

## Adult Social Care Customer Feedback

This questionnaire is for customers and informal carers who have used our services.

We want you to be involved in decisions about your social care support as much as possible - to give you choices and help you to feel in control.

Your answers are important to help us make the service better for our customers.

Thank you for completing the questionnaire.



If you want a paper copy please email: [Adult.PrincipalSocialworker@merton.gov.uk](mailto:Adult.PrincipalSocialworker@merton.gov.uk)





The information collected in this survey will be used by Merton Council officers to measure customer satisfaction, and to help with improving our Adult Social Care service. We may share the results of the survey. All information produced will be anonymised.

## Feedback

### 1: How did you find out about Merton adult social care services?

Please select one option only.

<input type="radio"/> <b>Internet</b>	
<input type="radio"/> <b>GP surgery</b>	 <p>GP Surgery</p>

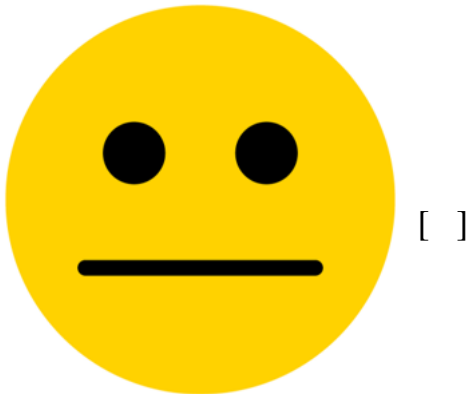
<ul style="list-style-type: none"><li>○ <b>Hospital</b></li></ul>	
<ul style="list-style-type: none"><li>○ <b>Merton Civic Centre</b></li></ul>	
<ul style="list-style-type: none"><li>○ <b>Local charity or organisation</b></li></ul>	
<ul style="list-style-type: none"><li>○ <b>Family, friend or neighbour</b></li></ul>	
<ul style="list-style-type: none"><li>○ <b>Other</b></li></ul>	

**2: Was it easy or difficult to find information and advice about adult social care services?**

**Please select one option only.**



**Easy**
















**Not sure**








**Difficult**

### 3. Which Adult Social Care Team did you talk to?



<p><input type="radio"/> Adult Safeguarding Team</p> 	<p><input type="radio"/> First Response Team</p> 	<p><input type="radio"/> Financial Assessment Team</p> 
<p><input type="radio"/> Hospital Team</p> 	<p><input type="radio"/> Locality Team 2</p> 	<p><input type="radio"/> Direct Payments Team</p> 
<p><input type="radio"/> Locality Team 2</p> 	<p><input type="radio"/> Reablement Team</p> 	<p><input type="radio"/> I don't know</p> 
<p><input type="radio"/> Occupational Therapy Team</p> 	<p><input type="radio"/> Integrated Learning Disability Team</p> 	<p><input type="radio"/> <b>Please tick all that apply.</b></p>
<p><input type="radio"/> Transitions Team</p> 	<p><input type="radio"/> Mental Health Team</p> 	

**4: How was the help you got from our team?**

Please select one option only.





<input type="radio"/>  <b>Very Good</b>	<input type="radio"/>  <b>Good</b>
<input type="radio"/>  <b>Okay</b>	<input type="radio"/>  <b>Bad</b>
<input type="radio"/>  <b>Very Bad</b>	

**5: Were you able to talk about the outcomes you wanted?** Please select one option only.

<input type="radio"/>  <b>Always</b>	<input type="radio"/>  <b>Sometimes</b>	<input type="radio"/>  <b>Never</b>
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**6: Do you feel you were treated with respect?**

Please select one option only.

 <input type="radio"/> Always	 <input type="radio"/> Usually
 <input type="radio"/> Sometimes	 <input type="radio"/> Never

**7: Has the help from our services made your life better?**

Please select one option only.

 <input type="radio"/> Yes	 <input type="radio"/> Partially	 <input type="radio"/> No
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**8: Tell us more about how the service has helped to make your life better.**



**9: Would you like to tell us anything else that would make our service better?**



**10: Would you like to help us again to make our service better for our customers?**

For example, you could complete more surveys or take part in group discussions about different topics.



Please select one option only.

[ ]

**Yes**

[ ]

**No**

If response is "No" then go to the end of step



**11: If you would be willing to be contacted, please provide your details**

First Name:

Last Name:

12: Your email address:

13: Your preferred telephone number

Telephone number:

14: Please tell us your preferred method of contact:

Please tick all that apply.

Email

Phone

## **About you**

You do not need to answer these questions but doing so helps us understand who has completed this survey.

15: Do you consider yourself to have a disability?

Please select one option only.

Yes

No

16: Are you?

Please select one option only.

Male

Female

Other

Prefer not to say

17: Please tell us which age band you fall into

Please select one option only.

- Under 18 [ ]
- 18 - 29 [ ]
- 30 - 44 [ ]
- 45 -64 [ ]
- 65 and over [ ]

18: What is your ethnic background?

Please select one option only.

- White British or Irish [ ]
- White Eastern European [ ]
- White Other [ ]
- Black British [ ]
- Black Caribbean [ ]
- Black African [ ]
- Mixed White & Caribbean [ ]
- Mixed White and African [ ]
- Mixed White and Asian [ ]
- Mixed Other [ ]
- British Asian [ ]
- Indian [ ]
- Bangladeshi [ ]
- Pakistani [ ]
- Tamil [ ]
- Chinese [ ]
- Other [ ]

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Thank you for taking the time to provide us with your comments.

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