

Self-assessment in community care: are service users satisfied?

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**Social Policy Association Conference
Edinburgh 29 June – 1 July 2009**

Abstract

Background: The Personal Social Services Research Unit at Manchester University was funded by the Department of Health to evaluate the efficiency and effectiveness of self-assessment practices in adult care in 11 English authorities (pilot sites). Self-assessment is understood to be a process in which a person assesses their own needs without or with only limited professional involvement, with the ultimate goal of determining eligibility for assistance and/or arranging care. **Methodology:** A user experience survey was conducted in 9 pilot sites. It included mainly older people accessing occupational therapy, preventative and assessment and care management services. Both recipients of self and traditional assessments were surveyed. 1,862 questionnaires were returned (54 percent), nearly two thirds of which came from self assesseses. Socio-demographic data collected in other modules of the study could be linked to the satisfaction questionnaires of 744 respondents, permitting some statistical modelling. The user experience was perceived as a multidimensional concept, suggesting at least three different summary measures upon which the majority of the analysis was based. **Results:** The majority of self and traditional assesseses found their assessment easy to complete and expressed a high degree of satisfaction with their experience. There was no suggestion that either self or traditional assessments are better from the perspective of the user. Measured variables predicted relatively little of the variation in user satisfaction. However, users of online self-assessment found the experience more difficult and less satisfying than did respondents participating in other forms of self or traditional assessment. Asian service users, people with concerns about their memories and individuals who rated their health less than very good also found it more difficult to self-assess than did other service users. Males and people with low mood were less satisfied with self-assessment, although they did not necessarily find the process more difficult than other users.

1. Background: the introduction of self-assessment to community care

The process of assessment – that 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. In community care settings the process is crucial in determining ‘who’ gets ‘what’ and thus is both an important resource allocation mechanism for governments to consider (Fisher, 1998) and an obvious precondition for the satisfaction of service users’ needs. More recently, changes to the way people are assessed for community care services have been advocated and these have focused around the ‘personalisation’ agenda, a need to offer a greater degree of choice, control and individually tailored approaches to people who may require personal support or assistance. Self-assessment, where the individual is located at the heart of their own assessment with their rights, wishes and goals upheld, is one such change promoted in recent policy. Although often presented as a novel idea, there are many precursors to such an approach. Examples are the ‘self managed’ support and supported self-assessment approaches advocated by the disabled people’s movement in England (Priestley, 1998) as well as self-screening approaches in primary care in the United States (Wasson et al., 1999) and other countries (Bowns et al., 1991; Tulloch and Moore, 1979). Often, these are linked to a second-stage assessment by a professional, such as a physician. In England, a more user-centred assessment, promoting choice and involvement, was always advocated as part of the mid-1990s community care reforms (Department of Health, 1990a), but implementing the idea as part of routine practice within local authorities faced challenges that were never fully resolved.

Despite being expressed in a range of more recent policy documents, self-assessment lacks specificity as to its role and its key elements. Is self-assessment envisaged as part of the comprehensive assessments undertaken by social workers and community nurses for example? If so, how should it link to professional judgement and eligibility for services? Does the approach only mean self-referral rather than assessment? Or, is self-assessment merely a label for a mechanism that bypasses formal assessment entirely and provides direct access to relatively low risk provision, such as equipment (Disabled Living Foundation, 2007). The limited evidence to date – including the pilot studies which informed this paper – suggests that self-assessment may be located within at least one of the following three service areas: (1) preventative services – where self-assessment may be part of ‘transforming’ social care for adults through a strategic shift to early intervention for those with lower-level needs (Department of Health, 2008; Cm 6499, 2005); (2) occupational therapy services – where self-assessment is considered pivotal in providing access to minor adaptations and equipment (Cm 6499, 2005) and as part of a retail model, with both an online component and a facility for ‘independent needs assessors’ to issue users with a prescription of equipment from an approved/accredited retailer (CSED, 2007; Her Majesty’s Government, 2007); and finally (3) assessment and care management arrangements – where self-assessment may fit within statutory assessment arrangements stemming from the community care reforms of the early 1990s, which were identified as a means of ensuring appropriate care, placement in residential and nursing homes and better use of resources in the care of very frail older people and adults with a disability (Cm 849, 1989). Consequently, the literature also testifies to at least four potential goals of self-assessment within the wider care process and within the aforementioned service areas: as a component of *screening*, where individuals are

identified for whom further professional assessment is appropriate; as a *contribution to the assessment process*, where the range of needs of individuals are more effectively identified; to facilitate *direct access* to services outside the formal assessment process; and as a *contribution to service planning* (Challis & Davies, 1986; Applebaum & Austin, 1990; Golden & Tropman, 2000; Hughes et al., 2005; Cm 6737, 2006).

2. Evaluating the effectiveness of self-assessment: the role of user satisfaction

The introduction of self-assessment to community care has numerous quality implications for the assessment process. In order to pass the tests of policy evaluation we would expect it to be at least cost-effective, produce valid assessment outcomes and lead to service provision of equal or better quality standards. The subjective evaluation of the assessment process by the service user is only one aspect therein, but one that has received much attention in recent years. The participation of service users in developing good quality health and social care services is now recognised by government policy (Cm 4169, 1998; Cm 6737, 2006). The White Paper *Modernising Social Services* (Cm 4169, 1998), for instance, stipulated that social service departments would need to design and conduct satisfaction surveys as one means of capturing experiences and perceptions of users and carers. Similarly, the National Service Framework for Older People (NSFOP) (Department of Health, 2001a) emphasised the importance of listening to older people as a means of encouraging improvements in the quality of services. Specific policy developments and the literature relevant to the measurement of user satisfaction encompass various themes including listening to the service user's voice during assessment, ensuring participation and involvement, being person-centred, quality monitoring, professional power shifts and the personalisation agenda (Department of Health, 1990a, 1990b, 2001a, 2002; Faulkner and Thomas, 2002). User participation in assessment and care planning has gained further credence in recent years as a result of lobbying from some user groups, particularly partnership and advocacy groups for young disabled adults such as 'In Control' (www.in-control.org.uk/) which promotes self-directed support and assists with individual budgets.

There is, however, no consensus in relation to the methods, tools or scales that should be used for assessing satisfaction. A number of studies have been conducted to assess the utility of face-to-face interviews, telephone interviewing, postal surveys and focus groups. Applebaum et al. (2000) concluded that all of the above have strengths and weaknesses. Their enquiry suggested that face-to-face interviews may produce reliable responses due to improved communication, but that interviewees may be more inclined to give the answers they think interviewers want to hear. On the other hand, Geron (1996) reported positive results using telephone interviewing techniques to assess user satisfaction with home care, suggesting that respondents felt less inhibited on the telephone or by completing postal questionnaires than in face-to-face situations. Bauld et al. (2000) suggested a mix of methods should be incorporated into the design of satisfaction questionnaires, which would reflect the priorities of users more accurately and improve the accuracy of findings. Kitzinger (1995) noted that focus groups do not discriminate against those who cannot read or write. Additionally, they may encourage more active participation than in a face-to-face

interview. However, some have argued that the focus group can distort public opinion if those with minority views are inhibited from voicing them because of peer pressure (Bowling, 1997). User satisfaction may be gathered online, for example within the SARA online assessment tool (Disabled Living Foundation, 2007). Evidence points to the need to distance from the providers of services the ownership and administration of satisfaction surveys. Philpot et al. (2004) concluded that service users were more critical about treatments and services when interviewed by a fellow user. Uttaro et al. (2004) similarly concluded that satisfaction ratings were higher when a staff member who was also responsible for the provision of care was the survey administrator compared to others. Thus, the methods of data collection and satisfaction measures used are likely to have some effect on user response (Challis et al., 2007; Malley et al., 2007).

There is some debate around the use of standardised tools for eliciting satisfaction judgements. Foord et al. (2004), for example, reported on their use within the sheltered housing sector, saying that the disadvantages included: power resting with the question setter; the tendency to be culturally inflexible with little regard for literacy ability; a lack of responsiveness to the changing aspirations of those surveyed; and tokenistic, as they embraced performance measurement targets rather than tenant feedback. The appropriate use of scales is frequently highlighted in the literature (Converse and Presser, 1986; Fowler, 1993). Likert-type scales with ordered, categorical response categories are the most commonly used response scales in satisfaction surveys. However, a high proportion of respondents tend to endorse categories at one extreme of the range (Challis et al., 2007). Bauld et al. (2000) noted that there are few standardised satisfaction scales designed to gauge the opinion of older people and these have been primarily developed for use in a health setting. Such scales are generally not appropriate to measure satisfaction with social care, which is provided in the user's home. The Home Care Satisfaction Measure and the Resident Satisfaction Survey Instrument in the United States are noteworthy exceptions as they relate to community-based social care and care home services for older people (Geron, 1999).

Global satisfaction measures have commonly been used. However, some have argued that these fail to discriminate between different aspects of services resulting in the loss of data and the production of unified responses (Applebaum et al., 2000; Bauld et al., 2000). Collins and O'Cathain (2003) commented on the need to distinguish rather than conflate dimensions and levels of satisfaction and in particular to tease out the differences between 'very satisfied' and 'satisfied'. However, it has also been suggested that expressions of dissatisfaction should be the focus of researcher and service provider attention (Carr-Hill, 1992; Williams et al., 1998). It has long been known that question wording can influence the way participants respond. Direct questions have been found to be intimidating for some interviewees. To combat this, Morse (2000) suggested that respondents be asked to comment on the experience of others in the hope that this less personal 'shadowed data' would allow them to answer more honestly. Measuring satisfaction regularly over time has also been suggested as a means of generating a more reliable picture than one-off, cross-sectional surveys (Bauld et al., 2000).

On a more critical note, the current practice of measuring user satisfaction has been criticised for being largely embedded in top-down performance management

frameworks (Boote et al., 2002). As a consequence, it has been dominated by standardised questionnaires, often administered by post and favouring closed items that are easily scored. The relatively low cost of such approaches compared to qualitative/open-ended methods as well as the provision of standardised data which lends itself to benchmarking between organisations have been key factors influencing the preferences of public providers (McIvor, 1993). This more technocratic approach to measuring user satisfaction, however, is believed to have side-effects which could contradict its very motivations. Foord et al. (2004) commented that when performance measurement is target driven the users' voice is often lost since the measurement of satisfaction is but one outcome measure. Accordingly, some commentators have noted that consultation with service users has not led to change and that their views have not been acted upon.

The literature is sparse concerning the measurement of user satisfaction with assessment. This is particularly true for self-assessment in social care and life skills (Griffiths et al., 2005). This is perhaps due, in part, to the complexities inherent in gathering and interpreting data within the assessment process, especially since many service users experience more than one assessment (Challis et al., 2007; Powell et al., 2007). There is also evidence that some service users are not aware of having had an assessment (Cornes and Clough, 2004; Challis et al., 2007) whilst the notion of satisfaction itself varies over time and place (Atwal and Cauldwell, 2005). Nevertheless, there is recent empirical evidence, for example in the form of the Personal Social Services (PSS) Survey on community equipment and minor adaptations (NHS Information Centre for Health and Social Care, 2008). It contained several assessment-related questions and has reported a consistently high degree of satisfaction. More specifically, two meta-reviews have focused exclusively on older people's experiences of self-assessment in a variety of settings including social care. Harris et al. (2007) reported that older people found self-assessment acceptable when they were assured of its value and if they could seek additional professional help. Similarly, Griffiths et al. (2005) found that older people considered self-assessment acceptable when they had direct support from a health professional. Evidence of satisfaction with self-assessment via an online survey has also been demonstrated (Purdie, 2003).

In conclusion, 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. Against this background, studies exploring service users' satisfaction with assessment in social care are still scarce, and even less is known about people's experience of self-assessment.

3. Methods

This paper presents findings from 11 English local authorities that, with funding from the Department of Health, implemented 13 pilot projects with the aim of evaluating the efficiency and effectiveness of various self-assessment approaches. Most focused on direct access to assistive equipment, while only a minority conducted self-assessments as a contribution to the wider assessment process and service planning. The pilot projects were conducted between October 2006 and November 2007 and a range of data were collected. One module of the study was a user experience survey, conducted in 9 authorities. Questionnaires (see appendix) were sent to 3,508 service users of whom 3,468 were identified as eligible cases. 1,862 (54 per cent) service users returned completed schedules, covering all three service areas: occupational therapy (66 per cent), preventative services (24 per cent) and assessment/care management (10 per cent). This compares favourably to the 55 per cent response rate of the most recent national PSS Survey (NHS Information Centre for Health and Social Care, 2008). 739 were related to the traditional assessment arms and 1,123 to the self-assessment arms of the pilot projects. The imbalance stems from the fact that not all pilot sites collected traditional assessment information.

Reflecting the nature of the pilot projects, a small number of questionnaires were returned online (3.6 per cent) and others were conducted over the telephone by the local authority (7.6 per cent), while the majority were returned by mail, either to the local authority or directly to the research team. During other stages of the project, information was also collected about the socio-demographic characteristics, health and functioning of approximately 2,100 people who participated in the pilot projects. However, not everyone for whom the latter information was provided received a questionnaire, whilst no descriptive information was collected about other people who did receive questionnaires. Nevertheless, both sets of information were collected for 744 people, and these are hereafter referred to as cases for which there are linked data. It should be noted that neither the full set of user experience data nor the linked set represents a true random sample of the target population. Owing to the de-facto 'multiple case study' design, a 'naturalistic' sample arose from the pilot sites' usual service population, only somewhat moderated by the fact that some pilot projects targeted specific groups for self-assessment (e.g. ethnic minorities). Nevertheless, a comparison with the nationally representative service population of the aforementioned PSS Survey suggests that, by and large, the sample is not atypical with regard to most service user characteristics. Table 1 summarises the socio-demographic and health data informing this paper's analyses. We have omitted the differences between self and traditional assessees here because they were rather small (we are preparing to publish details elsewhere).

Table 1: User characteristics – all types of assessment

Indicator	Core dataset*		Linked dataset		Comments
	Min/Max (n)	Mean (SD)	Min/Max (n)	Mean (SD)	
Age	18/107 (2,107)	73 (13.9)	19/104 (739)	72 (13.5)	
Sex (Female)	0/1 (2,108)	0.68	0/1 (740)	0.69	= 68 and 69 per cent respectively
Service user lives alone	0/1 (1,982)	0.46	0/1 (734)	0.53	
Asian service user	0/1 (2,071)	0.08	0/1 (737)	0.08	87 per cent of service users were White, the rest Black and Chinese
Katz dependency score (additive)	0/5 (1,574)	1.5 (1.4)	0/5 (707)	1.35 (1.3)	0=independent 5=dependent ¹ (Katz et al. 1963)
Self-reported health poor, fair or good (as opposed to very good/excellent)	0/1 (1,781)**	0.93	0/1 (697)	0.93	This indicator was included in the user experience survey
Low mood	0/1 (1,611)	0.36	0/1 (720)	0.34	
Concerns about memory problems	0/1 (1,659)	0.29	0/1 (719)	0.27	
Mediated assessment	0/1 (2,185)	0.34	0/1 (743)	0.34	

Notes:

* Although survey and core sample were not identical, the latter is still regarded as a reliable description of the full study population.

** Figure refers to the total user experience sample, not the core dataset

The questionnaire contains 13 individual satisfaction-related questions, which lend themselves to three distinct summary measures, reflecting three dimensions of the user experience of assessment:

- an ease of use score (QA1 to QA3), summarising whether respondents found it easy to self-assess or be assessed (maximum value 9);
- an information score (QA4 to QA7), summarising the extent to which the assessment included certain elements of good practice with regard to the collection and sharing of information (maximum value 4); and
- a satisfaction score (QB1 to QB6), expressing the respondent's overall user satisfaction (maximum value 12).

The validity of these additive indices was confirmed using principal components analysis. A truncated form of the measures is shown in Table 2 below, where for each subscale a score of zero indicates a complete absence of the quality of interest (e.g. complete dissatisfaction with the assessment), and the maximum score implies the most positive response possible. Questions QB2 and QB5 had a 'not applicable' category. Such responses (few) were included in the analysis in the form of the specific group averages of the applicable responses (i.e. their mean rounded to a discrete score value). This procedure rests on the assumption that 'not applicable'

¹ Whether unable to/help needed with: Bathing, Dressing, Toileting, Bed/Chair Transfer, Eating/Drinking

respondents, if they were applicable, would on average be as satisfied as their immediate peers.

As not all respondents answered every question, the variables used in the summary scales were chosen so as to maximise the number of valid responses. With regard to the satisfaction score this means that questions QB4 and QB6 were omitted due to their particularly patchy availability across the various projects. It was thus possible to calculate an ease of use score for 1,822 (98 per cent) of the 1,865 respondents, whilst information scores were calculated for 1,473 (79 per cent) and satisfaction scores for 1,717 (92 per cent). There was no evidence of item-nonresponse bias and most of the gaps in the data were due to some authorities distributing modified user experience questionnaires with fewer or slightly different questions.

4. Results

Table 2 conveys the very high degree of overall satisfaction (in the widest sense) of the service users who participated in these pilot projects. A key finding of this research project has been the fact that self-assessment as such does not seem to be associated with changed user satisfaction, although the ‘multiple case study’ design that generated this sample is a reason for caution regarding the necessary inter-group comparisons.

Table 2: All projects and assessment types – summary satisfaction measures

Ease-of-use		Information		Satisfaction	
Score	%	Score	%	Score	%
5 or less	5	0	5	7 or less	6
6	12	1	7	8	10
7	14	2	11	9	10
8	16	3	26	10	13
9	52	4	52	11	15
				12	45
n = 1,822		n = 1,473		n = 1,717	

Nevertheless, several intra-group comparisons of traditional and self-assesseees within individual sites are possible and they, with one noteworthy exception, confirm the larger picture. One of the pilot projects is notable here as it included a small randomised trial (n=71). People referred to assessment and care management arrangements and identified as having relatively low-level needs were randomly allocated to receive either usual care management, including face-to-face assessment by a care manager (the traditional arm), or to a new assessment pathway in which a team of self-assessment facilitators responded to information collected via the completion of a self-assessment form. Satisfaction levels were equally high (a mean of 10.9) in both arms. Although bigger group sizes would have instilled further confidence in these results, they nonetheless serve to reinforce the relatively high levels of satisfaction found in the other project sites, thus simultaneously dispelling concerns of selection bias and reinforcing findings comparable to the satisfaction ratings seen in the literature.

The noteworthy exception mentioned above relates to the trial of online self-assessment innovations in three pilot projects. Table 3 below compares the summary scores for these respondents with those of people who completed non-online self-

assessments in the seven other projects. In project 2, which piloted an online self-assessment tool for carers, and project 11, which piloted a web-based assessment for assistive equipment, individuals completed online assessments with or without the mediating support of a voluntary sector worker. However, in project 1, which sought to improve access to community equipment through the use of a web-based interactive software tool, individuals completed an online assessment in the presence of a staff member. The experience of the latter group has thus been described as ‘online plus’, for it seems likely that their experience will have been enhanced by the involvement of a professional, whilst the services they received were based on a combination of the software’s assessment and the staff member’s professional judgement. Given this, it is interesting to note that, as shown in Table 3, the three summary scores for those people who completed online plus assessments were very similar to those who completed telephone or paper-based self-assessments. There were, however, significant differences between the scores for people in project 2 and project 11 as compared with both people completing non-online self-assessments and online plus assessments. It would thus seem that users of online self-assessment found their assessment more difficult and less satisfying than did respondents participating in other forms of self-assessment. The relevant differences are statistically significant ($p < 0.05$) in Mann-Whitney non-parametric tests.

Table 3: User satisfaction with online self-assessments

Mean scores	Online Project 2*		Online Project 11**		Online plus Project 1*		Non online self-assessment***	
	n	value	n	value	n	value	n	value
Summary ease of use score (0-9)	33	7.2	66	6.9	263	8.0	744	8.1
Summary information-score (0-4)	n.a.	n.a.	n.a.	n.a.	235	3.2	662	3.1
Summary satisfaction score (0-12)	30	8.8	64	8.8	233	10.4	710	10.7

Notes:

* User experience data collected on paper

** User experience data collected online

*** User experience data collected on paper & by telephone (n=142)

The lower satisfaction levels of people who completed online self-assessments are further explored in Table 4 which examines the pattern of their responses to individual ‘ease of use’ questions from the survey tool. The similarity between the responses of the online plus and non-online groups is striking. However, marked differences are seen between the online and non-online groups, with significantly fewer respondents in the online sample endorsing the most positive categories. A similar picture is seen in Table 5. Respondents who completed an online assessment were significantly less likely than people who undertook other forms of self-assessment to say they completely agreed with five positive statements about their assessment, with the largest response category being ‘tend to agree’. Indeed, a sizeable minority of respondents said that they tended to disagree with certain satisfaction statements, thus expressing dissatisfaction.

Table 4: Questions used in the construction of the ease of use score – response patterns

Response	How clear was the purpose of the assessment to you?			In general, how easy did you find it to understand the questions?			Overall, how comfortable were you with the experience of completing the assessment?		
	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online
Very clear/easy/comfortable	76	75	44	68	71	40	70	66	44
Fairly clear/easy/comfortable	23	22	46	29	26	49	27	27	46
Not very clear/easy/comfortable	1	2	7	2	3	8	3	5	8
Not at all clear/easy/comfortable	1	0	2	0	0	2	0	2	1
n =	750	266	99	749	264	99	749	265	99

Table 5: Questions used in the construction of the summary satisfaction score – response patterns

Response	The assessment covered all the issues that I thought were important			I thought that sensitive issues were dealt with well			I was given enough information about the equipment/ services available			I had as much say as I wanted in the decisions about my care			The equipment/ services arranged will meet all the needs identified in my assessment			I was treated with respect		
	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online	Non-online SA	Online plus	Online
I completely agree	64	64	34	71	70	32	72	68	30	70	67	37	70	67	26	92	91	n.a.
I tend to agree	34	29	56	28	26	61	23	24	46	27	26	51	27	22	59	7	9	n.a.
I tend to disagree	1	5	8	0	2	5	4	7	18	3	5	8	3	8	7	0	0	n.a.
I completely disagree	0	1	2	0	2	2	1	1	5	1	1	4	1	4	9	0	0	n.a.
n =	739	259	99	626	245	61	740	261	99	506	263	97	716	225	46	744	258	n.a.

Notes

1: The figures represent the percentage of the valid numbers who gave the specified response.

2: SA = self-assessment

As indicated earlier, ‘linked’ data were collected for 744 respondents. This created the opportunity to investigate the value of a number of socio-demographic and contextual variables as predictors of user satisfaction. Although this subset of service users did not constitute a representative sample of all service users (the bulk of the information came from five of nine projects), it did reflect the overall response patterns extremely well. Furthermore, as 88 per cent of users in the linked sample were self-assessees, any identified predictors should be particularly relevant to the main research question.

It makes intuitive sense to regard the three summary scores as central outcome variables of users’ assessment experience, and to believe that these will, at least in part, depend on observed and unobserved characteristics of both the users and/or the approaches to assessment. Exploratory analyses suggested several potential predictors, although none with the large impact of the aforementioned online self-assessment. It is noteworthy that the only variable that appeared to predict the information score was the project the user had participated in, and that the considerable variation within projects seemed to be a random phenomenon. In light of the mostly very weak associations and the overall high degree of user satisfaction across all projects and demographic groups, it was decided that focusing on the extreme (dissatisfied) ends of the distributions of the ease of use and satisfaction scores would be the most promising approach. The guiding question thus became: given that most respondents felt very comfortable with the assessment and expressed a correspondingly high degree of user satisfaction, are there any factors associated with feeling uncomfortable and/or dissatisfied? Using logistic regression, two binary outcome variables were constructed as below:

- $Y_{\text{Difficulty-of-use}} = 6$ or less points on the ease of use score, indicating some difficulty with the completion of the assessment. This captured 16 per cent of the analysis sample, as the majority had ticked the ‘fairly easy/clear/comfortable’ boxes on the questionnaire three times (3×2 points = 6). Very few respondents chose the ‘not very’ or ‘not at all’ categories.
- $Y_{\text{Dissatisfaction}} = 8$ or less points on the satisfaction score, indicating relative dissatisfaction with the assessment process. This captured 15 per cent of the analysis sample, as the majority had ticked the ‘tend to agree’ category boxes on the questionnaire four times (4×2 points = 8). Very few respondents chose the ‘tend to disagree’ and ‘completely disagree’ categories.

An exploratory approach was taken to choosing suitable predictors (the x-variables). As the relationships between predictors and outcomes tended to be nonlinear², some indicators were derived as binaries in order to maximise the contrasts. Explicitly, Asian respondents were compared to all other ethnic groups (primarily white respondents), and the bottom three categories of self-reported health (good, fair and poor) were compared to the top two (excellent and very good). Although exploratory steps had highlighted a number of other potential predictors, including the individual’s age and dependency score, and whether the assessment was mediated or not, after controlling for other variables these did not retain predictive power. The two

² The coefficient of a middle category of an ordinal predictor may be bigger or smaller than the next higher or lower category, while a linear relationship would produce a stepwise increase or decrease of coefficients.

models presented in Table 6 list only those predictors which proved robust; i.e. sex (female), being Asian, having concerns about one’s memory and/or mood, being in poor, fair or good health and completing an online self-assessment. It should be noted that binary indicators of the full range of assessment characteristics (e.g. traditional assessment vs. other types of self-assessment such as paper, telephone and their combination) did not reveal additional effects, although this is in part due to the fact that the limitations of the sample prevented us from conducting robust enough tests. The pseudo-R² values suggest that the first model accounts for approximately 14 per cent of variation in the outcome variable, as opposed to 8 per cent in the second, indicating that ‘difficulty-of-use’ was more easily predicted than ‘dissatisfaction’. While the regressions were run for both self-asseesees and people who received a professional assessment, running the models for self-asseesees only produced virtually identical results. In fact, the number of valid traditional assessment cases going into this analysis is so small that we cannot draw any conclusions regarding the predictors of their user satisfaction. For instance, we could not test whether the effects vary by type of assessment (interactions). These models represent, for all practical purposes, predictions of the user satisfaction of self-asseesees. It must be acknowledged, as is reported in the literature, that these predictors could in principle also explain variation in traditional assessment satisfaction.

Table 6: Predictors of user satisfaction with self-assessment – logistic regression

Indicators	Y _{Difficulty-of-use}				Y _{Dissatisfaction}			
	Odds Ratio	95% CI		P	Odds Ratio	95% CI		P
Female	0.7	0.4	1.1	0.11	0.6	0.4	0.9	0.04
Asian	3.4	1.8	6.4	0.00	1.7	0.8	3.5	0.16
Memory problems	2.1	1.3	3.5	0.00	1.3	0.8	2.1	0.36
Low mood	1.5	0.9	2.4	0.12	1.8	1.1	2.9	0.02
Less than perfect health (i.e. self reported health poor, fair or good)	6.0	1.6	23.0	0.01	2.4	0.8	7.5	0.12
Online self-assessment	6.8	3.7	12.7	0.00	5.2	2.8	9.6	0.00
n	659*				623**			
pseudo-R ²	0.14				0.08			

Note

1: Statistically significant coefficients are printed in bold ($p < 0.05$).

2: Confidence intervals (CIs) for odds ratios are not symmetrical, as they are stated as the exponent of the logarithmic odds upon which logistic regression is based

3: Traditional assessment cases were much more likely to be excluded from the analysis due to listwise deletion (reflecting the patchy data coverage in some localities)

* Including 44 (6.7 per cent) traditional assessment cases

** Including 43 (6.9 per cent) traditional assessment cases

Whilst logistic regression predicts the logarithmic odds of belonging to a specific target group (here: finding the assessment difficult or being relatively dissatisfied), the output in the above table shows odds ratios, i.e. the relative change of the odds associated with a particular user characteristic, for example, being a woman as opposed to a man, or being Asian as opposed to belonging to any other ethnic group. The above coefficient of 3.4, for instance, indicates that the odds for Asians in this model are 3.4 times higher than those for all other ethnic groups, all other factors being controlled for. In contrast, an odds ratio of one would indicate that two groups faced the same odds, leaving the predictor without impact on the outcome variable. Relative odds are not the same as relative probabilities (or relative risks), however, for

odds and probabilities do not change together in a linear fashion. In particular, odds ratios much larger than one tend to overstate the relative increase in probabilities. Nevertheless, depending on a coefficient's reference probability, the popular interpretation of odds ratios as proxies for relative risks possesses some approximate validity, and in the models presented here the odds ratios for the most part roughly correspond to relative risks. Thus, staying with the above example, 41 per cent of Asian users actually reported relative difficulty in completing the assessment, as opposed to only 14 per cent of service users in all other ethnic groups. On a side note, White and Black British service users do not seem to differ so markedly in their response patterns, although it must be cautioned that the number of 'linked' respondents from the latter ethnic group is very small (n=17).

The models also tell us that online self-assessment is the strongest predictor of both outcome variables. All other things being equal, online self-assessees are predicted to be approximately six times more likely to find their assessment relatively difficult, and roughly five times more likely to be relatively dissatisfied. The remaining predictors only appear to affect one of the outcomes in a clear-cut manner. Thus women are significantly less likely (0.6 times) to be dissatisfied, but not to find the assessment difficult, whilst people with memory problems are significantly more likely to find the assessment difficult, but not to be dissatisfied.

5. Discussion

The literature on (self-)assessment in community care, albeit sparse, has suggested a number of potential analytical pitfalls, some of which may have been encountered in this paper as well. Bauld et al. (2000) in their review of the British and North American literature on older people's satisfaction with services cited evidence that older people are more likely than others to be susceptible to response bias, giving replies that they believe interviewers would like to hear. While levels of expressed satisfaction with services tend to be high in all age groups, older people are inclined to describe themselves as more satisfied than younger people. Consistently high satisfaction ratings suggest that responses may not accurately reflect service quality or outcomes. Reasons for response bias included fear of the service being removed or its quality compromised; reluctance to criticise individual workers; reluctance to appear as 'demanding'; lack of information about what they might expect from services, particularly in relation to technical standards; and a perceived power/information imbalance between themselves and the care providers (Bauld et al., 2000). Moreover, Atwal and Caldwell (2005) found that older people were unwilling to complete questionnaires issued to them by their assessors for fear of offending them and or their service being taken away. It is for these reasons that the difference between excellent and good responses can be so vital. It is even conceivable that a generally positive response pattern masks dissatisfaction.

Echoing our results, a number of studies have reported an interaction between service users' health status or other personal circumstances and their responses to user satisfaction surveys (Cleary et al., 1991; Sixma et al., 2000). Evidence from health care studies has shown that patients who perceive their own health as poor are less likely to be satisfied with the services they receive than patients with limiting long-standing illness (Cleary et al., 1991). Satisfaction with social care was found to be

higher amongst older people with long-standing chronic illness as opposed to those with other conditions (Judge and Solomon, 1993). Depression, often undetected in older people, is also an important factor that may affect satisfaction ratings (Bauld et al., 2000). A recent PSSRU study of satisfaction with the Single Assessment Process found that despite overall high satisfaction ratings, greater cognitive impairment was associated with lower satisfaction (Challis et al., 2007). Other studies have challenged the view that cognitively impaired service users are not capable of engaging with assessment (Lyman, 1998; Barnett, 2000; Boyer et al., 2004; Mozley et al., 2004).

These are all important caveats, for they remind us that responses on satisfaction scales are not absolute measures of service quality. Instead, they are subjective evaluations, partly determined by intrinsic personal characteristics and not without problems when used for inter-subjective evaluations. It goes so far that satisfaction might vary as a reflection of how people felt on the day they were interviewed or completed a questionnaire (Bauld et al., 2000).

In addition, this evaluation's multiple case study design posed a challenge insofar as it was likely to produce arbitrary grouping effects in the data, whereby the highly contextual impact of one locality can wrongly create the impression of a national phenomenon. Potential dangers in our sample include the findings for Asian service users, two thirds of whom came from only one pilot study. Corroborating the evidence with secondary data is always a good option. In this case, the 2008 PSS Survey describes the same effect nationwide, suggesting that it is not specific to self-assessment; although it, too, cannot readily explain why Asian service users tend to be less satisfied. The impact of online self-assessment must be interpreted carefully as well. In fact, the PSS Survey also included a small subgroup of 'internet self-assessees' (n=200) whose satisfaction levels did not differ from the population average of assistive equipment recipients. In contrast, pilot projects 2 and 11 were located in preventative services. However, we see no reason why this fact alone should explain the striking deviation from 'normal' response patterns, especially since project 11 also involved the provision of assistive equipment to a target population that was very similar to the one depicted in the PSS Survey. It is more likely that the specific self-assessment modalities in these two projects were suboptimal, starting with the possibility that service users in the pilot projects were actively encouraged to take part in a form of assessment which was new and unusual to them. The PSS Survey respondents, on the other hand, may very well have chosen to self-assess online; but regrettably we cannot tell from the published data. In any case, we can only speculate as to whether the hypothesised effect is endogenous to the two pilot sites or could be expected at the national level as well.

Finally, it must be stressed that logistic regression is an associational statistical technique. Thus causal inferences can only be made on the basis of prior theoretical insight, and as the previous section showed, this is lacking. It is also vital not to forget that any regression model can only make a prediction based on the available information, and that while the results are likely to be indicative of important underlying phenomena, they are more often than not rather crude. It must also be said that the linked sample was rather small given the chosen outcome variables. In a larger sample additional predictors might well have been statistically significant, potentially changing the context of our evaluation somewhat.

6. Conclusion

The key observations made in this paper can be summed up succinctly.

- The majority of both self and traditional assessment recipients found their assessment easy to complete and expressed a high degree of satisfaction with their experience. While it would be unrealistic to expect self-assessment to improve user satisfaction, given its commonly high level in the first place, there is every reason to believe that most self-assessment arrangements will not harm user satisfaction either.
- 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. One possibility is that the particular online tools trialled were suboptimal given the service user groups they were tested on.
- Measured variables predicted relatively little of the variation in user satisfaction. However, the completion of an online self-assessment was the strongest predictor of dissatisfaction and difficulty with self-assessment. 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. Men and/or people with low mood were less likely to be satisfied with their self-assessment.

In light of these findings, the main lesson to be learnt from the pilot projects must be 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. The evidence from the pilot projects is robust in this respect but still patchy. Further research should be aimed at shedding light on the limits of the applicability of self-assessment.

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Appendix

The Personal Social Services Research Unit University of Manchester

ASSESSMENT SATISFACTION SURVEY

Section A. For each of the following questions, please tick the box that best describes your experience. Remember that by 'assessment' we mean the information that you provided about the type of help and services you need.

A1. How clear was the purpose of the assessment to you?

- | | | |
|------------------|--------------------------|---|
| Very clear | <input type="checkbox"/> | 1 |
| Fairly clear | <input type="checkbox"/> | 2 |
| Not very clear | <input type="checkbox"/> | 3 |
| Not at all clear | <input type="checkbox"/> | 4 |

A2. In general, how easy did you find it to understand the questions?

- | | | |
|-----------------|--------------------------|---|
| Very easy | <input type="checkbox"/> | 1 |
| Fairly easy | <input type="checkbox"/> | 2 |
| Not very easy | <input type="checkbox"/> | 3 |
| Not at all easy | <input type="checkbox"/> | 4 |

A3. Overall, how comfortable were you with the experience of completing the assessment?

- | | | |
|------------------------|--------------------------|---|
| Very comfortable | <input type="checkbox"/> | 1 |
| Fairly comfortable | <input type="checkbox"/> | 2 |
| Not very comfortable | <input type="checkbox"/> | 3 |
| Not at all comfortable | <input type="checkbox"/> | 4 |

A4. Were you asked about your health?

- | | | |
|-----|--------------------------|---|
| No | <input type="checkbox"/> | 1 |
| Yes | <input type="checkbox"/> | 2 |

A5. Were you asked if you needed any help to care for yourself?

- | | | |
|-----|--------------------------|---|
| No | <input type="checkbox"/> | 1 |
| Yes | <input type="checkbox"/> | 2 |

A6. Were you asked if you received any help from family or friends?

- | | | |
|-----|--------------------------|---|
| No | <input type="checkbox"/> | 1 |
| Yes | <input type="checkbox"/> | 2 |

A7. Were you asked if the information that you provided could be shared with other health and social services staff?

No 1

Yes 2

Section B. Still thinking about the assessment that you completed for, for each of the following statements, please tick the box that most accurately describes your experience.

B1. The assessment covered all the issues that I thought were important

I completely agree 1

I tend to agree 2

I tend to disagree 3

I completely disagree 4

B2. I thought that sensitive issues were dealt with well

I completely agree 1

I tend to agree 2

I tend to disagree 3

I completely disagree 4

Not applicable – there were no sensitive issues 5

B3. I was given enough information about the equipment/services available

I completely agree 1

I tend to agree 2

I tend to disagree 3

I completely disagree 4

B4. I had as much say as I wanted in the decisions about my care

I completely agree 1

I tend to agree 2

I tend to disagree 3

I completely disagree 4

B5. The equipment/services arranged will meet all the needs identified in my assessment

I completely agree 1

I tend to agree 2

I tend to disagree 3

I completely disagree 4

Not applicable – no help was arranged 5

B6. I was treated with respect

- I completely agree 1
- I tend to agree 2
- I tend to disagree 3
- I completely disagree 4

Section C. It would be very helpful if you could also tell us how you currently rate your health. Please put a tick next to the response below that best describes this.

C1. I currently rate my health as:

- Excellent 1
- Very good 2
- Good 3
- Fair 4
- Poor 5

If there is anything else that you would like to tell us about your experience of being assessed, please do so in the box below:

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE

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