakeholders, including NASC, service users and carers, providers, Maori and other ethnic groups.

**Recommendation 5:** that the self-assessment questionnaire is developed as a standard template against the New Zealand standards and criteria to ensure that these continue to be met in the self-assessment process.

The final format of the SAQ should be agreed in the co-development process within the demonstration site, but based on the literature review and stock take interviews, it is recommended that a self-assessment questionnaire should be:

- **Fit for purpose.** This includes the purpose of self-assessment and its relationship to other aspects of the new model such as IF and LAC
  - As noted above, the RAS underpinning the IF model will greatly influence the form and function of the self-assessment tool and process
  - The link to LAC is less obvious. LAC is focused on building and reinforcing natural and community supports and social capital than it is on the assessment (Bennett & Bijoux, 2009)

- **Culturally appropriate and holistic.** (focused on all aspects of a person’s life) and encompassing the needs of the person and their family

- **In plain language, practical and easy to complete.**
  - The tick box, multiple choice approach (see above) is simple and easily standardised, but it is recommended that “comments” or “further information” boxes are also included for people to provide additional information
  - If the Ministry of Health require a standardised approach nationwide, the recommended option is to follow a standard template approach, such as that used across England with In Control providing a template/model SAQ that is then adapted by local authorities. The In Control model or template SAQ and the adapted version used by Hartlepool Borough Council are both attached in full as appendices 1 and 2.

The tool should include paper-based, electronic and alternative mediums as deemed appropriate, however, it is important to note that the literature does not support a fully online assessment as suggested by the Deloitte’s report, as this has not been the preferred option for service users and is less likely to lead to difficulties with completion and dissatisfaction.

**Recommendation 6:** that initially self-assessment would be paper-based with alternative mediums offered as tools and processes are refined and validated.

**Implications of phase one:**
• Minimal impact on current relationships, responsibilities and workforce configurations
• Utilises work already undertaken with the New Zealand context
• In effect this is simply an alternative method of assessment offered as an option to a defined group of service users. The internal processes and systems surrounding it will be relatively largely unaffected
• Some training will be required for NASC assessors who are those primarily affected by the inclusion of the self-assessment option as they will have an additional role in determining appropriateness for self-assessment
• Will require an expansion of the capabilities of Socrates to cater for the self-assessment option.

**Phase two: Incrementally roll-out self assessment to other sites building on the lessons learnt from the demonstration site pilot.**

In this phase the self assessment pilot will be extended beyond the demonstration site and incrementally rolled-out nation-wide. Unless the lessons learnt from the demonstration pilot indicate otherwise, the target groups will remain the same as in the demonstration site. By phase two the lessons learnt from the demonstration pilot will have been incorporated into a standard set of processes and tools for use elsewhere. The degree of adaptation possible at other sites will be a matter to be determined during the pilot phase.

**Implications of phase two:**

• Clear guidelines will be essential as self assessment is incrementally implemented nationwide.
• The way in which the new model is developed in the demonstration site will impact on this phase. The relationship between self-assessment, LAC and, in particular, IF needs to be determined and agreed. It may be appropriate, for example, for the LAC to facilitate a supported self-assessment. As noted elsewhere, the RAS underpinning the IF model will have a significant impact on the form and function if the self-assessment

**Phase three: Extend the self-assessment option to service users with higher, more complex needs.**

The purpose of phase three will be to extend the self-assessment option to the remaining service users, primarily those with high-complex needs, and to carers. In this group the risks are generally higher and support needs greater. Self-assessment for these service users is more likely to be supported or facilitated or a self-assessment completed on behalf of another, such as a child or someone with cognitive impairment.
Further into the future, once self-assessment has been trialled and validated, it may be appropriate to extend it use into other settings, such as primary care with practise nurses.

**Implications of phase three:**

Extending the self-assessment option to those with high-complex needs raises two significant issues that need to be addressed as part of the development and implementation of self-assessment.

- The capacity issue– does the person have the capacity to do all or some of the assessment, and what level of support is required for them to do so?
- How to ensure, even at low levels of need, that when a self-assessment is completed on behalf of someone else, such as a child or others who can not communicate or respond on their own behalf, that their needs are met as well as those of the carer and family, whilst militating against potential risk.

**The Requirements for Implementing Self-assessment**

Informed by the literature, in particular the work of the PSSRU (Challis et al., 2008a), and overseas experience (personal communications with John Waters and Michel Kendrick), the following are suggested as requirements for implementing self-assessment in New Zealand:

**Clear policy and political mandate** – shown by the commitment to demonstrating the new DSS model/framework and through clear links to current policy.

**A clear and agreed understanding of the purpose** of self-assessment is important to its implementation. Self assessment must be seen to provide an effective response to the issues it is intended to respond to. However the apparent confusion amongst some service users as to the purpose and function of self-assessment must poses a risk successful implementation.

**Close links with existing services and relevance to the wider agenda** is no guarantee of sustainability, but it is a necessary foundation to achieving this. This includes clarity around how self assessment links with the new developments in DSS, particularly IF. In England, the expense and effort to sustain IB projects was likely to be less for projects that operated alongside existing systems compared to those which were outside mainstream practice or only operated in part of the authority.

**A partnership, co-development approach** is particularly important in dealing with cultural and ethnic diversity. This requires active engagement of support networks and communities through partnership and collaboration with individuals, families, local organisations and the broader community.

**Scale and complexity of change** - less complex processes reflecting incremental shifts in practice appear to be more readily accepted into mainstream practice and are simpler to implement than more complex changes representing shifts in models of practice. The scale and complexity of change can be managed through a graduated approach with incremental changes that allows opportunities for evaluation, learning and adaptation. Such a phased approach is also endorsed by Lord and Hutchison (2003).
Management and leadership - Visible and ongoing senior management support and leaders who effectively engage and support staff and the wider community are essential to the successful implementation of innovation. Appropriate facilitating and supporting mechanisms are required to enable effective leadership.

Adaptability - flexibility and the ability to adapt to unforeseen circumstances is more likely to lead to successful implementation in the long term.

Challenging the culture – changing staff perceptions. Staff can be supported through a variety of means, but it is important to keep them informed of the changes and provide opportunities for them to voice their concerns. Training and involving staff directly in developing new processes can facilitate engagement in the project. A number of the IB pilot projects in England successfully utilised ‘change champions’ to lead the way in the change process. If used, change agents or champions must have credibility amongst those involved in implementing self-assessment.

Marketing and publicity are now accepted as having a role in public sector services as a means of learning about the public’s experiences, perceptions and concerns about current services and to tailor future services to better meet the needs of service users. Successful implementation will also require the promotion of a culture of self-assessment amongst service users.

Use of information technology The ability to obtain appropriate IT systems and support is an important factor in the promotion of implementation. Whilst we are not supporting InterRai, there are lessons to be learnt from the development and implementation of InterRai in New Zealand. It is recommended that NASCs who have implemented InterRai are canvassed so that key lessons can be shared.

A robust, independent and ongoing evaluation should accompany the implementation process. The evaluation should be comprehensive and where possible, compare self-assessment with traditional forms of assessment and include:

- Outcomes for and experiences of service users and carers (this could include consumer satisfaction questions as part of the self-assessment questionnaire)
- The views and experiences of staff involved in self-assessment
- Cost-effectiveness including financial risks
- Efficacy of the self-assessment process in terms types and number of services accessed, time taken between steps in the process, degree of professional input in self-assessments.

Recommendation 7: that the effectiveness of self-assessment is formally evaluated in the demonstration then in each site as it is incrementally implemented.

References


In Control. Retrieved September 2010, from [https://www.in-control.org.uk/home](https://www.in-control.org.uk/home)


Deleted because according to APA, personal communication is not cited in reference lists


Appendices
Appendix 1: In Control model SAQ

Self Assessment Questionnaire

(Generic Adult Social Work)

RAS4
## 2 Relationships

This part is about friendships and people I know – not just my family.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>For me to form a friendship or relationship outside of family or people paid to be with me.</td>
</tr>
<tr>
<td>2</td>
<td>For me to form more friendships or relationships outside of family or people paid to be with me.</td>
</tr>
<tr>
<td>1</td>
<td>To keep in touch with people who are important to me.</td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A) I don’t really have any relationships outside my family. I need support to make relationships – and keep them.</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>B) I have one or two relationships – but not enough for me. I need support to make relationships – and keep them.</td>
<td>2</td>
</tr>
<tr>
<td>C) I’ve got a lot of relationships – the right number for me. I need a bit of support to keep them.</td>
<td>1</td>
</tr>
<tr>
<td>D) I’ve got a lot of relationships. I don’t need support to keep them. I don’t want to make anymore relationship than I have presently.</td>
<td>0</td>
</tr>
</tbody>
</table>
### 3 Being part of the local community

This part is about doing things in my community – like using local shops, the library, going to the cinema, clubs, community centre, church or other place of worship, helping neighbours, or being involved in local organisations.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To remain active in my community</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>To do more things in and contribute more to my community.</td>
</tr>
<tr>
<td>3</td>
<td>To do things in and be part of my community</td>
</tr>
</tbody>
</table>

| A) I don’t do much in outside of my home in the community. I need support to do more. | ☐ | 3 |
| B) Sometimes I do things outside of my home in the community. I need support to do more. | ☐ | 2 |
| C) I do lots of things in outside of my home in the community. I need support to do them. | ☐ | 1 |
| D) I do lots of things in my community. I don’t need support. I do not want to or I am unable to do much outside of my home. | ☐ | 0 |
# 4 Work, leisure and learning

This part is about having a job, learning new things and enjoying life.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>To work and have a job, to gain new skills.</td>
</tr>
<tr>
<td>2</td>
<td>To have more chances to work and take part in ongoing learning.</td>
</tr>
<tr>
<td>1</td>
<td>To carry on working and learning</td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

A) I don’t have many chances to work, or learn new things, or enjoy life. I need support to do these more.

B) I have a few chances to work, learn new things, and enjoy life. I need support to do these more.

C) I am busy – with a job or learning new things – and I enjoy my spare time. I need support to keep these going.

D) I am busy and enjoy my spare time. I have the support I need to keep these going – from family, friends or workmates. I am of retirement age and feel that I am ok without this support.
5 Making Decisions

This part is about who decides important things in my life – things like where I live, who supports me, who looks after my money.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>To take more decisions about things important to me.</td>
</tr>
<tr>
<td>2</td>
<td>To take the decisions that are important to me.</td>
</tr>
<tr>
<td>1</td>
<td>To carry on making decisions with good advice.</td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

A) Other people make most decisions about my life. I need support to make more decisions.

B) I decide most day-to-day things. But I don’t have as much say in important decisions about my life. I need support.

C) I make all the decisions. I need support and advice to make them.

D) I make all the decisions. I just need a bit of advice. Or I am in a residential home.
6 Staying safe from harm

This part is about keeping safe when I’m going out on a bus, or using a gas cooker, or going down stairs. Those are the things that are important for me. But staying safe is about different things for different people.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) I need help to stay safe a lot of the time. People worry a lot about my safety. Or I am in a residential placement.</td>
<td>15 To be safe and free from harm</td>
</tr>
<tr>
<td>B) I need help to stay safe some of the time. People worry a bit about my safety.</td>
<td>4 To be safe and free from harm</td>
</tr>
<tr>
<td>☐ Sometimes I need a bit of help to stay safe. I’m happy and no-one says they’re worried.</td>
<td>2 To be safe and free from harm</td>
</tr>
<tr>
<td>☐ I don’t need help to stay safe. I’m happy and no-one says they’re worried.</td>
<td>0 To be safe and free from harm</td>
</tr>
</tbody>
</table>
7 Complex needs and risks

This part is about my behaviour – the things I do. Can my behaviour be dangerous for me or other people?

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) 15</td>
<td>To be free from harm and not cause harm to others</td>
</tr>
<tr>
<td>B) 10</td>
<td>To be free from harm and not cause harm to others</td>
</tr>
<tr>
<td>C) 5</td>
<td>To be free from harm and not cause harm to others</td>
</tr>
<tr>
<td>D) 3</td>
<td>To be free from harm and not cause harm to others</td>
</tr>
<tr>
<td>E) 0</td>
<td>To be free from harm and not cause harm to others</td>
</tr>
</tbody>
</table>

A) I often do things that could hurt me or other people. People have tried to help me change what I do. But there's still a risk I could hurt myself or other people.

B) I often do things that could hurt me or other people. People have helped me change what I do. There's not a big risk I could hurt myself or other people.

C) Some things I do are a problem for other people. But there's no real danger to me or other people.

D) In the past I've done things that could hurt me or others. Or I've done things that were a problem for other people. But there's no problem now.

E) I've never done things that could hurt me or others. People around me support me well.
### 8(a) Family carer and social support

**My family carer**
This part is for my family carer. What does supporting me mean for my family carer? What is their life like?

**To the family carer:**
This part is for you. To answer this question you need to imagine you are caring full-time for your family member – even if you’re not; even if your family member has support.

<table>
<thead>
<tr>
<th>Points</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>15</td>
</tr>
<tr>
<td>☐</td>
<td>For my caring role to change so that it no longer has such a detrimental impact on my life.</td>
</tr>
<tr>
<td>☐</td>
<td>10</td>
</tr>
<tr>
<td>☐</td>
<td>For my caring role to change so that it no longer has such a detrimental impact on my life.</td>
</tr>
<tr>
<td>☐</td>
<td>7</td>
</tr>
<tr>
<td>☐</td>
<td>For me to feel supported to carry on in my caring role.</td>
</tr>
<tr>
<td>☐</td>
<td>5</td>
</tr>
<tr>
<td>☐</td>
<td>For me to feel supported to carry on in my caring role.</td>
</tr>
<tr>
<td>☐</td>
<td>0</td>
</tr>
</tbody>
</table>

A) My caring role has a critical impact on my lifestyle - including a significant impact on my health and wellbeing. I am unwilling or unable to continue in the role as it currently is. (Resuming a greater caring role would have this effect)

B) My caring role has a substantial impact on my lifestyle. Playing this role has led to high levels of stress and some health problems. (Resuming a greater caring role would have this effect)

C) I have some difficulty and stress in carrying out my day-to-day caring tasks. There is some impact on my lifestyle and playing this role leads to minor stress. (Resuming a greater caring role would have this effect)

D) I am able and willing to continue in my current caring role. My caring responsibilities have only a small impact on my daily life. (I would like to play a greater caring role than I currently do, and have some time to provide support)

E) I am able and willing to continue in my current caring role. My caring responsibilities have no negative impact on my daily life. (I would like to play a greater caring role than I currently do, and have time to provide support)

Or I have no carer and/or I am in a residential placement.
### 8(b) Family carer and social support

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>X</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am able to get nearly all the help I need from my family and friends or I am in a residential placement</td>
<td>I currently need no paid support</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>I am able to get most of the help I need from family and friends</td>
<td>I have or need some occasional paid help</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>I am able to get only some of the help I need from family and friends</td>
<td>I have or need ongoing regular help</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>I can get little or no help at all from family or friends</td>
<td>I have lots of paid support Full time day care Respite I currently have 24 paid support</td>
<td>4</td>
</tr>
</tbody>
</table>

![Table and Diagram]

If you would like a full version of In Control's Resource Allocation System or to know more about in Control, visit our website: [www.in-control.org.uk](http://www.in-control.org.uk)
Self Assessment Questionnaire (SAQ)

This is a self-assessment for people who under Fair Access to Care (FAC) are considered eligible for support.

In order to complete this some people may require help, perhaps from a friend, family member or a Care Manager.

(Version 5.4 - April 2008)

Easy read
ELIGIBILITY CRITERIA - FROM JULY 2007

The government guidance allows Council's to decide which level they will provide services for. In Hartlepool we will offer advice and information to everyone but at present we must focus our support on people who have critical or substantial needs. These levels may change in the future. If you are assessed as being in the low or moderate band you will only be eligible to be provided with advice, information and signposting to other services / agencies.

Please tick ☑ the boxes that are relevant to you

<table>
<thead>
<tr>
<th>Threshold set at Low</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I need help to carry out one or two personal care or domestic routines</td>
<td></td>
</tr>
<tr>
<td>I need help to be involved in one or two aspects of work, education or learning</td>
<td></td>
</tr>
<tr>
<td>I need help to maintain important relationships</td>
<td></td>
</tr>
<tr>
<td>I need help to keep one or two family and other social roles and responsibilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threshold set at Moderate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I need help to carry out our several personal care or domestic routines</td>
<td></td>
</tr>
<tr>
<td>I need help to be involved in several aspects or work, education or learning</td>
<td></td>
</tr>
<tr>
<td>I need help to maintain several important relationships</td>
<td></td>
</tr>
<tr>
<td>I need help to keep several family and other social roles and responsibilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threshold set at Substantial</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I have experienced abuse or neglect</td>
<td></td>
</tr>
<tr>
<td>I need help to carry our most personal care or domestic routines</td>
<td></td>
</tr>
<tr>
<td>I need help to be involved in many aspects or work, education or learning</td>
<td></td>
</tr>
<tr>
<td>I need help to keep most of my important relationships</td>
<td></td>
</tr>
<tr>
<td>I need help to keep most of my family and other social roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>I have only partial choice and control over the world around me</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threshold set at Critical</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>My life is, or will be at risk</td>
<td></td>
</tr>
<tr>
<td>I have significant health problems</td>
<td></td>
</tr>
<tr>
<td>I have little or no choice and control over the world around me</td>
<td></td>
</tr>
<tr>
<td>I have experienced serious abuse or neglect</td>
<td></td>
</tr>
<tr>
<td>I need help to carry out vital personal care or domestic routines</td>
<td></td>
</tr>
<tr>
<td>I need help to be involved in work, education or learning that is vital to my independence</td>
<td></td>
</tr>
<tr>
<td>I need help to keep relationships vital to my independence</td>
<td></td>
</tr>
<tr>
<td>I need help to keep family and other social roles and responsibilities vital to my independence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completed By:</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

2
Contact Information

Name
Address
Telephone

My Date of Birth is
Age
My National Insurance Number is

CONSENT TO SHARE THIS INFORMATION
Please complete this information where consent has not already been gained
I do / do not (please delete where applicable) consent to this document being shared.

Signed
Date

Has someone supported you to complete this for
Yes  No

Name of person supporting you
Relationship to you:
### Current support

I currently get support from:

**TICK THE BOX THAT FITS YOU BEST**

- Family, friends or neighbours
- Adult & Community Services
- Health Services
- Other
  - Please specify

[ ]

[ ]

[ ]

[ ]
### Current Income

I currently receive the following benefits:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>(amount)</td>
</tr>
<tr>
<td>Pension</td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Disability Living Allowance</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td>High Rate Care</td>
<td></td>
</tr>
<tr>
<td>Mid Rate Care</td>
<td></td>
</tr>
<tr>
<td>Low Rate Care</td>
<td></td>
</tr>
<tr>
<td><strong>Attendance Allowance</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td>High Rate</td>
<td></td>
</tr>
<tr>
<td>Low Rate</td>
<td></td>
</tr>
<tr>
<td><strong>Mobility Allowance</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td>High Rate</td>
<td></td>
</tr>
<tr>
<td>Low Rate</td>
<td></td>
</tr>
<tr>
<td><strong>Incapacity Benefit</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Income Support</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Pension Credit</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Retirement Pension</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Severe Disablement Premium</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td>Does anyone receive Carers Allowance on your behalf?</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>Carers Allowance</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Independent Living Fund</strong></td>
<td>(amount)</td>
</tr>
<tr>
<td><strong>Number of hours (ILF)</strong></td>
<td>hrs</td>
</tr>
<tr>
<td><strong>Housing Benefit</strong></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td><strong>Council Tax Benefit</strong></td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>
Savings and property

Do you currently have savings over £13,000 Yes □ No □
£21,500 Yes □ No □

Do you live alone? Yes □ No □
Do you have a partner? Yes □ No □
Do you own your home? Yes □ No □
Do you own any other property or land? Yes □ No □

Accommodation

What type of accommodation do you live in? (e.g. sheltered accommodation, supported living, mortgaged/owned home)

Do you have difficulties within the property?

Is there any reason why you need to change your living situation?

Do you hold a tenancy for your home? Yes □ No □
Do you have/need any minor aids/equipment/adaptations to your home to make it easier for you to move around? (e.g. grab rails etc)

Do you have/need any major aids/adaptations to your home? (e.g. stair lift, ramp etc)
Are you deaf/hearing impaired?  
Yes □ No □

If yes, please provide further information

Are you blind/visually impaired?  
Yes □ No □

If yes, please provide further information

Do you need help to communicate, help from an interpreter or to understand what is said to you?  
Yes □ No □

If yes, please provide further information

Are you a wheelchair user?  
Yes □ No □

If yes, please provide further information

The Resource Allocation System is designed to assess how having support needs affects your day-to-day life. It is not just about how your disability affects you but also about the life you lead at present.
# Quality Of Life Questions

This information needs to be collected so that we can find out what the benefits are in taking up Self Directed Support.

You can complete this section yourself or it can be filled in by someone else such as a Care Manager.

Please answer ALL questions by ticking the relevant boxes

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the past year, would you say your health has been:</td>
<td>Very good, Fairly good, Not good</td>
</tr>
<tr>
<td>2. Do you feel safe when you are at home?</td>
<td>Very safe, Fairly safe, Fairly unsafe, Very unsafe</td>
</tr>
<tr>
<td>3. Do you have enough money to lead the life you want?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough</td>
</tr>
<tr>
<td>4. Do you have the right amount of control over your life?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough, Don’t know</td>
</tr>
<tr>
<td>5. Do you have the chance to be with the people you like being with?</td>
<td>Definitely enough, Just enough, Not enough, Definitely not enough</td>
</tr>
<tr>
<td>6. Thinking of your whole life, would you say that you are:</td>
<td>Very happy, Fairly happy, Fairly unhappy, Unhappy</td>
</tr>
</tbody>
</table>
1. **Complex needs and risks**

This part is about the things I may do. Can the things I do be dangerous for me or other people?

*Tick the box that fits you best*

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past I have done things that could hurt me or others or I've done things that were difficult for other people. But there is no problem now.</td>
<td></td>
</tr>
<tr>
<td>To keep from doing things that other people find difficult.</td>
<td>□</td>
</tr>
<tr>
<td>Some things I do other people find difficult. I have help to manage this so there's no real danger to me or other people.</td>
<td></td>
</tr>
<tr>
<td>To do things that are difficult for people less often.</td>
<td>□</td>
</tr>
<tr>
<td>I do not know when I am in a situation where I can be hurt or when I can hurt others.</td>
<td></td>
</tr>
<tr>
<td>To make sure myself or other people are not harmed.</td>
<td>□</td>
</tr>
<tr>
<td>This section is not relevant to me as I do not have any needs in this area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□</td>
</tr>
<tr>
<td>I am not able to maintain personal safety as I have no control over my environment due to a physical disability.</td>
<td></td>
</tr>
<tr>
<td>To make sure myself or other people are not harmed.</td>
<td>□</td>
</tr>
</tbody>
</table>

**Additional Information**

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2. Meeting personal needs

This part is about looking after myself – things like washing, getting up out of bed, going to the toilet, dressing and personal support needs

**TICK THE BOX THAT FITS YOU BEST**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to meet my personal needs and do not require any support in this area.</td>
<td></td>
</tr>
<tr>
<td>I am able to meet my personal care needs with occasional physical / gestural / verbal support.</td>
<td></td>
</tr>
<tr>
<td>I need significant physical / gestural / verbal support from another to meet my personal care needs.</td>
<td></td>
</tr>
<tr>
<td>I need full intimate support to meet my personal support needs. I need this from someone else.</td>
<td></td>
</tr>
<tr>
<td>To maintain independence but ensure essential care needs are met.</td>
<td></td>
</tr>
<tr>
<td>To have essential personal care needs met and remain free from harm.</td>
<td></td>
</tr>
<tr>
<td>To have essential personal care needs met and remain free from harm.</td>
<td></td>
</tr>
</tbody>
</table>

Additional information

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
### 3. Meals and Nutrition

This part is about the help that I may need to help me to stay healthy

**TICK THE BOX THAT FITS YOU BEST**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need any help in this area.</td>
<td></td>
</tr>
<tr>
<td>I need <strong>some</strong> help with preparing meals.</td>
<td></td>
</tr>
<tr>
<td>I need <strong>all</strong> of my meals provided or prepared for me by someone else.</td>
<td></td>
</tr>
<tr>
<td>I need <strong>total support</strong> from someone else to help me to prepare my meals and to help me to eat and drink.</td>
<td></td>
</tr>
</tbody>
</table>

**To acquire increased independence and remain well nourished.**

**To remain well nourished and free from harm.**

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**Additional information**

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4. Work, Learning and Leisure

This part is about having a job, learning new things or keeping busy and enjoying life (including vocational activities).

**TICK THE BOX THAT FITS YOU BEST**

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need any help in this area.</td>
</tr>
<tr>
<td>I have a work role / job / am enjoying my spare time. This gives meaning and purpose in my life and I need some support to keep this.</td>
</tr>
<tr>
<td>I need support to take part in work, leisure or learning. I need more support to get more opportunities for work, learning or leisure.</td>
</tr>
<tr>
<td>I need support to take part in work, leisure and learning and I have few or no chances for work, leisure or learning in my life.</td>
</tr>
</tbody>
</table>

**Additional Information**

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5. Making important decisions about life

This part is about who decides important things in my life – things like where I live and who supports me

Tick the box that fits you best

<table>
<thead>
<tr>
<th>Outcome</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need any support in this area.</td>
<td></td>
</tr>
<tr>
<td>I need support to make decisions but I have full control over all day-to-day and life changing decisions.</td>
<td></td>
</tr>
<tr>
<td>I need support to make decisions. I have control over most day-to-day decisions but less say in life changing decisions.</td>
<td></td>
</tr>
<tr>
<td>I need support to make decisions about my life, but most day-to-day decisions are taken by others on my behalf.</td>
<td></td>
</tr>
<tr>
<td>To maintain opportunities to make supported decisions.</td>
<td></td>
</tr>
<tr>
<td>To have control over life changing decisions.</td>
<td></td>
</tr>
<tr>
<td>To take more control over day-to-day decisions.</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information

________________________________________________________________________

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________________________________________________________________________
6. Being part of the local community

This part is about doing things in my community – like using local shops, the library, going to the cinema, clubs, community centre, church or other place of worship, helping neighbours, or being involved in local organisations.

**TICK THE BOX THAT FITS YOU BEST**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t need any support in this area.</td>
<td></td>
</tr>
<tr>
<td>I do things I want to in my community. I need support to continue to do these.</td>
<td></td>
</tr>
<tr>
<td>I need support to do more in the community.</td>
<td></td>
</tr>
<tr>
<td>I need someone to support me closely to help me to make connections with people in the community where I live because I have difficulty making friends or get very lonely.</td>
<td></td>
</tr>
<tr>
<td>To keep doing things I want to in my community.</td>
<td></td>
</tr>
<tr>
<td>To be part of and take part in the local community.</td>
<td></td>
</tr>
<tr>
<td>To be part of and take part in the local community and use a range of community facilities on a regular basis.</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
7. Essential Family / Caring Role

This section is about the help that I may need to care for someone who needs my help, e.g. child or a dependant. For example, Parent, sibling, partner, grandparent, other family member, friend etc.

**Tick the box that fits you best**

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not need any support with my parenting / caring role or am not a parent.</td>
</tr>
<tr>
<td>I need some support with parenting tasks, or some support in my role as a carer.</td>
</tr>
<tr>
<td>I need lots of support with many parenting tasks, or a lot of support in my role as a carer.</td>
</tr>
</tbody>
</table>

Additional information

_________________________
_________________________
_________________________
_________________________
# 8. Available Social Support

This part is about the help I have and the help I need.

**Tick the box that fits you best**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to get nearly all the help I need from my family and friends.</td>
<td>To maintain ongoing involvement and family relationships.</td>
</tr>
<tr>
<td>I am able to get <strong>much</strong> of the help I need from family and friends and have or need occasional paid help</td>
<td>To keep existing support and have occasional support of my choice.</td>
</tr>
<tr>
<td>I am able to get only <strong>some</strong> of the help I need from family and friends and need significant paid support.</td>
<td>To keep existing support and have access to significant support of my choice.</td>
</tr>
<tr>
<td>I get little or no help at all from family or friends.</td>
<td>To form and keep relationships with people who are not paid to offer support and also have access to essential paid support.</td>
</tr>
<tr>
<td>I need 24-hour / 7 days per week paid support.</td>
<td>To form and keep relationships with people who are not paid to offer support and also have access to essential paid support.</td>
</tr>
</tbody>
</table>

**Additional Information**
8. Available Social Support

This part is about the help I have and the help I need.

**TICK THE BOX THAT FITS YOU BEST**

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to get nearly all the help I need from my family and friends.</td>
<td>To maintain ongoing involvement and family relationships.</td>
</tr>
<tr>
<td>I am able to get <strong>much</strong> of the help I need from family and friends and have or need occasional paid help</td>
<td>To keep existing support and have occasional support of my choice.</td>
</tr>
<tr>
<td>I am able to get only <strong>some</strong> of the help I need from family and friends and need significant paid support.</td>
<td>To keep existing support and have access to significant support of my choice.</td>
</tr>
<tr>
<td>I get little or no help at all from family or friends.</td>
<td>To form and keep relationships with people who are not paid to offer support and also have access to essential paid support.</td>
</tr>
<tr>
<td>I need 24 hour / 7 days per week paid support.</td>
<td>To form and keep relationships with people who are not paid to offer support and also have access to essential paid support.</td>
</tr>
</tbody>
</table>

Additional Information

__________________________________________________________________________________________

__________________________________________________________________________________________
9. Family carer and social support

This part is for an unpaid carer (this is often a family member or close friend). What does supporting me mean for my carer? What is their life like?

| I currently do not have anyone who is my unpaid carer. |

To the carer: This part is for you. Which of these statements best describes your current circumstances?

TICK THE BOX THAT FITS YOU BEST

- I am able and willing to continue in my current caring role. My caring responsibilities have no negative impact on my daily life. [ ]
- I am able and willing to continue in my current caring role. My caring responsibilities have only a small impact on my daily life. [ ]
- I have some difficulty and stress in carrying out my day-to-day caring tasks. There is some impact on my lifestyle and playing this role leads to minor stress. I am willing to continue in my role as a Carer. [ ]
- My caring role has a substantial impact on my lifestyle. Playing this role has led to high levels of stress and some health problems. I am willing to continue in my role as a Carer. [ ]
- My caring role has a critical impact on my lifestyle - including a significant impact on my health and well-being. I am unable or unwilling to continue in the role as it currently is. [ ]
- I would like to receive a carers assessment. [ ]

Additional comments

__________________________________________________________

__________________________________________________________

__________________________________________________________
### FOR OFFICE USE ONLY

#### CHECKLIST FOR ELIGIBILITY

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aged between 16 - 65?</td>
<td></td>
</tr>
<tr>
<td>Is your net Resource Allocation over £16,640 per annum or £320 per week?</td>
<td></td>
</tr>
<tr>
<td>Are you in receipt of high rate care component of Disability Living Allowance (DLA) or awaiting a decision from the DWP?</td>
<td></td>
</tr>
<tr>
<td>Are you living in the UK and expect to live in your home for 6 months after you have applied?</td>
<td></td>
</tr>
<tr>
<td>Do you have capital / savings of less than £18,500 (this must include any money your partner has)?</td>
<td></td>
</tr>
</tbody>
</table>

### FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Category</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>As of Date</td>
<td></td>
</tr>
<tr>
<td>Total Number of Points in RAS</td>
<td></td>
</tr>
<tr>
<td>Indicative Allocation Amount</td>
<td></td>
</tr>
<tr>
<td>Community Care Budget via HBC or HPCT</td>
<td></td>
</tr>
<tr>
<td>Carers Allowance</td>
<td></td>
</tr>
<tr>
<td>Supporting People</td>
<td></td>
</tr>
<tr>
<td>DFG</td>
<td></td>
</tr>
<tr>
<td>ICES</td>
<td></td>
</tr>
<tr>
<td>ILF</td>
<td></td>
</tr>
<tr>
<td>Access to Work</td>
<td></td>
</tr>
<tr>
<td>Financial Contribution</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL AMOUNT FOR SUPPORT NEEDS</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: List of stock-take interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judy Bilderbeck</td>
<td>CEO</td>
<td>AccessAbility</td>
</tr>
<tr>
<td>David Darling</td>
<td>Service Leader</td>
<td>Capital Support</td>
</tr>
<tr>
<td>Helene Dore</td>
<td>Team Leader</td>
<td>Focus</td>
</tr>
<tr>
<td>Rosalie Eilering (&amp; Kay Thomas)</td>
<td>Manager NASC</td>
<td>NorthAble</td>
</tr>
<tr>
<td>Ann Fowler (&amp; Raewyn Cameron)</td>
<td>Manager</td>
<td>Supportlinks</td>
</tr>
<tr>
<td>Sue Hansson</td>
<td>Manager</td>
<td>Access Ability</td>
</tr>
<tr>
<td>Sonia Hawea</td>
<td>Chief Executive</td>
<td>Taikura Trust (INSA)</td>
</tr>
<tr>
<td>Marlon Hepi</td>
<td>Senior Leader: Tairawhiti &amp; Petone</td>
<td>LIFE Unlimited</td>
</tr>
<tr>
<td>Kim Holt</td>
<td>Manager</td>
<td>Disability Support Link</td>
</tr>
<tr>
<td>Craig Hutchison</td>
<td>Managing Director</td>
<td>Life Links</td>
</tr>
<tr>
<td>Carole Kerr</td>
<td>District Manager</td>
<td>Support Works</td>
</tr>
<tr>
<td>Tony McLean</td>
<td>Manager</td>
<td>Access Ability Taranaki</td>
</tr>
<tr>
<td>Karen Mora</td>
<td>Team Leader</td>
<td>Options, Hawkes Bay</td>
</tr>
<tr>
<td>Jane Pembleke</td>
<td>National NASC Manager</td>
<td>LIFE Unlimited Charitable Trust</td>
</tr>
<tr>
<td>Anne Simpson</td>
<td>Manager</td>
<td>Life Links</td>
</tr>
<tr>
<td>Don Sorrrenson</td>
<td>Regional Manager</td>
<td>Support Net Kupenga Hao Ite Ora</td>
</tr>
</tbody>
</table>
Appendix 4: Self-assessment stock-take interview questions

1. - What does self-assessment mean to you in the context of your work?

2. - What do you see as the purpose of self-assessment?

3. - Under what conditions, and for whom, do you think self-assessment is most appropriate?

4. - What do you think are the key domains for a self-assessment to enable service coordination?

5. - Do you use, or are you aware of any examples of self-assessment tools or practices?

6. - If you currently use self-assessment tools or practices, please describe:
   i. Their purpose
   ii. The client group(s) they are used with
   iii. How they were developed (e.g. in-house or adapted from elsewhere)
   iv. When and how they were implemented
   v. The impact of the tools/processes on staff, clients and processes.

7. - Are there any other comments or information you would like to add?