Satisfaction with adult social care assessment: the development of a measure

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Abstract
Seeking the opinions of service users is an important aspect of ensuring services are designed and adapted with their views in mind. The evaluation of social care assessment in the UK and elsewhere has to date been limited. This paper describes the development and implementation of a new tool – The User Satisfaction Assessment Tool (USAT), validated by older people, designed specifically to measure older service users’ views of social care assessment, in particular their satisfaction with it. This was undertaken as part of an evaluation of the Single Assessment Process (SAP), introduced into England in 2004. The challenge was to create a tool that could be used by a broad range of people, be administered in a variety of ways, and be sensitive to variation in response. The paper considers the concept of satisfaction and its measurement, describes the administration of the USAT, and further explores a number of methodological issues arising from this. Following discussion of both its strengths and limitations, the paper concludes that the USAT is an appropriate and reliable satisfaction tool to collect baseline data from which more detailed and in-depth responses could be drawn.

Keywords: User satisfaction, social care assessment, older people

Introduction
For many years policies and practices have been implemented both in the UK and internationally that have sought to improve assessment: making it a more integrated and personalised experience focussing on issues of importance to the individuals concerned (Ministry of Health, 1994; Ministry of Health and Welfare of Japan, 1995; Dutch Ministry of Health, 1997; Department of Health [DH] 2001, 2002, 2009, Department of Health and Ageing, 2002; Leichsenring & Alaszewski, 2004; Samsa et al., 2007; Lymbery, 2010; Law Commission, 2011). Evaluation of such initiatives is required if policy makers and practitioners are to learn about their impact, build on their successes and adapt to their shortcomings. Differences in the priorities of service users, carers and practitioners in relation to both assessment content (Preston-Shoot, 2003) and service provision (Robinson et al., 2004) have been well documented. To understand whether resources are being both effectively deployed and achieving their goals (Barnes & Wistow, 1992) requires that the service user’s voice is heard. The measurement of user satisfaction is one element of this (Cm 6737, 2006; DH, 2010).

The measurement of satisfaction is relatively new to social care, although it has a long history within health care (e.g. Cleary et al., 1991; Meakin & Weinman, 2002; Sáía et al., 2008). Additionally, the majority of tools have focused on the measurement of satisfaction with service provision (Geron & Chassler, 1998; Sixma et al., 2000; Wilson et al., 2004). This paper describes the development of a new tool: The User Satisfaction with Assessment Tool (USAT) to measure older people’s satisfaction with social care assessment, validated by older people and capable of being administered in a variety of ways. The survey of user satisfaction was undertaken as part of an evaluation of the Single Assessment Process (SAP), introduced into England in 2004 (DH,
2002), an initiative designed to improve assessment practice. The paper considers the concept of satisfaction and its measurement, describes the development of the new tool and explores a number of methodological issues arising from its administration.

The measurement of satisfaction

A lack of theoretical underpinning to the concept of satisfaction has been identified (Sitzia & Wood, 1997; Edwards & Staniszewska, 2000), suggesting that it is ‘elusive and subjective’ (Atwal & Caldwell, 2005, p.1), meaning different things to different people at different times and therefore unlikely to provide a good measure of quality (Sitzia, 1999; Bauld et al., 2000). Interaction between personal circumstance and responses to user satisfaction surveys is recognised with a number of studies commenting on the impact of perceived health status (Cleary et al., 1991; Sixma et al., 2000), expectations (Qureshi & Henwood, 2000), resources, user and carer characteristics (Chesterman et al., 2001) or simply how people feel on the day they are interviewed or complete a questionnaire (Bauld et al., 2000), on responses to questions about satisfaction with services. Recent efforts to address this include Hsieh’s model (2006) based on life satisfaction measurement theory, which replaces life domains with discrete aspects of service. Hsieh comments on the similarity between service user and life satisfaction suggesting that both involve subjective evaluations of objective conditions, are multidimensional constructs, measurable by either a single item or composite of responses to various domains. Disentangling the ‘objective’ features of service provision from the characteristics and circumstances of users remains a challenging problem.

A review of the literature on service user satisfaction with health and social care services suggests a dominance of the survey method with standardised questionnaires favouring closed items that are easily scored and administered by post. Issues of efficiency and the provision of standardised data that lend themselves to benchmarking between organisations have been key factors influencing provider preferences (McIvor, 1993). Critics of these approaches suggest limitations including poor cultural sensitivity; an assumption of consistent standards of literacy; a lack of responsiveness to changing aspirations; risk of tokenism (Faulkner & Thomas, 2002; Foord et al., 2004) and provider-led agendas (Boote et al., 2002; Robinson et al., 2004). Additionally, the notion of efficiency has been challenged by the lack of variation reported which undermines utility (Bauld et al., 2000; Williams et al., 1998; Edwards & Staniszewska, 2000). Powell and colleagues (2004), however, argue that despite the limitations of satisfaction surveys they merit continued use as a basis for further qualitative evaluations of dissatisfaction. Additionally they urge designers to pay closer attention to the validity and reliability of tools; to strike a balance between the generic and the local; and to ensure comparison between responders and non-responders.

In relation to the most appropriate methods of administering satisfaction measures, the literature lacks consensus (Geron, 1996; Bauer et al., 2001). Postal or self-completion questionnaires have been criticised for being difficult for users to read, tiring to complete (Atwal & Caldwell, 2005), and producing low response rates (Applebaum et al., 2000). Edwards and colleagues (2002) however, noted that by ensuring that questionnaires are short in length, personalised, and that researchers have some contact with participants, response rates can be increased. The use of service user interviewers is considered by some to be a means of encouraging more critical responses (Powell et al., 2004). Others have highlighted the need to use research approaches appropriate to the task (Chapple & Rogers, 1999). A mixed method approach is generally supported, enabling older people to choose from a portfolio of consultation methods according to their preferences (Bauld et al., 2000; Hayden et al., 2000; Scottish Executive, 2005).
These, then, are some of the challenges facing researchers, service providers and commissioners, when they seek to measure service user satisfaction. Whilst some might argue it is better to use an existing tool that has been sufficiently tested than embark on the creation of a new one, if the existing tools do not meet the needs of the various stakeholders, including service users, the argument for the development of a new tool becomes compelling (Chapple & Rogers, 1999; Bauld et al., 2000).

The development of the USAT

Our brief was to develop a tool that could be used by a broad range of older people and be administered in a variety of ways. It therefore needed to be short so as not to exclude the possibility of very frail older people taking part (Atwal & Caldwell, 2005; Lebow, 1983) and to permit the font to be large enough to enable it to be used by people with a degree of visual impairment (Hadjistavropoulos et al., 2003). The development of the USAT involved three stages of work: a review of existing tools embedded in the literature; a series of focus groups with older people; and a small scale pilot of a questionnaire developed from earlier stages, an evaluation of which resulted in the final version. These stages are summarised below followed by a description of the administration of the final version which is appended to this article with discussion of some of the methodological issues raised.

Review of existing tools

The literature outlined above, together with tools where available, were used to identify relevant topics, wording, and rating scales in respect of exploring user satisfaction with the assessment process. Two were found to be assessment specific (Scottish Executive, 2005; Torbay Adult Social Services, 2005) with the majority focussing on services, which in turn were mostly health rather than social care related. Five domains of enquiry, encompassing 31 themes, were identified that were considered to be of importance to the assessment interview: the style or manner in which the interview was conducted; the content of the assessment; the nature and level of involvement of the service user in the process; the clarity of communication; and the range of information provided. These themes, outlined in more detail in Table 1, formed the basis of discussions with groups of older people in a series of focus groups.

The focus groups: conduct and outcomes

Whilst it has been recognised for some time that involving older people in the research process can improve research and be beneficial to all involved (Warburton et al., 2009), there is little evidence of this practice within the current field of interest. Using contacts developed through previous studies and professional work, four groups of older people (35 individuals in total) were asked and agreed to participate in this aspect of developing the USAT by considering the relevance and relative priority of the themes noted above and to produce a shortlist of the most germane. The focus groups were held during January 2006. Participants of three of the groups came from Older People’s Resource Groups based in the North West of England (10, 7 and 7 people respectively). The fourth group comprised residents of a sheltered housing complex in the same geographic region (11 people). All group members were over the age of 65 years, many having had experience of assessment either directly or as carers. Both men and women were represented in all of the groups though none included BME representatives.

Three members of the research team took part in each session, one acting as a scribe to ensure that comments were accurately recorded. At each meeting the 31 themes, written as statements and grouped by domain, were distributed to participants and also put up on the walls, printed on large sheets of paper. Following explanation and discussion of the research, participants were asked to prioritise 12 topics they thought were the most important to be considered during an assessment.
Table 1. Domains and themes of enquiry

<table>
<thead>
<tr>
<th>Style</th>
<th>Content</th>
<th>Involvement</th>
<th>Communication</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person assessing me made me feel comfortable about the assessment</td>
<td>The assessment covered all the issues that were important to me</td>
<td>The person assessing me gave me the opportunity to talk about all my needs and concerns</td>
<td>The person assessing me made sure that we could understand each other</td>
<td>The purpose of the assessment was made clear/explained to me</td>
</tr>
<tr>
<td>I was happy with the way the person assessing me dealt with sensitive issues</td>
<td>The assessment covered issues that I did not think were relevant</td>
<td>The person assessing me discussed with me what mattered most to me</td>
<td>The assessment was undertaken in language that I understood</td>
<td>The assessor gave me the information I needed</td>
</tr>
<tr>
<td>I felt that the assessor treated me with respect</td>
<td>The person assessing me asked about any concerns I had about my health</td>
<td>I was asked about what I hoped I would get from the assessment</td>
<td>I was asked if I was happy for the information I gave to be shared with other health and social services staff</td>
<td>I was asked to sign a form as part of the assessment</td>
</tr>
<tr>
<td></td>
<td>The person assessing me asked about any help I might need in caring for myself</td>
<td>The person assessing me listened to my opinions and concerns</td>
<td>I was asked about any communication requirements I might have in advance of the assessment</td>
<td>The person assessing me explained what signing this form meant</td>
</tr>
<tr>
<td></td>
<td>The person assessing me took note of any important matters relating to my race, culture or religion</td>
<td>I felt I had some say in deciding what help or services should be given to me</td>
<td></td>
<td>I was asked for the same information that I have recently given to other health or social services staff</td>
</tr>
<tr>
<td></td>
<td>My abilities as well as my current difficulties were discussed</td>
<td>The person assessing me ignored my opinion about the care I needed</td>
<td></td>
<td>I was told about the direct payments scheme</td>
</tr>
<tr>
<td></td>
<td>The person assessing me asked about any help I might be receiving from family, friends and/or other sources</td>
<td>I felt involved in the discussion about my care</td>
<td></td>
<td>I have received a copy of my assessment of the summary or my assessment</td>
</tr>
<tr>
<td></td>
<td>The person assessing me discussed my carer’s situation with me</td>
<td></td>
<td>Communication was undertaken in language that I understood</td>
<td>The documents I received accurately reflected what I had agreed with the person assessing me</td>
</tr>
</tbody>
</table>

They were encouraged to do this by reading and discussing the statements with each other and/or the researchers and then sticking a label next to their choices. People with difficulties due to poor mobility, eyesight or literacy, were aided by members of the research team. At the end of this process further discussion took place to record comments about any statements that were difficult to understand, how they might be
clarified, and whether there were missing themes.

Choices from each group were summed to produce a list of 13 themes that became questions or statements in the USAT pilot. These can be seen in Figure 1, which also shows the percentage of ‘votes’ given to each of the prioritised themes. Thirteen themes were used rather than 12 due to closeness of votes for the twelfth and thirteenth and their related nature. Overall there were more similarities than differences between the groups. Four of the 13 most popular themes were chosen by all four groups, six by three of the four groups, and three by two of the groups. Each theme used in the USAT was voted for by over 40 per cent of participants with 5 themes being voted for by over 60 per cent. Groups received feedback on both their own and the overall top thirteen questions. A question referring to self-rated health was added as was space for respondents to add more information as free text.

**Piloting the USAT**

A pilot USAT was developed and trialled in face-to-face interviews initially with 14 older people with complex long-term support needs, who were involved in a separate part of the wider study (Clarkson et al., 2007). They were asked to complete the questionnaire independently, if possible, although researchers were present to help if necessary. Cognitive question testing (Qureshi & Rowlands, 2004) was then conducted and participants were asked to state whether they had found the questionnaire easy or difficult overall and if there were specific questions which they had found problematic in terms of wording or scoring system. The majority found the questionnaire relatively easy to complete, taking only a few minutes although a minority struggled with some questions. Analysis of these completed questionnaires found little variation between respondents with a strong bias towards positive responses.

**Figure 1.** Themes prioritised by focus groups (in order of overall scores)

1. The documents I received accurately reflected what I had agreed with the person assessing me (79%)
2. The purpose of the assessment was made clear/explained to me (77%)
3. The assessment covered all the issues that were important to me (67%)
4. I was given enough information for me to make choices about the care options available (61%)
5. The person assessing me made sure that we could understand each other (61%)
6. I was asked if I was happy for the information I gave to be shared with other health and social services staff (55%)
7. The person assessing me made me feel comfortable about the assessment (53%)
8. I was happy with the way the person assessing me dealt with sensitive issues (52%)
9. I felt that the assessor treated me with respect (50%)
10. I felt I had some say in deciding what help or services should be given to me (49%)
11. The person assessing me asked about any help I might be receiving from family, friends and/or other sources (47%)
12. I was asked about any help I might need in caring for myself (44%)
13. The person assessing me asked about any concerns I had about my health (40%)
In the light of these findings, although it was important to retain the subject matter intact, the wording of some questions and the response options of the USAT were revised and a second pilot tested with 11 older people. This version included two negative questions, the potential impact of which is discussed later. It was important to ensure that people with cognitive deficits could complete the USAT as there is evidence that the presence of cognitive impairment does not necessarily limit meaningful engagement in assessments or evaluation of satisfaction (Mozley et al., 1999; Barnett, 2000; Smith et al., 2007). The questionnaire therefore invited respondents to ask a relative, friend or carer to help with completion if required. Concerns about the use of proxies (Boyer et al., 2004) were tempered by stressing in the questionnaire guidance that the carer was to provide answers that they thought the person with dementia would give rather than their own views. This issue is discussed in more detail below. The final questionnaire is appended to this article.

**Administration of the final USAT**

Whilst acknowledging its limitations, the survey method was chosen for this evaluation as it allowed us to consult with a wide range of service users about their experiences. However, rather than relying on a single method of data collection, a mixture of methods, described below, was used, facilitating the inclusion of those with both mental and physical frailty. It therefore provided information from a wide set of circumstances, whilst representing those with ‘core observable commonalities of experience’ (Morse, 1998; Patmore et al., 2000).

**The sample**

Older people participating in this study incorporated those from a variety of situations and with a range of experience of social care assessment, allowing them to be split into three distinct groups, each with particular features. These are described in Table 2 above.

**Data collection**

It could be argued that many of the respondents in the new access group were older people with lower level needs and consequently the group most likely to be able to self-complete a questionnaire (Bowns et al., 1991). In this group, the mode of delivery was postal or hand-delivered by their care manager. In all cases questionnaires were returned to the research department by pre-paid envelope. In the care planning group, questionnaires were personally administered by Age UK workers to older people in their own homes. This group was given the option of completing the questionnaire themselves or with assistance from the Age UK worker acting as a mediator. Members of the research team provided training to the Age UK staff in order to ensure that interviews closely resembled those undertaken by the research

### Table 2. Participants

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New access group</strong></td>
<td>people having an assessment for the first time or having a new assessment following a break in services (three local authorities).</td>
</tr>
<tr>
<td><strong>Care planning group</strong></td>
<td>people considering direct payments following an assessment of their needs and confirmation of their eligibility for services (one local authority).</td>
</tr>
<tr>
<td><strong>Major life transition group</strong></td>
<td>people on the verge of major life change – either: in receipt of extensive care packages; in need of such services but either declining them or being supported informally; or those considering long-term care (one local authority).</td>
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</tbody>
</table>
team. In the major life transition group, older people identified as being on the cusp of major life change were interviewed face-to-face by study researchers. The different data collection methods are considered in relation to responses by service user group, adding a further dimension to the analysis (Uttaro et al., 2004).

In each of the participating authorities, data collection was linked to the assessment process as closely as possible. However, some differences between the groups were inevitable, reflecting the variety of approaches to the completion of the questionnaires. In the new access group, questionnaires were left with service users straight after the assessment in one authority, whilst in the other two, questionnaires were posted to service users following their assessment. For the care planning group the questionnaire was administered some time after the assessment, but immediately following discussion with the Age UK ‘mediator’ about how identified needs might be met. It was then completed either independently or with the help of the mediator or a carer. In the major life transition group, there was a longer gap between assessment and the administration of the USAT than in the other two groups. However, if the service user (or their carer, if appropriate) could not recall the assessment, they were excluded. Again, completion could be with or without help. The possibility of recall bias (Bowling, 1997) in respect of all three groups must be acknowledged (Atwal & Caldwell, 2005; Smith, 2000). The various combinations of group type and administration method are shown in Table 3.

**Response rate**

Overall, 163 completed questionnaires were returned. In the new access group the response rate was 20 per cent (n=55). Although this may be regarded as low, it is fairly typical of postal survey responses (Geron, 1998; Krosnick, 1999). The care planning group was, in effect, a convenience sample of service users in the process of considering direct payments. This group completed 28 questionnaires, with no users recorded as either unwilling or unable to complete them. The major transition group were service users who had consented to take part in a separate health and social care needs evaluation study (Clarkson et al., 2007). As all had already given their consent to this there were no refusals.

**Table 3. Data collection methods**

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Data collection methods</th>
<th>Completion options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Postal or hand delivered</td>
<td>Service user</td>
</tr>
<tr>
<td></td>
<td>Personally administered</td>
<td>Carer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mediator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Researcher</td>
</tr>
<tr>
<td>New access</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Care planning</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Major life transition</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>


However, out of 110 interviews undertaken in this separate study, 30 users were unable to complete the USAT, due to cognitive impairment or an inability to remember the assessment being carried out, resulting in 80 completed questionnaires. This represented a 73 per cent response rate. In total, 67 questionnaires (41%) were completed by a proxy respondent, 80 (49%) by the service user, and in 16 cases (10%), this information was not known.

Methodological issues

A number of methodological issues which arose during the study are discussed below, in particular the use of negatively worded statements; response format; use of proxy respondents; and mode of administration.

As previously described, there is evidence in the literature to support the use of some negatively-worded questions when designing measures, as these tend to result in greater variation in response. Bryman (2001) noted that reversing the format of question direction can reduce the likelihood of respondents exhibiting acquiescence response sets (agreeing regardless of their true opinion), observed in relation to older people in receipt of social care (Bauld et al., 2000). However such questions may also be misinterpreted by respondents, reducing reliability (Babbie, 2004; Bryman, 2001). Misinterpretation of negative questions has been found to be lessened where the specific word ‘not’ is avoided (De Vaus, 1996). The USAT utilised two reversed statements, where disagreement with the statement denoted satisfaction, for example, ‘the assessment missed out some issues that were important to me’, and ‘I felt I had no say in deciding what help or services I should receive’. These were also the two questions that elicited the least satisfaction overall. In order to determine whether these questions were misunderstood by respondents, a comparison was made between respondents who self-completed the questionnaire and those who had the assistance of a researcher/mediator. No differences between them were found suggesting that the reverse statements were not misunderstood and provided reliable findings.

When designing a new scale, it is important that the items within it have internal consistency; they should measure the same construct. Cronbach’s Alpha was used to test the extent to which each item on the satisfaction scale consistently reflected the construct being measured (Field, 2005). A figure of .801 was achieved, high enough to suggest that the USAT had overall good internal reliability, and was measuring a single construct. Subsequently, it was decided to create a scoring method to elicit an accurate and reliable overall satisfaction score, by summing together responses to the 13 satisfaction items. Research has suggested that a global measure may provide better score reliability and validity, and reduce skewness (Geron, 1998). However this method has been criticised by others (Applebaum, 2000; Hsieh, 2006). Since literature indicates that older people are less negative or critical of care and services than other groups (Owens & Bachelor, 1996; Williams et al., 1998), determining whether responses indicate genuine satisfaction, or a reluctance to express dissatisfaction has been consequently problematic. Interestingly, research on patient satisfaction by Collins and O’Cathain (2003) found that respondents do distinguish between being satisfied with services and being very satisfied. Their research suggested that these categories, which are often combined for purposes of analysis, should in fact be distinguished, thus creating a concept of very satisfied compared with all other categories, generating a standard to which audit and evaluation could aim. Therefore, to incorporate this approach in creating the overall satisfaction score, one point was given only for a response expressing very or strongly positive satisfaction, or coded ‘yes’ for questions with a yes/no response, giving a possible maximum total score of 13. It could be argued that this approach resulted in a more accurate and valid measure of outcome given the reluctance of older people to state dissatisfaction.
As noted above, carers or relatives were invited to complete the questionnaire on behalf of service users who might otherwise find completion problematic. Whilst some have urged caution when using proxies (Boyer et al., 2004), others have highlighted difficulties in the analysis of survey results that do not distinguish between service user and proxy responses (De Vaus, 1996). For this reason, a tick-box was provided for respondents to record whether the USAT had been completed with the assistance of a carer. There was also a reminder for proxies on the questionnaire that responses should indicate the service user’s views. It is nevertheless possible that these responses reflected the carer’s own views, rather than those of the service user. Notwithstanding this, overall no significant differences between service user and proxy respondents were found in terms of expressed satisfaction. Analyses of the three groups separately showed no significant differences between responses from service users and proxies for any satisfaction item in the new access group or major life transition group. There was one statistically significant difference in the care planning group in response to the question: ‘Did the person assessing you make sure you could understand each other?’ Carers acting as proxies were less likely to agree with this ($\chi^2=5.075$, 1 d.f., Fisher’s Exact test $p=0.044$) than service user respondents. Overall, however, the use of carers or relatives as proxies did not appear to influence the findings but did improve the overall response rate and permitted responses from service users who may otherwise have found it difficult to take part.

The fieldwork for this study was undertaken using a mix of methods in both distribution and completion of questionnaires. One area of inquiry was to determine whether user responses were affected by the mode of administration. Analysis of the data appeared to indicate some significant differences between the three respondent groups in respect of expressed satisfaction, with the new access group being the most satisfied overall. In this group, all questionnaires were completed by the service user or proxy alone. It is debatable as to whether this was due to particular service user characteristics of the group, or whether the method of administration could have affected patterns of response. When the overall sample was divided into user-completed and researcher-administered questionnaires, there were significant differences in their responses with the researcher-administered sample appearing less satisfied. Bauer and colleagues (2001) reported that interviewer-patient responses were more critical compared to self-completion responses. The only questionnaires administered by researchers/mediators were in the care planning group and the major life transition group, both expressing less satisfaction than the new access group. However, when the former groups were analysed separately no differences were found in the major life transition group between user completed or researcher administered responses, although the majority (88%) were researcher administered. In the care planning group, significant differences were found between those completed by the user or carer alone, and those completed with the assistance of a mediator. It is possible that the mediators administered the survey differently to the researchers, despite efforts to avoid this, introducing interviewer bias (Boyer et al., 2004; Uttaro et al., 2004). It can be argued that differences may have been due to the specific needs of the service users since those in the care planning group were considering direct payments and this may have reflected some dissatisfaction with assessment in relation to their service plans. Alternatively, surveys that are interviewer administered may allow respondents to consider issues more fully and having verbalised any minor dissatisfaction, give responses that are less positive than those who self-complete. This is consistent with the apparent conflict between immediate high ratings and negative responses when experiences are explored in depth (Powell et al., 2004). Given the potential for different influences on response, mixed methods of administration can offer
possible benefits, permitting the views of a wide range of service users and carers.

Discussion

This article has described the development of a tool to assess older people’s satisfaction with assessment within health and social care settings. Whilst the measurement of outcomes, such as quality of life, have come to the fore in recent policy (DH, 2012), satisfaction with care and with the assessment process remain relevant aspects of this wider ambit with a positive experience of support being judged significant in the measurement of the success of social care (DH, 2012). User satisfaction with the assessment of needs is an intermediate or process outcome of the quality of care at a transitional point between the meeting of needs and eventual quality of life (Challis et al., 2006). Empirical research has established that satisfaction with the process of care delivery can positively impact on outcomes (Alazri & Neal, 2003) and that having one’s needs met as a user relates to quality of life outcomes (Slade et al., 2005). Although imperfect as a measure, user satisfaction is also arguably a more objective and sensitive indicator of the effectiveness of services as it can be directly linked to service receipt. In contrast, quality of life can be influenced by many external factors, including relationships, money, work, family and environment (Okun & Stock, 1987).

In describing the development of the USAT issues have been raised related to the involvement of older people in both the research process and as active participants in service evaluation and the complexities of the measurement of the concept of satisfaction. In particular, findings from administering the tool to a variety of service user groups, in several different ways, highlighted both the strengths and drawbacks of this tool: demonstrating its reliability and its limitations. These issues are considered further below.

The potential benefits of involving the public in the research process include ensuring that issues of importance to them are identified and prioritised, that resources are not wasted, that marginalized groups are accessed, that research findings are more widely disseminated, and that service users are encouraged to press for service outcomes and quality measures that are more relevant to them than those defined by professionals alone (Boote et al., 2002; Powell et al., 2004). Indeed user involvement in this context has been defined as:

An active partnership between the public and researchers in the research process, rather than the user of people as the ‘subjects’ of research. (Involve, 2011)

Public involvement can take many forms ‘from developing priorities and research questions, to discussions about methodology and approach… and promotion of research outcomes’ (Warburton et al., 2009, p.43). This study involved people in the early stages of the research, thought by some to be the most important (Hanley et al., 2000). By so doing the themes included in the USAT are likely to represent those of importance to service users rather than service providers, a criticism of previous satisfaction tools within this sphere.

Satisfaction measures to date, particularly those that rely heavily on survey responses, have struggled to identify dissatisfaction. Analysis of responses to the USAT, separating those that were very satisfied from the rest, demonstrated that the tool was sensitive enough to pick up variation. Given the known reluctance of older service users to express dissatisfaction, due to a range of reasons including perceived and perhaps actual vulnerability, this may be a valid means of achieving variation and one supported by previous research (Collins & O’Cathain, 2003).

The tool has been shown to be useable by a range of older people including those with cognitive impairment via the use of proxies whose responses were demonstrated not to have differed significantly. Other studies where proxies have been used have shown distinct differences between these responses
and those of service users (Preston-Shoot, 2003; Atherly et al., 2004). The findings of the current study are therefore encouraging and suggest that it can be used with confidence with people whose voices are often excluded from research and service feedback. Cognitive testing of the tool when piloted suggests that it can be easily understood by the most vulnerable amongst the overall sample. However, this group did not include BME community members and therefore its cultural sensitivity (Ingersoll-Dayton, 2011) in this respect remains unknown.

The individual questions within the tool can be analysed separately, or can be summed to provide a global measure of satisfaction. Whilst recognising concerns that the latter can potentially mask variation, the brevity of the current tool and the fact that the items and domains within it are closely related, providing internal reliability, may reduce this problem. The criticisms of the survey method, whilst not overturned by this tool, are challenged by them as a result of the careful construction of questions and scales, the extra space provided for further elaboration of responses, and, perhaps most importantly, the fact that it could be easily administered to large numbers of people in different settings and by different means. The variation in the method of administration in itself did not appear to influence the results of the survey and might be considered a strength of the tool, although the biasing effect of mode of administration is recognised in the literature (Bowling, 2005). Indeed, the fact that different user populations with both potential and real differences between them had the tool administered to them in different ways complicated the picture and we would suggest that this aspect of the study weakened the generalisability of the findings.

**Conclusion**

The tool considered here is relevant to measuring the quality of assessment, whether it is self- or professionally-orientated, the latter remaining a statutory duty of local authorities. Satisfaction with the assessment process is a key intermediate marker of outcome and is crucial to the measurement of the success of service delivery. The USAT was designed to meet the needs of a specific study but to be flexible enough to enable it to be used by others (Powell et al., 2004). The characteristics of the tool have also demonstrated that its performance was neither skewed by proxy responses nor insensitive to variation. However, further validation would be beneficial. It has since been used, although with a slightly amended response format, but using the same content by another study funded by the Department of Health which provided reliable results, demonstrating the stability of the underlying concepts (Clarkson et al., 2010) and which informed the development of the Common Assessment Framework for Adults (DH, 2009). This would suggest that it can be used in its simple form with confidence. If used as one of a battery of tools to collect baseline data from which to target more detailed evaluation then its limitations might also be its strength: identifying those with whom further in-depth responses might be of particular benefit.

**Table 4. Summary findings**

- The satisfaction items within the questionnaire have good internal reliability, indicating that the satisfaction tool is reliably measuring that construct.
- Differences in the method of administration may have influenced differences in reported levels of satisfaction between respondent groups.
- Outcomes were not affected by the use of carers or relatives as proxy respondents but allowed the inclusion of service users who would otherwise not have been able to participate.
Acknowledgements

We would like to thank all the service users who completed the USAT and the care management teams in North West England who distributed them; Cheshire Older People’s Resource Groups and sheltered housing tenants in Warrington who made up the focus groups; Age UK Cheshire; and Judy Scott, formerly of the PSSRU, for their contributions to the study. The study was funded by the Department of Health in England. The views expressed here are those of the authors and are not necessarily shared by the Department of Health.

References


Satisfaction with adult social care assessment


Torbay Adult Social Services (2005) *Questionnaire for Service Users and Carers who Have Had an Assessment*, Torbay: Social Services Department.


Notes on Contributors

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Paul Clarkson, PhD, MSc, BA, CQSW, is a Research Fellow at the PSSRU, University of Manchester. He previously worked as a social worker in psychiatric and acute medical settings before research posts in London and Leeds. His interests are in performance measurement in long-term care of older people, assessment in community settings and the use of routine data to evaluate practice.

Judith Unell, PhD, BA, is an independent researcher consultant with experience in conducting agency reviews, social research, project evaluation and funding scheme evaluation. She held a position as an Honorary Researcher with PSSRU, University of Manchester, during 2005.

David Challis, PhD, MSc, BA, Cert PSW, CQSW, Cert Ed, is Professor of Community Care Research and Director of the PSSRU, University of Manchester. He has undertaken the development and evaluation of a series of studies of community based care for older people which provided alternatives to hospital and nursing home care; national studies of care coordination in older people's services; evaluations of assessment procedures in England; and a range of studies on the mental health of older people.

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Appendix

User Satisfaction with Assessment Tool

(Reproduced in a smaller font here)

(Organisation name removed)

[Name of local authority] social services have recently completed an assessment of your needs. The (organisation name removed) is seeking your help in understanding people’s satisfaction with the quality of assessment. By this we mean the discussions you have had with health or social services staff about the kind of help and services you need.

The (organisation name removed) is an independent research organisation. We are not connected to your local authority. All the information you give us will be strictly confidential and will not affect the services you receive.

The questionnaire will help us find out what mattered to you in the assessment process. It will also help us find out what is working well and what is not working so well. The information that you and other service users give us will be written up as a report for the Department of Health informing them of older people’s views about assessment practice.

A relative, friend or carer can help you to complete the questionnaire.
Here is a list of questions and statements. They are followed by a list of options. Please circle or tick the option that most closely relates to your views and experiences. If you cannot answer the question don’t worry, just move on to the next one.

1. How do you rate your health at the present time?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
</table>

THE ASSESSMENT

2. Was the purpose of the assessment made clear to you?

<table>
<thead>
<tr>
<th>Very clear</th>
<th>Reasonably clear</th>
<th>Not very clear</th>
<th>Very unclear</th>
</tr>
</thead>
</table>

3. Did the person assessing you make you feel comfortable about the assessment?

<table>
<thead>
<tr>
<th>Very comfortable</th>
<th>Fairly comfortable</th>
<th>Fairly uncomfortable</th>
<th>Very uncomfortable</th>
</tr>
</thead>
</table>

4. Did the person assessing you make sure you could understand each other?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Mostly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
</table>

5. Did the person assessing you ask about your health?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

6. Were you asked about any help you might need in caring for yourself?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

7. Did the person assessing you ask about any help you might be receiving from family, friends and/or other sources?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>
8. Were you asked if you were happy for the information you gave in the assessment to be shared with other health and social services staff?

| No | Yes |

YOUR VIEWS

9. I felt that the person assessing me treated me with respect

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |

10. The assessment missed out some issues that were important to me

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |

11. I was happy with the way the person who was assessing me dealt with sensitive issues

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |

12. I felt that I had no say in deciding what help or services I should receive

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |

13. I was given enough information to make choices about the care options available

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |

14. The information in the documents I received following my assessment was what I had agreed with the person assessing me

| Strongly agree | Slightly agree | Slightly disagree | Strongly disagree |
If you would like to tell us something else about your assessment, please use the space below to do so.

<table>
<thead>
<tr>
<th>This questionnaire was completed by (please tick one box)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myself  □ OR A relative or carer □ on my behalf</td>
</tr>
</tbody>
</table>

Thank you for your help in responding to this questionnaire.

Please return it in the pre-paid envelope provided.

If you would like any further information regarding this research please contact (removed for review purpose).