CONSULTING CONSUMERS

A GUIDE TO
GOOD PRACTICE

FOR THE NHS IN SCOTLAND

THE NATIONAL HEALTH SERVICE IN SCOTLAND

SCOTTISH CONSUMER COUNCIL
THE PURPOSE OF THE NHS IN SCOTLAND IS

- to promote good health
- to diagnose and treat those who are ill
  and
- to provide health care for those with continuing needs

irrespective of the individual’s ability to pay, in partnership with people and with other organisations, and within the resources that the country makes available.

THE VALUES OF THE NHS IN SCOTLAND ARE

- to provide fair entitlement and access to its services
- to identify and seek to meet people’s needs and wishes
- to set out to achieve the highest standards possible
  — of care and respect for each person
  — of results
  — of value for money
- to improve standards through research, education, monitoring and review
  while enabling those who work in the Service
- to achieve its purpose
- to share its values
  and
- to feel valued themselves.
SCOTTISH CONSUMER COUNCIL

The Scottish Consumer Council (SCC) aims to promote the interests of Scottish consumers, with particular regard to those people who experience disadvantage in society. The SCC researches and critically assesses the policies and practices of government, industry and the professions. The following four objectives are fundamental to the work of the SCC:

- identifying and investigating consumer issues and concerns
- influencing key policy practices and decision-making processes
- informing and raising awareness among consumers
- playing a distinctive and leading role in Scottish affairs.
# Contents

1 INTRODUCTION .......................................................................................................................... 1
   1.1 Why ask consumers? ................................................................................................................. 1
   1.2 Who to ask? ............................................................................................................................ 3

2 POTENTIAL PITFALLS .................................................................................................................. 4
   2.1 Reluctance to criticise ............................................................................................................. 4
   2.2 Difficulty with recall ............................................................................................................... 4
   2.3 Anonymity and confidentiality ............................................................................................... 5
   2.4 Ethical approval and data protection ...................................................................................... 5

3 RESEARCH ISSUES ..................................................................................................................... 6
   3.1 Defining research aims and objectives .................................................................................... 6
   3.2 Other research ....................................................................................................................... 6
   3.3 Reliability ............................................................................................................................. 6
   3.4 Sensitivity .............................................................................................................................. 7
   3.5 Validity ................................................................................................................................ 7
   3.6 Selectivity .............................................................................................................................. 8
   3.7 Defining the target population ............................................................................................... 8
   3.8 Representativeness .................................................................................................................. 8
   3.9 Combining research methods ................................................................................................. 9
   3.10 Ensuring quality and co-ordination ...................................................................................... 9

4 QUANTITATIVE RESEARCH — HOW MANY? ......................................................................... 10
   4.1 Background ............................................................................................................................ 10
      4.1.1 Sampling techniques .......................................................................................................... 10
      4.1.2 Sample size ....................................................................................................................... 10
      4.1.3 Non-response and sampling bias ....................................................................................... 11
      4.1.4 Piloting a survey ................................................................................................................. 11
      4.1.5 A snapshot or monitoring survey? ...................................................................................... 12
      4.1.6 Questionnaire design ........................................................................................................ 12
      4.1.7 Public participation and agenda setting ............................................................................ 14
   4.2 Methods to choose from ......................................................................................................... 14
      4.2.1 Self-completion questionnaire ........................................................................................... 14
      4.2.2 Postal questionnaire .......................................................................................................... 15
      4.2.3 Personal interviews .......................................................................................................... 16
5 QUALITATIVE RESEARCH

5.1 Background

5.1.1 Logical inference

5.1.2 Choosing a sample

5.1.3 Public and private accounts

5.2 Methods to choose from

5.2.1 In-depth personal interviews

5.2.2 Critical Incident Technique

5.2.3 Focus/discussion groups

5.2.4 Nominal Group Technique

5.2.5 Rapid Appraisal

5.2.6 Observation/shadowing

5.2.7 User panels

5.2.8 Diary-keeping

5.2.9 User consultation days/open days

5.2.10 Complaints tracking and analysis

5.2.11 Drama workshops

5.2.12 Meetings with interest groups and liaison with local health councils

5.2.13 Phone lines

5.2.14 Public meetings

5.2.15 Search conferences

5.2.16 In the user's shoes

5.2.17 Suggestion boxes

5.2.18 Roadshows

5.2.19 Patient supporters

6 ONCE YOU'VE COLLECTED THE INFORMATION

6.1 Analysis of data collected

6.2 Interpretation of results

6.3 Feedback of results

6.4 Follow-up action

7 CONCLUSIONS
APPENDICES

I  A SHORT CHECKLIST .......................................................... 37
II  GLOSSARY ................................................................. 38
III LIST OF CONSULTANTS .................................................. 39
IV  SUGGESTIONS FOR FURTHER READING ............................ 41
V  REFERENCE LIST .......................................................... 42
We are grateful to all of those who assisted in the preparation of this guide whose names are too numerous to mention. Any incidences of misinterpretation within the guide are acknowledged as being the fault of the author and are not in any way attributable to those who gave the information.
There has been a quantum growth in citizen participation in many areas of government in recent years. In the health context, the World Health Organisation articulated the right and duty of people to participate individually and collectively in the planning and implementation of their healthcare as long ago as 1978. The main aim of the Citizen's Charter is to improve public services and ensure that they respond better to the needs of those who use them. The Charter also set out the Government's continuing commitment to providing good quality health care through the NHS and promised that the public were entitled to choice wherever practicable; that there should be regular and systematic consultation with those who use services and that these views would be taken into account in final decisions on standards. The Patient's Charter for Scotland promised users that they are entitled to be involved so far as is practical in making decisions about their care, and that any comment they may have will be taken seriously. Framework for Action reiterated these points and noted that feedback from patients is especially valuable in finding out whether standards of care are improving.

However, there have been criticisms of the lack of public participation in the NHS and a tendency for health professionals views to dominate. Perhaps most famously, the 1983 Griffiths NHS management inquiry in England and Wales condemned the failure of the NHS to use the well established techniques of market research to elicit the views and experiences of users. More recently, Bell et al., in discussions on patient-defined audit in the reformed NHS, argued that the consumer view remains neglected and that although patient satisfaction surveys are fairly common, in general they reflect the designer's views of what is important. The new commitment to listening to the consumer voice goes further than patient satisfaction surveys and public meetings about hospital closures. It is about participation of consumers in decision-making and meaningful consultation where views on subjects ranging from hospital food to prioritisation of clinical services are sought and paid heed to.

Finding out what people think, how they feel or what they have experienced is a complex task. Chosen methods must be accurate, sensitive, and reliable, and must really measure what you want to know. Also, there are particular problems associated with finding out what people think about health services.

Health service users may have difficulty recalling the details of their experience and questionnaires may need to jog their memories. Furthermore, there appears to be a general reluctance to criticise the NHS probably due to a combination of low expectations, fear of reprisal and the general 'halo effect' which can influence public perception of health professionals. Patient satisfaction surveys can too often paint a misleadingly rosy picture of services unless they are carefully designed to overcome these problems.

1.1 Why ask consumers?

Service providers have much to learn from consumers. They are an expert resource. Knowledge of people's experiences of illness, disability and using health services is invaluable. Furthermore, health service planners need input from as broad a sector of society as possible when making decisions which incorporate social and ethical choices.
More specifically, their views can help:

- **to inform health needs assessment:** Assessing local health is one of the Health Board roles outlined in *Framework for Action*. Listening to the voices of local people on their health needs is a key feature of this assessment and the resource allocation decisions which it informs.

- **to shape health policy:** Public participation in health will require consumers to be asked difficult questions as well as easy ones. Consumer views are needed to feed into decisions on issues like prioritisation of services. People should not be asked for decisions they are ill-equipped to make — that is, on issues they know little about.

- **to set standards:** User views can be useful in defining standards for aspects of care. Such standards can be useful in the process of drawing up contracts between purchasers and providers of services.

- **to evaluate and monitor services:** This can be either fine-tuning or a complete overhaul, from how hot hospital meals are, to how and when to run a chiropody clinic. Consumer views should feed into the monitoring of standards.

Six basic consumer principles (access, choice, information, safety, redress and representation) guide all the research of the Scottish Consumer Council and are used in relation to all types of goods or services — from buying a car to going into hospital. In relation to health care specifically, an additional principle is relevant: effectiveness.

In relation to health service provision these principles translate into a number of questions:

- **ACCESS** Are there problems — such as language, travelling costs or disability — which are restricting access to health services?

- **CHOICE** Are consumers presented with real choices about their health care wherever appropriate?

- **INFORMATION** Are consumers given all the necessary information about health services? Is it relatively easy to access and understand that information?

- **SAFETY** Consumers are entitled to safe services. Are they given information about any risks associated with their health care? Are they safe from unwanted side-effects or hospital-acquired infections?

- **REDRESS** In the health service context the principle of redress is really about channels of complaints and complaint handling. Are these channels open, easy to use, sensitive to consumer concerns and not hostile? Do complainants get something in response, such as an apology?

- **REPRESENTATION** Are there effective mechanisms for consumer representation in the health service? Is the representation robust and independent?

- **EFFECTIVENESS** Did the treatment, intervention or care do what it was supposed to do?
1.2 Who to ask?

Consumers, customers, service users or patients? There tends to be some confusion about what to call these people whose views you want to canvass.

This Guide will refer mainly to consumers. This term includes not only people who are current service users, but also people who may use the services in the future and people who use services indirectly, such as carers.

There are some particular categories of health consumers that may warrant particular consideration in this respect. The views of certain groups of consumers may be under-represented unless care is taken to consider the most appropriate approach to tapping into them.

Some groups, such as children or people with learning difficulties, for example, are not often asked for their views. There are also particular methodological considerations to bear in mind when consulting people who have difficulties reading or writing, people whose first language is not English and people with mental health problems. Consumers in these groups are likely to be disenfranchised by a traditional questionnaire approach (See Section 3.8).
There are a number of general difficulties with finding out what people really think about health services. Some methods will be more prone to these problems than others, but they should be borne in mind when designing any consumer consultation exercise.

2.1 Reluctance to criticise

To look at the results of many previous patient satisfaction surveys you would think that very little improvement could be made to health services. To assess people’s real views, attitudes and experiences of health services you must first get through the gratitude barrier. Health service consumers are often vulnerable, dependent, intimidated and quite simply relieved when their ordeal is over. They may be so grateful for the treatment received at an out-patient clinic that they tend to forget how little information they were given or how uncomfortable the waiting area was. Some people will remember times when there was no National Health Service and remain grateful for even a minimal service. Careful design of questionnaires to include positive suggestions for improvement, instead of asking only for criticisms, may help overcome this problem.

It is also clear that there is some relationship between consumer satisfaction with health services and their expectations of standards of care. It is a sobering thought for any health service manager contentedly perusing a reassuring patient satisfaction survey to consider that the results may say more about the low expectations of consumers than the service actually received.

It appears that there are two dimensions to consumer expectations of health care. They cite ideal expectations based on what they think should happen. At the same time they often harbour practical expectations which reflect what they think will happen based on their personal experiences, what they read, see and hear in the media and hearsay.

There is another — crucial — reason why consumers may be unwilling to criticise health services or health professionals — a fear of reprisal if they make unfavourable comments. This is why it is absolutely essential to ensure that participants in any survey or consultation are assured of anonymity and free from the threat of any comeback. Steele argues that the inhibiting effects of dependency in a health service context are very much greater than in almost any other because of the seriousness of the consequences were the dependency to fail.

This can be seen from the results of the survey of NHS users in Scotland “What Users Think 1992” where only 25 per cent of people who wanted to make a complaint about hospital services actually made one. Seven per cent of those people gave “worried it might affect the way staff treated me” and 30 per cent gave “didn’t want to cause trouble” as their reasons.

This fear of reprisal element can be even stronger in rural areas where people may be more worried that they will be easily identified and labelled if they complain or criticise.

2.2 Difficulty with recall

Once the healthcare episode is over people may want to forget it as quickly as possible.

Research suggests that asking consumers direct questions about specific aspects of their experiences will jog their memories. Locker and Dunt suggest that the more impact an experience had on a consumer the more likely they are to offer it in response to an open question.
Someone whose entire hospital stay was marred by lack of privacy, for example, is likely to say so in response to an open question asking them to comment on their stay. Another consumer, however, may have noticed the same problem but was less bothered by it. This consumer is less likely to comment on that aspect in response to the open question, but may well recall it when asked a specific direct question on the privacy in the ward. Questionnaires which include a combination of open questions and specific, direct questions would distinguish between the two attitudes and will give a better overall picture of consumer views.

2.3 Anonymity and confidentiality

The importance of ensuring respondent confidentiality and anonymity cannot be over-emphasised. Everything possible must be done to ensure that if consumers comment on health services or health professionals their identity should not be revealed without their express permission.

Slight methodological adjustments can help in this respect. People directly involved in delivering the service being evaluated should not be used to administer or collect questionnaires. Consumers do not want to be labelled difficult, nor do they want to seem ungrateful for the aspects of the service they did appreciate.

The Code of Conduct of the Market Research Society is useful in spelling out the principles of ensuring participant confidentiality. The code sets out a number of rules on responsibilities to informants. These include the fact that no information which could be used to identify people should be revealed to anyone, except to those who are checking or processing the data. The rules also state that "where there is a possibility that a respondent may be identifiable even without the use of his/her name or address, then this must be made clear to him or her and he/she must be given the opportunity to withdraw from the research".

2.4 Ethical approval and data protection

The Local Ethics Research Committee must be consulted about any research proposal involving access to records of past or present NHS patients and the Committee will need to be assured that all research will be conducted in accordance with current codes of practice and data protection legislation.

The possible application of the Data Protection Act 1984 which applies, broadly speaking, to information about individuals which is processed by computer is also relevant. If you are already registered under the Act, it may be necessary to ensure that your registration enables you to use the data you collect in the manner you wish. Data users should bear in mind that data which they already hold (ie payroll data/patient records) can only be used for the purposes for which users are registered with the Data Protection Registrar. If you are not registered under the Act, then it is likely that you will need to do so in order to hold the information you collect on computer and possibly pass that information to other specified bodies. If you are in doubt about the application of the Act or the sufficiency of your registration, you should consult your legal adviser.
There is a wide array of methods from which to choose when setting up a consumer consultation exercise. The method you choose will depend on the type of question you wish to address and types of consumers you wish to consult. There are many methodological issues to consider when designing your research. McIver\textsuperscript{11} divides them up into accuracy and usefulness. Accuracy she describes as asking the right questions, to the right people, in the right way. Usefulness relates more to the aim of the study and whether or not the results can actually be used for a purpose. These concepts of accuracy and usefulness can be carved up into the more specific issues of representativeness, reliability, sensitivity, validity and selectivity.

3.1 Defining research aims and objectives

There is no point whatsoever in doing research unless you know exactly why you are doing it and define very carefully the aims and objectives. Clear definition of what you want to know will guide you on who to ask, what to ask and how to ask them. It is also important to decide what type of information you hope to get out of the process, and how it will be used. It may be statistics, such as "90 per cent of outpatients said that the doctor had given them adequate information about their treatment", or descriptive information, such as "some people found the information doctors gave them inadequate because the medical jargon was confusing". The former approach will help you to quantify any problem, whereas the latter could give you insight into the nature of the problem.

3.2 Other research

Once you have clearly defined what it is you want to know, it is worth finding out if others have asked the same question. It may turn out that there are already answers in the published literature and you don't actually need to do a research exercise yourself. Or you may find that others have conducted similar pieces of research from which you could get a few pointers.

3.3 Reliability

The reliability of a method refers to its repeatability or consistency. That is, if you were to re-run the exercise, how likely are you to get the same results? Just how much reliability you need from a chosen method depends on the nature of the research. A very high degree of reliability is obviously crucial wherever the research is to be repeated to spot changes over time. Surveys give estimated values for populations based on what is seen in a sample from the population. It is important to be aware that these estimates can have varying degrees of accuracy, precision and reliability. The amount of confidence one can have in the precision of an estimate can be indicated by looking at confidence intervals for each estimate. These are based on the size of the sample and the value in question. When, for example, a 95 per cent confidence interval of 23-26 per cent is cited, it means that you can be 95 per cent confident that the real value lies within the range 23 to 26 per cent.

In general, simplicity is much better than complexity and a large number of variables can make it more difficult to get a high degree of reliability. Information collected from quantitative research can be simplified by putting responses into defined categories as long as there is a clear rationale for the categories used. Information collected by qualitative methods tends to be much more complex and contain many variables. The
reliability of qualitative research can be enhanced by ensuring careful recording of data. As much data as possible should be recorded. If the research is in the form of interviews or discussions, use of a tape recorder is advised, preferably with the additional help of someone taking notes. Memory tends to be biased and unsystematic in the way it records information; don't rely on it.

When considering the reliability of a method some useful questions included the following. Has the potential influence of the researcher been taken into account? Is there a logical flow between the information and the inferences drawn from it? Would the people the research is supposed to describe say "that's not what I said!" if they were shown transcripts?

3.4 Sensitivity

Research methods should be sensitive enough to identify differences between people and to pick up changes over time. If a survey suggests that 90 per cent of people were satisfied with a service for months or years on end, it could be because the service really is excellent, but it is more likely that the research tool is not sensitive enough. A questionnaire, for example, may contain this question:

Did the doctor give you enough information?

YES
NO
DON'T KNOW

If 95 per cent of people ticked YES, it would do little to tell you if doctors could make the information they give out better. The sensitivity of the question could be improved by asking the following question instead:

Did you find the information the doctor gave you?

EXCELLENT
GOOD
ADEQUATE
POOR
VERY POOR

In that case, it could be that only 10 per cent of respondents said 'excellent' or 'good', and that the findings were not as reassuring as the responses to the first question would have suggested.

3.5 Validity

The validity of a research tool refers to how well it actually measures what it is supposed to measure. In this respect, qualitative research is more likely to have validity than quantitative research because information is collected without fitting it into existing concepts. Some authors have queried the validity of the concept of satisfaction on which many surveys are based. They suggest that surveys should look for sources of dissatisfaction rather than trying to quantify the concept of satisfaction which has questionable validity12.

Validity is usually assessed by comparing results with "observations of the same phenomena using undisputed measurement tools"13. In truth, validity is difficult to assess in this area of research, since there is no real gold standard to compare with. In practical terms, the issue of validity relates to the quality of information that is collected. McIver describes validity as "how closely the information collected represents a slice of reality"11. The validity of research and interpretation of findings also depend on how much one can generalise from results. Issues of sampling (Sections 4.1.1 and
5.1.2) and representativeness (Section 3.8) are important.

### 3.6 Selectivity

Some research methods may exclude people who were intended to be included in the target population. Self-completion questionnaires, for example, may not be suitable for people with difficulties in reading or writing English, people with poor eyesight and people with learning difficulties. Telephone surveys are limited to those who have a telephone in their home. This kind of selectivity problem, however, is not confined to the questionnaire approach. Focus group discussions may disadvantage those who are reticent about speaking out in groups. Consultation with voluntary organisations will tend to involve certain types of consumer and exclude others. Because of this selectivity of different techniques there is often value in using a combination of methods to compensate for selectivity.

When setting up consumer research some fairly straightforward things can help overcome the limitations of survey techniques. Research should be set up to remove the barriers to participation that can exist for some groups of people. Things that can help include:

- translation of questionnaires or use of an interviewer for non-English speakers;
- use of an interviewer instead of a self-completion questionnaire for people with difficulties in reading or writing;
- provision of Braille versions of questionnaires for blind people;
- use of a relatively large typeface in questionnaires and provision of adequate space for written answers.

### 3.7 Defining the target population

Along with selectivity of the chosen methods, it is important to consider the target population. If a target population is not clearly defined, people may have to wade through lots of questions that are clearly not relevant to them and they may lose interest in the questionnaire. Careful definition of the target population can prevent this happening and will, in turn, lead to good response rates. There should also be benefits in terms of keeping down costs. There is little point, for example, in surveying the general population if you only want to find out about recent experiences of maternity services — unless, that is, you are interested in why people have not used a service or there is a suspicion that services are not well known.

**Screening questions can be used to narrow down the sample and ensure that only appropriate respondents are included.**

### 3.8 Representativeness

The way you consult with consumers and the way you choose the sample will affect the representativeness of the results. It has already been pointed out that traditional survey methods may disenfranchise certain groups of people.

Use of large representative samples for quantitative surveys will not help in any exploration of the views and experiences of minority groups. Alternatives to traditional survey methods — many of those outlined in Section 4.2, for example — must be used to tap into their views.

Another group whose voices often go unheard are users of mental health services.
Research in this field had often been hampered by the idea that people suffering from mental illness may not be able to give reliable accounts. Research has shown this not to be the case; Raphael reported that only two per cent of patients of psychiatric hospitals surveyed were unable to give rational answers. There can be problems, however, in using traditional methods in this group. Service users may be difficult to trace after they have been discharged from care and some may not want to take part in anything that reminds them of their period of mental illness. Confidentiality and a sensitive approach are clearly important in this area. The National Consumer Council reported on a guideline consultation study on elderly people with dementia living at home. They used individual interviews and found that with adaptations it was possible to achieve productive interviews which gave them useful insights. Other approaches such as Patient Councils, advocacy schemes and close liaison with user groups may be useful.

The views of people with learning difficulties are even less likely to be heard than those of people with mental illness. Despite the difficulties with survey methods in this group, there are means of communicating with people with learning difficulties so that their opinions can be heard. Drama workshops, advocacy schemes and other qualitative techniques may be appropriate.

3.9 Combining research methods

It is best to consider using a combination of research methods. It is often worth using a qualitative technique, such as the nominal group technique, to identify priorities from a consumer point of view and to ensure the most effective use of a survey. Alternatively, you may want to combine in-depth individual interviews, to explore an area in detail, with a survey to quantify issues.

3.10 Ensuring quality and co-ordination

Very few Health Boards in Scotland go as far as setting up a consumer feedback team, but those that have feel that it has paid off. Giving one person — or a team of people — responsibility for consumer research is one form of quality control. The consumer feedback officer — or whatever other name is chosen — can try to identify consumer views for the Health Board and, in effect, act as a consultant for others in the Board's area wishing to set up research. This could help to ensure some consistency of approach and standard of research.

Equally, drawing up a strategy for identifying consumer views can be a valuable approach. Establishing priorities and a systematic approach to feedback can help prevent unnecessary duplication and unsuitable research. In addition, a written strategy can be a document which clearly demonstrates commitment to public participation and consumer consultation.
4 quantitative research – how many?

4.1 Background

There are a number of quantitative research methods which can be used if your research question begins 'how many' or 'what proportion'? But beware. Unless you are absolutely satisfied that you know your research question(s), large quantitative exercises will not be appropriate.

This chapter gives detailed guidance on the practicalities of setting up quantitative research. Unless you are about to begin a research exercise you may want to read the main points but skip the detail until a later date.

4.1.1 Sampling techniques

The starting point for any survey is to define the population, which is the group of people about whom you want to obtain information — for example, all people who attended a particular out-patients' clinic during a given period. Since a survey of the entire study population is rarely possible, it is usually necessary to select a smaller sub-group of the population — a sample — to participate.

The idea is that a sample replicates as closely as possible the population from which it is drawn. How you select a sample, therefore, is very important because it can introduce a bias into the survey.

The best type of sample is a probability sample, which is drawn using a technique which gives every member of the population a statistically equal chance of being chosen. The best way of obtaining this is through a technique known as simple random sampling. The process of simple random sampling involves assigning everyone in the population a number and using a set of random numbers to select the sample. This gives everyone in the population an equal chance of being chosen.

Simple random sampling, however, can be very costly and very time-consuming. One modification of the technique — known as cluster sampling — is often used. With cluster sampling the population is divided into sub-sections — such as geographical areas — and random sampling methods are used to draw samples within these sub-sections.

Where time and money are very limited a technique known as quota sampling is sometimes used. This is where interviewers are given details of the particular types of people they have to find and interview. They keep interviewing people until they fill that quota. Using this technique, however, reduces the likelihood of the sample closely mirroring the population and increases the chance of introducing bias.

4.1.2 Sample size

One of the most important aspects of designing a survey is deciding how many people to ask. In general, the bigger the sample size, the smaller the error and the more solid the conclusions. Surveys can give only estimates of results. If an estimate is based on 500 individual responses it will be more precise than if it was based on 50 responses.

Exactly how big a sample should be, however, is often subject to debate, and can depend on who is being asked and what they are being asked. In practice, the more categories, such as age groups or socio-economic status, you want to compare within the sample the bigger the sample should be. The ideal sample size can also be influenced by the likely variation in responses and how carefully the target population has been defined. Although a bigger sample is generally better, experts point out that benefits from increasing sample size start to tail off quite
quickly. The actual sample size is more important than the percentage of the population that it represents. See the Suggestions for Further Reading listed in Appendix IV for some helpful texts on deciding sample sizes. It is important to take potential response rates into account when calculating sample size; remember the sample may be a third less than you had planned.

4.1.3 Non-response and sampling bias

In a way, the number of people responding to a survey is not as important as the number of non-responders. A large number of non-responders can be a source of bias in the survey because there may be characteristics specific to non-responders which make them different from those who did respond. Different methods can expect different response rates. Postal surveys, for example, tend to have low and slow response rates. For face-to-face interviews response rates of at least 65 per cent should be sought, but slightly lower rates may be more realistic for postal surveys. People who do respond to a postal questionnaire become, in effect, volunteers. They tend to have more education, more free time, and come from upper socio-economic groups.

Some practical pointers can help improve response rates. Careful definition of the target population and sample selection may help, as will designing a user-friendly questionnaire which is not too long. Prepaid or FREEPOST envelopes should be included with postal questionnaires or self-completion questionnaires which are to be returned by post. (FREEPOST are cheaper as you only pay for those which are used.) First and second reminders may be sent to jog memories. Sending an advance letter may increase response rates in telephone or face-to-face interviews.

Including an incentive — such as entry into a prize draw — can also increase response rates. Care must be taken, however, that you are not going to increase the differences between responders and non-responders with any incentive that you include.

Where possible, information should be collected on non-responders and, where anything is known about them, checks should be carried out to see how they differ from those who were included in the survey. This will be easier with some methods than others; interviewers, for example, may be able to record some information about non-responders. Or the sample may have been drawn from a list of people recently discharged from hospital, so something is already known about them.

4.1.4 Piloting a survey

You should not do a survey without first doing a pilot study. Not only is it bad practice not to pilot a study, but piloting will help avert potential problems during the actual survey. Running a small pilot study should show up problems with the clarity of questionnaires and any ambiguities which exist. A pilot survey could also flag up at an early stage if a survey looks as if it might not really be of value.

Points to look out for in a pilot study include: acceptability of the language used; conditioning effects (see Section 4.1.6); degree of interest shown by respondents; and the logical flow of the survey and the time it takes people to complete the questionnaire. The study should ideally be piloted on people as similar as possible to your intended sample. Piloting on hospital staff, students or colleagues will not necessarily tell you much about how the people in your sample will react to a questionnaire.
4.1.5 A snapshot or monitoring survey?

A one-off survey can be thought of as taking a snapshot of views, attitudes or experiences at a particular moment in time. If you want to monitor changes over time, a tracking survey or a longitudinal survey will be needed.

In a tracking survey, the same research exercise is repeated at intervals. The samples will not include the same people but, if the sample size is big enough, results will be comparable. More accurate monitoring of trends can be achieved by a longitudinal survey — that is, where a panel of people is selected and surveyed from time to time. Using this method you can be more confident that the changes identified are real changes over time and not due to any sampling bias.

The Scottish Office have set up a national ‘tracking’ survey of users’ views of the NHS. The first results, of face-to-face interviews with 2,539 people, were published in 1993. People were asked about their experiences of the NHS in Scotland in the previous year. The survey is to be repeated at regular intervals to check progress17.

4.1.6 Questionnaire design

(i) Overall design

How well a questionnaire is designed is more important than it might seem. Attractive and easy to follow self-completion questionnaires are likely to get better response rates than muddled, complicated questionnaires. The print size should be large enough for most people to be able to read it easily, and the spaces left for responses should be big enough to accommodate larger than average handwriting. It may help to include a large space at the end for “further information”.

Questionnaires must be kept short: delete all questions that are not strictly relevant. There should be a logical flow to the questionnaire. Questions where respondents are guided to the next question depending on the answer they give, such as “if yes, go to question 13”, complicate questionnaires and should be avoided if possible on self-completion questionnaires. Interviewers can be used to carry out surveys which are more complicated in structure.

Personal details and background information, such as age, sex and occupation, should be included at the end of the questionnaire — not the beginning, unless they are needed at the start as screening questions or to help interviewers fill quotas.

(ii) Wording questions

Questions should be worded in plain, informal language. Vague, lengthy or ambiguous questions will not give good results. Each question should deal with a single idea. Double-barrelled questions, such as “were you satisfied with the comfort and privacy of the consulting areas?” can cause confusion. The question covers
two issues and should deal with privacy and comfort in separate questions.

(iii) **Open and closed questions**

Questionnaires can contain open questions such as,
Q1 How do you think the waiting area could be improved?

or closed questions which give respondents a choice of options, such as:

Q2 Which of the following changes do you think would improve the waiting area?

- More comfortable chairs
- A separate play area for children
- More newspapers and magazines

The open-format of Q1 would result in a wider variety of responses and would represent the ideas most important to respondents since they offered the information unprompted. The information collected by Q1 would be very time-consuming and difficult to analyse. In addition, people may have difficulty remembering what they thought about the waiting area at the time and, without the help of the responses given in the closed question, might be able to offer very few suggestions. Care should be taken to make sure that questions are not too taxing for the respondents — is it reasonable to ask them to remember?

The closed format of Q2 would be quick and straightforward to analyse, but might miss issues of vital importance to respondents. Take, for example, women attending a breast screening clinic for routine screening. South Ayrshire Hospitals NHS Trust recently discovered that some women waiting for first time screening were distressed at having to wait alongside women who were agitated because they were there for diagnosis instead of routine screening. Q2 would not tap into this concern at all. Inclusion of another category goes some way to tackling this issue, but the choice of responses offered will clearly influence the type of answers people would give. Several authors have suggested that a combination of general open questions and more specific closed questions will give a better insight into what consumers think*. This would ensure that results include the most important issues that spring immediately to mind and those issues which a respondent may have forgotten about, but which did occur at the time.

(iv) **Likert scales**

One approach is to run the question as an open question during the pilot study, and to use the responses to the pilot question to formulate the choice of responses for a closed question in the final version. This can be done by formulating sentences from the pilot work and using Likert scales to rate them. That is, people are shown a range of statements, such as:

- "I found the seating in the waiting area uncomfortable"
- "There were plenty of newspapers and magazines to read"

and asked to give each one a score between one and five, where 5=strongly agree, 4=agree, 3=uncertain, 2=disagree and 1=strongly disagree.

(v) **Learning effect and response acquiescence**

There is a tendency for people to agree with whatever is being suggested in a questionnaire. This problem of 'response acquiescence' can be tackled by tinkering with questionnaire wordings to ensure that positive and negative statements
are presented. Similarly, there can be a 'learning' or 'confounding' effect as people progress through a questionnaire. In other words, previous questions begin to influence the answers. It is important to bear these issues in mind when deciding on the order of questions.

(vi) Hypothetical questions

There is another reason to treat the results of Q2 with caution. It deals with a hypothetical situation and the wording is somewhat leading. Questions such as

If your GP ran a health promotion clinic would you attend?

should not be treated as realistic indicators of how many people would, in reality, use the hypothetical service on offer. Questions should, in general, refer to a specific episode — such as a visit to the GP or a stay in hospital. Asking questions about general views on health services will give quite different results and will be of questionable relevance to the planning and running of services. Issues of a more hypothetical and general nature may be better tackled with qualitative methods.

4.1.7 Public participation and agenda setting

One of the criticisms commonly levelled at quantitative research into consumer views is that it often follows a professional agenda and does not allow for any real participation by consumers. Surveys tend to focus on priorities as seen by managers and these may differ radically from the priorities of consumers.

This approach may miss out on some key issues, simply because the questionnaire does not ask questions which are important. There is more to it than that, however. If research does not involve consumers more actively, it may end up alienating them. People involved in the survey may resent giving up time and effort to complete a questionnaire when they do not see any results of their efforts or get any feedback throughout the process.

Qualitative techniques can be used to enable users to set the agenda for research. They can identify issues and set priorities. It can also be useful to get users' descriptions of issues in their own words. These wordings can be used in further research to help iron out ambiguities. Other activities such as meeting with interest groups, regular discussion forums and feedback of study results can help foster public participation.

Argyll and Clyde Health Council has set up a series of discussion groups — using the nominal group technique — to identify issues and define questions on GP services. The results of these groups will form the basis of a large quantitative survey.

4.2 Methods to choose from

The following sections describe quantitative methods which you can choose from. The strengths and weaknesses of each method are outlined. A wide variety of case studies are included as illustrative examples of different techniques in practice. These case studies are not presented as the biggest, best or only examples. Pointers towards further information or people who may be able to advise on usage are given.

4.2.1 Self-completion questionnaire

This is a very popular form of survey, where people are given or posted a questionnaire to fill out themselves. Careful questionnaire design and
attention to detail, such as inclusion of stamped addressed or FREEPOST envelopes where questionnaires are to be returned by post, are important if self-completion questionnaires are used. If questionnaires are to be given out by hand a decision has to be made as to when they will be handed out. It is generally agreed that it is best to ask people to recount their experiences after discharge from hospital or when they've got home from their appointment. However, asking people to fill in short questionnaires before they leave hospital can improve response rates. Preferably, anyone directly involved in delivering the care that people are being asked about should not be used to hand out questionnaires. Other options include attachment of questionnaires to discharge papers or using external survey staff to distribute questionnaires.

ADVANTAGES
- Inexpensive, not too labour intensive and easy to administer.
- People may be more willing to answer some questions than they would with an interviewer asking questions.
- No interviewer bias.
- Large samples can be handled quite easily (with pre-coded questionnaires).

DISADVANTAGES
- Can get poor response rates.
- Can cause problems for people with difficulties in writing/reading, non-English speakers, people with poor eyesight etc. (See Sections 3.6 and 3.8).
- Too often reflects the professional/managerial agenda and is inflexible to consumer priorities.
- No opportunities exist to clarify any issues or answer queries from respondents.

One local Health Council carried out a study of two health centres. They used a combination of methods and asked staff as well as users for their views. One part of the process involved the use of self-completion questionnaires which were handed out to people attending a community service or clinic. The results from the 457 returned questionnaires complemented the results of 812 interviews with people visiting a GP. However, the response rates were low (25 per cent) and the researchers believed that questionnaires were not handed out consistently by the staff. In their plans to run a similar study in another health centre the researchers are employing people to hand out the questionnaires and emphasise the importance of returning them.

Greater Glasgow Health Board carried out a study of patients attending an emergency family planning clinic which caters for women who require post-coital contraception. Due to the sensitive nature of the service provided, a self-completion questionnaire was used to ensure respondent anonymity. Questionnaires were distributed to 300 patients and a response rate of 74% was achieved. Issues covered included welcome on arrival, waiting times, privacy during appointment, sensitivity of nursing staff, information from and explanations by the doctor, time with the doctor and instructions about medication. Overall, 95% of patients would be happy to return to the clinic if necessary.

4.2.2 Postal Questionnaire

Sending questionnaires to your sample by post is one way of administering a self-completion questionnaire survey (see Section 4.2.1). This is a popular survey technique and is relatively easy to administer, although response rates are
notoriously low. It is important to use reliable, up-to-date lists of names and addresses, since one reason for low response rates can be questionnaires never reaching people who have moved on. A clear explanatory covering letter is also important to improve response rates. Sending reminders two to three weeks after the initial questionnaire may also help.

It is important to satisfy the terms of the Data Protection Act before using lists to send out postal questionnaires (see section 2.4).

ADVANTAGES
- As for 4.2.1
- Respondents receive questionnaire after their experience is over and they have had time to reflect.
- Respondents can answer in the privacy of their own home without any pressure.

DISADVANTAGES
- As for 4.2.1.
- Sampling list may be incomplete or out-of-date.
- Response rates can be very low.

Scottish Health Feedback have run a number of postal questionnaire surveys on maternity services. They have had response rates of 80 per cent, which is very high for a postal survey. This success can be attributed to carefully focusing the survey on a defined group of people and good design of questionnaires to make them relevant and friendly so that people can actually relate to the questions. Also, attention was given to the detail of administration — such as sending reminders and making sure address lists are accurate.

4.2.3 Personal interviews

(i) Face-to-face interviews

An alternative to the self-completion questionnaire is the interview method. Skilled interviewers take respondents through questions and record their answers on a record form. Interviews can be conducted face-to-face or by telephone and they may be structured (all the questions and the order in which they are asked are preset) or semi-structured (some of the questions are open). The reliability of this method depends to a large degree on the skill of the interviewers. It also varies according to the type of questions asked. For example, where interviewers offer people a choice of pre-coded responses there is less scope for interviewer bias than when people are asked open questions and interviewers have to record or code responses. The personality of the interviewer is also important because the quality of information collected will depend on the rapport between the interviewer and the person being interviewed. Other details can help in this area — for example, by telling people about the survey before the interviewer calls on them. Interviewers should be carefully trained to use standardised wordings and phrases which help probe for more information without biasing the interview. Trained interviewers are less likely to bias the results and they also tend to get higher response rates.

Interviewing can now be computer-assisted. That is, interviewers key responses into a computer and results are processed quickly. In addition, the software can guide interviewers through complicated questionnaire format, such as “if yes, go to…” questions.
ADVANTAGES

- Interviewers can help explain ambiguities, answer respondents’ queries and motivate reticent respondents.
- Interviewers can build up a rapport with people and tackle sensitive subjects.
- Higher response rates.
- Helps overcome the limitations of the self-completion questionnaire — selectivity etc.
- Less likely to get answers missing to particular questions than with a self-completion questionnaire. On the whole, interviews collect fuller, more accurate information.

DISADVANTAGES

- Possibility of interviewer bias.
- Time-consuming and costly (needs lots of trained staff).
- People may be inhibited by the interviewer and say what they think they ought to say instead of what they would really like to say. In particular, they may be less willing to criticise.

(ii) Telephone interviews

Conducting interviews over the telephone can be a lot less time-consuming than sending interviewers off to do face-to-face interviews. What you gain in speed and reduced costs, however, may be lost in interviewer-respondent rapport and the high response rates that face-to-face interview tend to give. The most important point to bear in mind, however, when doing telephone surveys is the limitation of the sample frame; that is, only households with telephones can be included and within that household different people may be more or less likely to answer the phone. Young people tend to be out more often than older people, for example. Telephone interviewing is particularly suited to computer-assisted interviewing.

The market research society Code of Conduct states that ‘No calls in person or by telephone shall be made to a domestic household before 9am weekdays, 10.00 am Sundays, or after 9.00 pm any day, unless by appointment’.

ADVANTAGES

- Interviewers can explain ambiguities, answer queries etc.
- Can be useful in finding out whether people are prepared to take part.
- Quick and easy to carry out.
- Less labour intensive than face-to-face interviews.
- Less likely to get answers missing to particular questions than with self-completion questionnaires.

DISADVANTAGES

- Can only include people with telephones in their homes.
- Difficult to build up rapport between interviewer and respondents.

The health centres study described in 4.2.1 included an interview survey. People attending the health centre to see a GP (812 in total) completed face to face interviews using a structured questionnaire. They answered questions on how often they used the health centre, how they reached the centre, the waiting areas, the appointments system and consultations with GPs. The Health Council who conducted the study made a number of recommendations and an option appraisal group was formed to take things forward at one of the health centres.
May get errors in the recording due to the interviewer or interviewee mishearing or misunderstanding what the other has said.

Grampian Health Board used a telephone survey to investigate views on general health needs in small rural communities. The researchers were anxious not to alarm people when they first contacted them, and they wanted to make sure that people had some prior notice. The Board's Community Liaison Team put out a press release about the survey and wrote to the residents of the village in question warning them that they would be contacted. This was even more effective in the most recent survey when the letter also explained the questions that would be asked; respondents appreciated the chance to think about their answers in advance. The letter gave people a chance to opt out of the survey, although only one person did so. After that nobody refused to answer questions. Researchers arranged for all the respondents who lived alone to be contacted in the morning by a woman to allay fears. The interview combined pre-coded and open questions and Grampian found the results very useful. In particular, there had recently been the some media speculation and public agitation for a general practice to be based in one village. The survey asked people directly about whether they had ever needed services and not had access to them and how the provision of local general practices would help respondents, their families and members of the local community. The results helped Grampian to quantify the real extent of local concern, and to assess local priorities.

4.2.4 Standardised packages

It is possible to pay a fee for a questionnaire — or a set of questionnaires — and a consultancy service to help you put it into practice. A number of these standardised packages have been developed over recent years. Their advantages are fairly obvious but extreme caution is advised in the use of standardised instruments. Carr-Hill suggests that "any health service manager should beware of standardised instruments. The reasons are simple, context and objectives differ." If you do decide to use a standardised technique you should be certain that the package is set up to measure exactly what you want to measure.

ADVANTAGES

- Quick and easy to use.
- Cuts down time at the developmental stage.
- Results become available quickly and in an easily understandable format to enable managers to take appropriate action.

DISADVANTAGES

- Can be costly, particularly set-up costs where computer software is necessary.
- Most are fairly rigid and formal in structure and the type of information collected can be limited.
- When results are combined into single indices there may be a loss of validity and sensitivity.

4.2.5 Using outside consultants

You may need to recruit expert help at various stages of any consumer feedback work. Or you may want to contract the whole process out to external experts. There are a number of organisations in Scotland and elsewhere who can take on this task. See Appendix III for a list of consultants who have been successfully used within the NHS in Scotland. If you do contract out the work, however, it is still essential to consider the aims and objectives of the research carefully and ensure that the brief reflects them.
5 qualitative research

5.1 Background

Your research question may not begin ‘how many?’ but may be more about why, what or how. You will probably want to use a qualitative research method. There is, perhaps, a tendency to think that qualitative methods are somehow inferior to large, statistical surveys. In truth, there are many situations when qualitative research is a more appropriate means of tapping into consumer views than are quantitative methods.

It may be that the subject area does not fit into the ‘how many?’ format, or that some exploratory research is needed to identify what the ‘how many?’ questions should be. Qualitative methods are useful where you want to hear from people whose views are difficult to tap into using less flexible methods. A representative sample of your local population, for example, may include only a very small number of people from ethnic minority groups. The views and health needs of any of those groups could not be explored, therefore, in a large survey. They could, however, be tapped into using focus group discussions of other qualitative techniques.

Quantitative and qualitative methods can, of course, work well in combination, as described in Section 3.9.

5.1.1 Logical inference

An important point to make about qualitative results, however, is that they should not be squeezed into a quantitative format. The instruments are not designed to be representative with statistically significant results and should not be presented as such. Quantitative methods use statistics to draw conclusions, whereas qualitative methods rely on logic to generalise findings.

5.1.2 Choosing a sample

The issues involved in choosing a sample for qualitative research differ from those involved in doing surveys. The size of the sample is not as important and complex sampling techniques are more complicated and costly than need be. Since interpretation relies on logical inference, however, the logic of your sample must be considered when selecting people to take part. People are usually chosen specifically to add different perspectives and broaden the base of the research. Qualitative work on hospital food, for example, may specifically include vegetarians or diabetics. Equally, researchers doing qualitative work on a general practice may seek people who live at the furthest corners of the practice boundaries. This type of selection is known as theoretical or purposive sampling. Sometimes, it can be quite difficult to locate the type of people you wish to include because there is no appropriate list or people may not want to be identified. In these circumstances a technique known as snowball sampling may help. If, say, you wished to do a series of in-depth individual interviews on gay men and HIV/AIDS health promotion services, you could start off by interviewing one or two appropriate individuals and asking them to suggest others who might be willing to participate.

5.1.3 Public and private accounts

Qualitative research can be useful in tackling sensitive issues which may not be suitable for structured questionnaires. There is a distinction between the public accounts and private accounts which may emerge during qualitative research. In our study respondents talked about their beliefs in a polite, formal manner when first interviewed. After intensive interviewing for several hours, however, the beliefs they held most
strongly came out. It is clear that careful selection and thorough training of interviewers is important if private accounts are to be accessed.

The type of interview can also have a bearing on how much people will say about what they really feel or think. Sometimes people will be more comfortable talking about their experiences in a group of similar people than in an individual interview. At other times, people may only divulge their views in a one-to-one situation after establishing a rapport with the interviewer.

The UK National Survey of Sexual Attitudes and Behaviour uses an alternative method for questions about extremely sensitive topics. Respondents could write their answers on to cards which were immediately sealed in envelopes thus increasing privacy and confidentiality.

5.2 Methods to choose from

There is ample choice of qualitative research tools to pick from and, since it is an innovative area, new techniques are being developed all the time. The following sections summarise each method, give guidance on their strengths and weaknesses and, where possible, provide examples of their use.

5.2.1 In-depth personal interviews

Longer, more extensive personal interviews can be useful for handling particularly sensitive topics and exploring issues in some depth. The interviewer introduces topics for discussion and tries to build up a rapport with the interviewee. This method is useful for overcoming the problem of public and private accounts described in 5.1.3. It is important to make the interviewee feel as comfortable as possible throughout the interview; privacy, physical comfort of the surroundings and a leisurely timetable can all help.

ADVANTAGES
- Allows in-depth exploration of views and experiences.
- Can allow interviewers to tap into those views which are kept very private and would very rarely be expressed to anyone else.

DISADVANTAGES
- Costly and time-consuming. Not a good method for a large sample.
- Coding and analysing data collected can take a long time and is a highly skilled task which is quite susceptible to bias. A limited amount of information can be processed.

Borders Health Board commissioned a study into the arrangements for discharge from hospital for older people. In-depth interviews were conducted with 41 people over 70 years old who had recently come out of hospital. Interviewers asked them about the way the health services had worked for them and how things could be improved. The research generated a lot of useful information and ideas for improvements emerged - such as putting together an individual information pack for older people leaving hospital. A larger postal survey was planned to supplement these results.

5.2.2 Critical Incident Technique

This increasingly popular approach — using personal interviews — was developed for training pilots and analysing their performance in the Second World War. It is based on collecting factual accounts of things that have happened,
comparing them to expectations and then asking for subjective judgements about the events. In practice, it is based on asking people to reconstruct the events as they happened, almost in a diary form, and asking them to note anything they liked or disliked about each stage. A number of techniques—group interviews, questionnaires or analysis of records—can be used to collect the information. Individual interviews, however, have proved most effective. Interviewers take respondents through the events of their hospital appointment, for example, stage by stage. The process for Critical Incident analysis is quite complicated and people considering this approach are advised to read the report of studies by North West Thames Regional Health Authority into users’ views of services (see below).

**ADVANTAGES**
- This is a useful method for finding out facts as well as finding out what people think. It can point very clearly to where there are opportunities for improvement and what the necessary improvements might be.

**DISADVANTAGES**
- It is a slow, time-consuming and expensive process. Trained interviewers are essential and analysis of the information will not be quick or easy.
- Particularly useful where there appears to be a mismatch between what service users say about a service and the picture staff present.

5.2.3 **Focus/discussion groups**

This qualitative research tool is very popular in market research and is used quite widely throughout social science. The terms focus group, discussion group, group interviews and focused group discussions all describe the process of bringing together a small group of people to discuss issues. The people involved should not, as a rule, know each other and the best size for a group is thought to be between seven and ten. The discussion is guided by a facilitator who introduces topics for discussion. Proceedings are recorded by a tape recorder, in note form or, preferably, both.

The method is very flexible and lets people say what they think with minimal direction from research staff. The use of a skilled facilitator is crucial and careful attention should be given to the people included in the group to allow free-flowing discussions. On the whole, the more similar a group is in terms of age, sex and social class, the easier communication will be within the group. Researchers find, for example, that if both men and women are included in a group the dynamics change and some people are inhibited. Who you choose to include in your groups depends on who you are interested in and how many groups you can afford to run.

**ADVANTAGES**
- People may feel more comfortable in a group discussion than in a one-to-one interview.
situation. They may feel more able to articulate themselves as part of the group. They may spark ideas off one another and are more likely to generate spontaneous comments.

- This is a useful technique when you want to let consumers identify the issues of importance or you have little knowledge about the area in question.
- An inexpensive way to generate a lot of qualitative information.

**DISADVANTAGES**

- A trained and experienced facilitator is necessary to ensure that all members of the group get their views heard, not just those with the loudest voices.
- The group may, in effect, inhibit one another and the views expressed may all tend towards the norm. Some people might be afraid to say what they really think if it deviates slightly. In other words, you might not get the true breadth of opinions that exist within the group.
- It is not possible to prioritise or attach weight to the issues identified.

Greater Glasgow Health Board commissioned consultants to carry out a study at the Royal Hospital for Sick Children. Focus groups were used to obtain the views of children and their parents on their experiences in hospital. Children between 7 and 11 years old who had been in hospital for varying lengths of time took part in the focus groups. Researchers found that children were less 'capable of voicing their own personal reflections on what they experienced in the hospital' than the groups of adults had been. As the groups went on, however, the children gained confidence and became more able to express their views. It appeared that activities and facilities on the ward were most important to the children and that they had low expectations about how they 'should' be treated in hospital. The parents, in contrast, valued highly the amount of attention given to their child and staff attitudes towards themselves and their child.

**5.2.4 Nominal Group Technique**

The nominal group technique (NGT) is a group discussion method which can be used to facilitate agenda setting and priority listing by consumers. The technique sets out a structured process to tap into individual ideas and reach a group consensus.

A group of between five and 12 people is asked to consider a topic, such as "what are the essential requirements of a good outpatient clinic?". Each person is asked to record their ideas about this topic on paper. Ideas are collected by a facilitator and displayed on a flip chart. There is then discussion of each item and the facilitator tries to ensure that each point is clear and that the list is not repetitive. Each participant then chooses the 10 or so most important items from the list and transfers them to cards. They are then asked to identify priorities by awarding each item a numerical ranking. The facilitator collates the individual scores and ranks items according to the highest score.

If the group includes people who have difficulty in writing — such as people with failing eyesight or arthritic hands — the technique can be modified to use the facilitator to transcribe discussions and pull out a list of the ideas which were generated.
ADVANTAGES

- One advantage that the NGT has over other qualitative methods is that the end result is a short list of ranked priorities. Other methods may yield more information, but may leave you with little feel for what the most important issues were or whether consensus was reached.

- Unlike other discussion group methods, this technique does not necessarily favour those members of the group who are happiest speaking out in such situations. The use of paper and individual cards requires full participation of each individual. The systematic ranking also allows all participants an equal say in the process. It is also important to note that the only person who writes anything on the flip chart is the facilitator — only his or her spelling that is under scrutiny.

- One popular aspect of the NGT is that it allows for immediate feedback to the participants. People who have used the method report that participants thoroughly enjoy taking part in the NGT exercise.

LIMITATIONS

- Success in using the NGT depends on following the structured process described above. Missing out any of the stages will influence the quality of the end product.

- NGT is not appropriate for exploring issues in depth or for eliciting details of peoples' experiences or attitudes. The end result is a list of points — such as key features of a good outpatient clinic. It won't give you information, however, on why people think that the issues are important, or what the range of participants' experiences were.

Ayrshire & Arran Health Board and Glasgow University conducted a collaborative project to develop and utilise the nominal group technique. They have been using it to investigate the quality of care for elderly people and the young mentally ill. The technique was used with groups of patients, groups of relatives and groups of nurses (acting as patient advocates) to elicit views on the requirements of a good service in long-stay wards.

The exercise produced lists of key requirements as defined by the three groups. The top six patient criteria, for example, were nurses' attentiveness, visitors, company and the chance to make friends, cleanliness of wards, church services and knowing what your tablets are for. There were notable differences between the requirements as defined by each group. Food, for example, was ranked eleventh by patients but was given the second highest score by nurses. The patient requirements were then incorporated into questionnaires to conduct a survey of patient satisfaction with long-stay wards in Ayrshire & Arran. Now that the development work in this area is over, Ayrshire and Arran are satisfied with the robustness and flexibility of NGT and are using it in setting standards for their purchaser-provider contracts.

5.2.5 Rapid Appraisal

This is a means of tapping into the concerns of a local community by doing a series of interviews with key informants. The idea is that this will result in a feel for the concerns which are important in the community. The key informants are people who live or work in the community and they should be drawn from a wide range of perspectives. Health Boards might find this a particularly useful technique for health needs assessment and locality planning.

The interviews are designed to be informal and gather as much qualitative data as possible. The information collected should then be condensed into a list of issues which emerge. Researchers can then return to informants, and ask them to look over the list of issues and then to put the list into priority order. Researchers can then collate an overall list of priorities. The interviews with key informants should be carried out by managers and other key staff.

ADVANTAGES

- Can be completed very quickly and little training is needed.
- Managers can easily get involved - allowing them to get a feel for local concerns. This can create a useful channel of communication between service providers and service users.
- Allows consumers to set the agenda and identify priorities.

DISADVANTAGES

- This approach is not really suitable for tackling very specific issues. It is better suited to general issues - such as health concerns - and can set the agenda for more specific research.
- The selection of key informants may mean that the views of those people most isolated in the community may not be tapped into.

Dumfries and Galloway Health Council used rapid appraisal to explore health concerns and issues in the Eastriggs area. Their 26 key informants included, among others, a fireman, a home help, a health visitor, a shop assistant, a social worker, a minister and four housewives. Informants were asked a range of fairly general questions about living in Eastriggs, things that make people ill/ well and views on health and social services in Eastriggs. The local Community Council, who requested the report, then used the findings as a means of promoting further local interest and action in health matters.


5.2.6 Observation/shadowing

Shadowing exercises — sometimes known as participant observation — can be useful when other types of research are not feasible and would be disruptive. It may also be useful if you have doubts about the quality of information that you would get by asking people. People may, for example, have difficulty remembering the issue in question or you may be more interested in understanding what actually happens rather than someone's perception of it. For example, if you ask people if it was easy to find their way to an outpatient clinic they may answer 'yes', because they already knew their way around the hospital and did it on automatic pilot. The quickest way to throw light on the experience of first-time attenders may be to shadow them when they turn up.
The method can be done by someone sitting in a place where he/she can record events as they happen — for example, in a waiting room. Alternatively, observers can follow or shadow service users and note what happens. In some cases, the service user can also be the observer — if they are given an observation checklist beforehand.

ADVANTAGES

- Allows you to record actual events rather than an individual’s perspective. In some situations this may take you closer to the truth about their experiences.
- Useful when questionnaires or other types of research would be too disruptive, such as in Accident & Emergency departments.

DISADVANTAGES

- Would give you no insight into what users thought about the events that were recorded. Observers and managers may think everything went swimmingly; actual service users may not.
- Information gathered in this way tends to be of limited generalisability, but it can help you understand what goes on when someone uses a service.

5.2.7 User panels

One way of keeping in frequent contact with service users is to set up a user panel. This is essentially a group of service users that you go back to from time to time. This can be just getting them together to discuss issues from time to time or it could be sending detailed questionnaires on, say, an annual basis. If it is the latter, all the rules of quantitative research should be followed. With the former approach, however, it is more a question of setting up a forum for a dialogue between managers and users. Many companies and other services have adopted this approach. BT, for example, set up consumer panels several years ago, as did the Ministry of Agriculture, Fisheries and Food in partial response to calls to open up its decisionmaking process.

Panels should reflect a broad base of service users but they are not intended to be representative.

ADVANTAGES

- Can be useful as a sounding board for ideas or plans.
- This is one way of establishing a two way dialogue between those who run services and those who use them.

DISADVANTAGES

- May be a tendency for managers to get complacent that this is the only kind of
consultation that they need to do. Panels are not meant to be representative and should not be treated as such.

People who are on the panel may feel more as if they are part of the organisation as time goes on. They may, in other words, get a bit too close to have the same perspective as other users.

Argyll and Clyde Health Board have set up a panel of 750 volunteers. The panel is called REACT and is to function as a ‘public sounding board’ for the Health Board. Although the fact that the panel is made up of volunteers weakens its representativeness, the response rates for questionnaires are very high. This may be because being on a panel can give people a sense of participation that other surveys do not.

HEALTHWATCH is the name of the panel of 120 people set up by Dumfries and Galloway Health Council. The panel is used to gain an insight to public opinion on selected key health issues. Meetings are organised for groups of around 30 and prior to each meeting members receive a professionally prepared information pack. The meetings themselves take the form of open discussions described by the Council Secretary as “an Oprah Winfrey kind of set up”. There is always an expert on the topic present to answer questions or to separate fact from fiction during discussions. After the meetings a questionnaire is issued to all members and their replies form the basis of a report.

5.2.8 Diary-keeping

Similar to the idea of observation or shadowing is that of service users keeping diaries of their experiences. This could be useful in cases where people are asked to recall quite detailed information afterwards which they may have difficulty remembering. Asking people to keep a diary about hospital food could give you detailed information on the timing, temperature and acceptability of food on a meal-by-meal basis.

It is also a useful tool for giving managers an insight into the experience of users.

ADVANTAGES
- Useful for recording details which people can’t reasonably be expected to remember later.
- Relatively quick and easy to organise.

DISADVANTAGES
- The quality of information in the diaries will vary — in terms of accuracy, comprehensiveness and legibility — from person to person.
- Can only be used by people who can write.
- The fact that people are being asked to keep a diary may influence their views or their behaviour. It may, for example, make people more critical or more detailed in their scrutiny than they would otherwise be. This is not necessarily a disadvantage, but should be borne in mind when interpreting the findings.

5.2.9 User consultation days/open days

Previous sections have pointed out that it is important that consumer consultation is more than just asking people to fill out questionnaires from time to time. It should also be about opening up channels of communication between services and people who use them. One means of doing this is to have open days or user consultation days.

Open days can be useful for letting people become familiar with premises or services — particularly if they are new or revamped. At its simplest this could just be one day of opening the doors for people to wander round and find out about things. Poster presentations, guided tours, slide shows and just making staff available for chatting can all increase the value of the exercise.

User consultation days may take a more structured format. They can be set up to address particular issues. A wide range of people can be invited and there may be presentations and the proceedings may split into workshops.

ADVANTAGES
- This type of exercise can help create the right climate of openness and user involvement.
- Can give you a chance to tell people about what you are doing and get some instantaneous feedback on it.

DISADVANTAGES
- People who attend open days or consultation days tend to be more motivated and interested than most service users. Although any exchange of views will be useful, it must not be used to gauge consumer opinion in general.

Before the new Ayr Hospital opened in 1991 there were a series of open weekends. Staff were involved in taking the thousands of visitors around the hospital to explain the new set up and let them have a look around. The idea was that people who use the hospital — patients and staff — should have a feeling of ownership of the new hospital from the start.

5.2.10 Complaints tracking and analysis
A lot of valuable information can be extracted from complaints. Surveys of complaints tracking systems can tell you a lot about how an organisation functions at its strongest and its weakest. If a person contacts the service provider with a complaint it gives the system an opportunity to get it right next time round. If a complainer is happy with the way the complaint was dealt with, he or she may actually be more satisfied with a service than people who had no cause for complaint in the first place. The information generated by complaints can be a valuable resource and is often not tapped into.

ADVANTAGES
- Complaints tracking systems helps tap into information which can identify recurrent and remediable problems.

DISADVANTAGES
- Complaints systems must be easily accessible, simple procedures and well-publicised if people are to bother reporting complaints.

Grampian Healthcare have set up a system where they routinely follow up 50 per cent of complaints. Every three months there will be a telephone survey (although people will have been informed beforehand). People are asked about how their complaint was handled and how satisfied they were with this treatment. The results of each survey are presented to the Chief Executive.

Ayrshire and Arran Health Board commissioned a study into complaints handling. As a result they have developed a system of classifying and coding complaints as they are recorded. They have looked at their complaints system and are finding that complaints are increasing as the system becomes more accessible.
5.2.11 Drama workshops

Drama workshops can be a means of tapping the views of people with learning difficulties. The idea is that a skilled facilitator takes a workshop and people are encouraged to act out their interpretation of what they want or do not want from a service.

ADVANTAGES
- Can be useful where questionnaires, discussion groups etc. are not really appropriate.
- Participants may enjoy the experience a lot more than more formal methods. Results may be more spontaneous as a consequence.

DISADVANTAGES
- Some participants may be inhibited in this situation.
- As with many other research methods described here, the results are of limited generalisability. They can be of great value, however, in allowing an insight into users views in more depth than might otherwise have been possible.

Newcastle Health Authority has recently run a series of drama workshops with a user group for people with learning difficulties. The sessions were taken by a drama teacher and groups were asked to role play what makes a good hospital and what makes a bad hospital. The exercises were successful in drawing out a lot of information on things that matter in hospital. The things that make a really bad hospital, for example, included rude staff, old gloomy buildings, awful food, green paint and uncomfortable trolleys. Everyone would be lying down waiting to be seen and would have to wear hospital nightwear. There would only be one hour for visits at night and wards would be very big and noisy with phones ringing day and night.

5.2.12 Meetings with interest groups and liaison with local health councils

Consultation with interest groups is an important feature of consultation. Service user groups, carer groups, consumer organisations and other interest groups can all be a useful source of consumer views. You may want to set up regular meetings with individual groups or you may want to set up a regular forum, where various interest groups get together to exchange views. Seeking comments from interest groups on issues of interest — before rather than after the event — can also be helpful in establishing a regular and constructive dialogue.

ADVANTAGES
- Can be helpful in establishing a regular and constructive dialogue with users.
- User groups and interest groups can be useful as a sounding board to discuss future ideas with.

DISADVANTAGES
- People who are involved in or represented by interest groups tend to be particularly motivated and should not be taken as representative.

Greater Glasgow Health Board has carried out surveys jointly with the Greater Glasgow Health Council to seek views of maternity patients on the length of hospital stay after delivery. The Health Board has also funded a full-time researcher for the Local Health Council who will carry out surveys to assist the Health Board in monitoring service provision.

5.2.13 Phone lines

Setting up phone lines — to give information to consumers and to let consumers express their views — is another option you could add to your portfolio. They can be set up as hot-lines to deal
with specific issues or they may be permanent fixtures.

It is important that the staff that answer the phones are friendly, encouraging and not defensive.

ADVANTAGES
- Can be a two-way exchange of information.
  Provides an instant outlet for people to express their views, or pass on ideas.

DISADVANTAGES
- Can be expensive to run if the service is not used very often. Needs to be well publicised.
- Callers to help lines are not representative of service users in general.

Grampian Health Board runs a freephone line called Grampian Health Freeline. The phone line operates to provide information and answer questions on a whole range of issues and log in suggestions, informal complaints or comments that people want to make. Everything is kept very strictly confidential — summary data about the type of enquiries/comments are presented to the Board at regular intervals, but no information is ever passed on that would lead to identification of an individual. The service is advertised widely and cards and leaflets are available at GP surgeries. It is sometimes advertised to encourage specific feedback on a time-limited basis linked with particular research programmes or issues.

5.2.14 Public meetings

Public meetings are already a common form of consumer consultation in the health service. They can be useful as a forum for discussion of issues that arise and may create controversy. On their own they are not very effective means of consultation, because they can too easily turn into heated exchanges of familiar arguments. Nevertheless they can form part of a programme of consultation, dialogue and openness.

ADVANTAGES
- Useful forum for discussion of controversial issues. A means of ensuring that those who are desperate for their views to be heard can put them forward.

DISADVANTAGES
- Attendances at public meetings can be very poor. Simple things can help: publicise meetings well in advance; make sure they are easily accessible.
- Meetings often end up being attended by the same — very vocal — people time after time. It can be difficult to get a more widespread attendance and, even then, to make sure that they get a chance to speak. Meetings can turn into a re-run of the same entrenched viewpoints time after time with no real dialogue.

5.2.15 Search Conferences

A search conference is a type of meeting or conference. Instead of an audience listening to the views of expert speakers, however, the search conference approach seeks to involve everybody and most of the time is spent in small working groups. It was originally developed by the Tavistock Institute of Human Relations to bring together groups of people with differing perspectives on an issue and to try and increase their understanding of one another.

Participants in search conferences are asked to stick to some ground rules. These are that people must listen to what others have to say without interrupting or disagreeing, speak as an
individual (rather than as a spokesperson of an organisation), respect the opinions of other participants, be willing to participate fully and be committed to carrying forward what has been learned.

ADVANTAGES
- Can create a setting for ensuring a variety of viewpoints are given a fair hearing.

DISADVANTAGES
- Attendees are not representative. It can be difficult to get people who are affiliated to an organisation to speak as individuals not as representatives.

The King’s Fund Centre held a search conference to bring together people with disabilities and carers to discuss community care plans. The conference was held over two days, with 30-50 participants, and was considered successful. Despite the organisers fears, there was not a conflict between the views of users and carers. They found no clear cut “user’s view” or “carer’s view” and people were able to understand other perspectives.

5.2.16 In users’ shoes...

One of the quickest and easiest ways for managers or health professionals to gain some insight into a service from a consumer perspective is to spend some time in users’ shoes. Although this happens to some extent anyway, since everybody uses health services, managers and professionals might find putting themselves firmly in the users shoes is a useful exercise. This could be as simple as a GP sitting in a practice waiting room for half an hour. The value of this experience is even greater if the manager, doctor or nurse remains anonymous.

The change of attitude that can happen when someone involved in the health service experiences life as a service user has been the subject of a Hollywood film. In The Doctor a ‘gifted but insensitive heart surgeon’, played by William Hurt, experiences life as a patient in a hospital which completely changed his attitude to medicine and patients.

ADVANTAGES
- A very, quick easy way for managers and professionals to gain some insight into or to be reminded what it is like to use a service.

DISADVANTAGES
- The information is very limited and can only be used to aid understanding. If managers do not come across any problems in their time as users this does not mean there are no problems.

Scottish Action on Dementia recommend that anyone involved in a planning group without experience of dementia should spend at least a day learning what it is like to be a carer. They suggest spending a whole day working alongside a carer in their home, working a shift in a nursing home, hospital or day-centre. They also point out that voluntary organisations would help arrange an experience of caring.

5.2.17 Suggestion boxes

Putting a few suggestion boxes in a hospital, surgery or centre is one small action that helps create good channels of communication. People should be encouraged to jot down ideas, comments or criticisms and pop them in the box. This is likely to gather more spur of the moment comments than waiting for people to write a letter later.
ADVANTAGES

- Useful ways of tapping into the views of people who may not want to make a more formal approach.
- Can yield useful positive ideas as well as valuable criticism.

DISADVANTAGES

- Relies on public actively making the effort to put their views across. No substitute for actively seeking the views of users.

Ayr Hospital has a number of “You can make a difference” boxes which are emptied regularly and the results fed back to managers. There were a number of comments in the box which suggested that the ‘hotel’ services for parents staying over with their children could be improved. The hospital followed this up with a survey and have now appointed a housekeeper to look after the interests of parents staying with their children.

5.2.18 Roadshows

Roadshows are effectively a means of taking an open day or a public meeting out to the public. A roadshow could be as simple as parking a van in a busy shopping centre, making sure lots of leaflets and other information is available, sitting someone in a desk to answer questions and putting up some posters. Alternatively, it could be a more sophisticated set up — setting up ‘the show’ in different locations with presentations, lots of people answering queries and taking comments and special displays.

ADVANTAGES

- Useful way of getting ad-hoc feedback on services or plans for changes to service provision and also a means of disseminating information.

DISADVANTAGES

- Cannot rely on this either as a method of disseminating information or of collecting feedback. People who go to roadshows will not be representative.

A SCOTMEG/CRAG working group ran a series of roadshows to consult users and staff on maternity services. The exercise did give some consumers an opportunity to voice their views on maternity services. It was felt, however, that the predominance of professionals attending the roadshows may have inhibited free flow of consumer comment.

5.2.19 Patient supporters

The term patient’s supporter encompasses the idea of patient’s representatives, patient’s friends and advocacy. This can be in the form of projects where skilled volunteers or workers work in the interests of individuals. Alternatively, patient’s friends or patient’s representatives may be appointed in a particular setting to liaise between service users and service providers. Schemes involving patient supporters are becoming an increasingly popular way of ensuring that consumer voices get heard. Often these schemes involve groups of more vulnerable users whose voices have tended to go unheard in the past. Increasingly, however, they are seen as an effective link between services and people who use them. A number of groups — service providers and user organisations — have set up advocacy projects. Other hospitals — such as the Frenchay Trust in Bristol — have appointed a patient’s representative whose job it is to talk to patients and relay their ideas, comments and
criticisms to hospital management. Guidelines on patient supporters for service users, carers, NHS staff and patient supporters have recently been issued by the Scottish Office.

ADVANTAGES
- Patient's supporters can facilitate the airing of views from users that would otherwise go unheard. They can improve channels of communication between service users and service providers.

DISADVANTAGES
- Consulting patient supporters should not, in general, be seen as an alternative to consulting actual service users.
6.1 Analysis of data collected

Having collected all this information you need to make some sense of it. Some sort of analysis will be needed. People involved in doing the analysis should be aware of the aims of the research and this should influence the shape of the analysis, just as those involved in setting up the research should consider the type of analysis that will have to be done. The importance of appropriate statistical analysis simply cannot be overemphasised. It is wise to consult a statistician if in the slightest doubt.

Quantitative results will have to be collated and the numbers analysed to produce statistical results. The decision on whether to do the analysis by hand or by computer will depend on a number of factors. These include:

- available computing facilities
- available skill and expertise
- number of respondents
- length and complexity of questionnaires
- type of comparisons required.

A large number of short, simple questionnaires will probably be best suited to computerised analysis. It may take a disproportionately long time, however, to set up a computer analysis for a relatively small number of long, complex questionnaires. In such cases, it may just be quicker to do it by hand. Analysis of open questions tends to be done by hand.

"If 50 people are given a questionnaire with 10 questions of which 5 are of the open type, then the use of a computer is unlikely to bring with it any advantage."

International Hospital Federation, 1988.

To enable statistical comparisons the data must be coded into categories. The process of analysis can be made easier by pre-coding questionnaires, — that is, defining the categories of response and offering respondents a choice between them. For example,

How long was your stay in hospital?

- Less than 4 days
- 5 days to 1 week
- 1 to 2 weeks
- Between 2 weeks and 1 month
- Over a month.

Coding is a very important aspect of questionnaire design. Inappropriate coding can affect the validity of the research. It is essential to thoroughly research the questionnaire to ensure that the categories chosen for pre-coding are appropriate. Coding can be particularly difficult when it comes to open questions and information from qualitative research exercises. Qualitative data in its raw form is usually just a large number of words. Converting these words into more manageable categories is a time-consuming and highly-skilled task, which involves summarising the information from each response and sorting recurring points into categories.

One factor to consider at the analysis stage is the possible existence of confounding factors. That is, there may be something about your sample which is influencing the results, but which is not directly related to what you are trying to measure. For example, older people consistently rate satisfaction with medical care higher than younger people. If you wanted to compare satisfaction ratings between two general practices, for example, you should examine the age profiles of the two practices and see how they differ. If one practice has significantly more people aged over 60 than the other, statistical techniques can be used to control for this.
Dumfries and Galloway Royal Infirmary fared well in the “What the Patient Thinks” survey compared to the national average. While this may well be the case, the sample did have an older age distribution than the national average. Statistical tests on the data could be used to tell whether or not age is acting as a confounding factor.

The Centre for Health Economics book *The NHS and its Customers*\(^4\) gives useful guidance on practical aspects of data analysis. See Appendix II for a description of some of the statistical tests which may be appropriate.

6.2 **Interpretation of results**

You need to be extremely careful when it comes to interpreting and presenting the results of your research. If you make mistakes or misleading statements they may well be quoted again and inaccurate statements may become accepted as truth. It is important to remember that results from a survey only represent answers to your set of questions. Carr-Hill\(^5\) describes the fact that at this stage there is a “*temptation to forget that what are confidently described as respondents' views are only their replies to questions devised by the researcher and not necessarily the patients' own views*”.

Reporting of results must be exact. Take the following example:

Nurses were never too busy to attend to you quickly

<table>
<thead>
<tr>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I strongly agree</td>
</tr>
<tr>
<td>I agree</td>
</tr>
<tr>
<td>I disagree</td>
</tr>
<tr>
<td>I strongly disagree</td>
</tr>
</tbody>
</table>

Imagine you were interested in reporting the number of people who strongly disagreed with this statement. It would be misleading to say “13 per cent of respondents said that nurses were always too busy to attend to them quickly”, because the results do not tell you that. All you can say is that “13 per cent of respondents said that they strongly disagreed with the statement “nurses were never too busy to attend to you quickly””. Equally, it would be misleading to say “67 per cent of respondents thought that nurses were never too busy to attend to them quickly”. It would be more accurate to say “67 per cent of respondents said that they agreed or strongly agreed with the statement “nurses were never too busy to attend to you quickly”. It is a useful exercise to run through the wording you will be able to use to present the results when you are designing the questionnaire.

When quoting comparative survey results it is important to compare like with like. Satisfaction ratings should be compared with satisfaction ratings and dissatisfaction rates with dissatisfaction rates. Satisfaction rates should not be quoted comparatively with dissatisfaction rates.

Some authors have described the tendency to collapse down results from rating scales when presenting the results. This can lead to a loss of sensitivity. A five-point satisfaction scale, for example, could be collapsed down to combine very dissatisfied and dissatisfied into one percentage and very satisfied and satisfied into another one. Presenting the results in this way, however, gives no indication of the strength of feeling which could substantially change the meaning of the results.
6.3 Feedback of results

There are several reasons why it pays to get research results out to as wide an audience as possible. They include:

- if no-one hears about research results there is less likely to be any follow-up action
- others engaged in similar research can learn from your example, or your mistakes
- feedback of the results to people who have taken part in the exercise is an important form of participation.

This latter point is very important, and you should consider the most appropriate way of disseminating results to those who participated. Failure to inform people of the results of research and any follow-up action can result in alienation, and many may feel that their time and effort were wasted.

Long stay hospital patients in Greater Glasgow’s Care for the Elderly Hospitals who participated in an interview study were sent a letter explaining the key findings and outlining the action planned to improve the service.

Members of Argyll and Clyde Health Board’s REACT panel are sent a newsletter after questionnaires, telling them about the study, its results and any follow-up. The newsletter presents the results clearly using pie charts and simple percentage statements.

Staff involved in services which have been evaluated should be told about the results and their implications. Sensitive issues may emerge and the process of informing staff needs to be handled carefully.

A range of media can be used to disseminate research results. Initially, however, a comprehensive research report should be written up. The full report can then be used as a reference for compilation of concise summaries. Writing short, punchy summaries too early on may result in inaccuracies or omissions. Other means of letting your audience know about your findings include public meetings or seminars, distribution of concise summary sheets, papers for professional journals, posters on notice boards, and local radio and newspapers.

6.4 Follow-up action

Commitment to follow up action should be firmly in place before the research gets underway. Those people involved in setting up research, carrying out the research or taking part as research subjects will all be frustrated by the failure of management to make any changes in line with the results. People are likely to become cynical about the research and will see it as a cosmetic, tokenist exercise. Enthusiasm for consumer consultation in all forms will wane unless follow-up action is taken and seen to be taken. The follow-up action may not result in eventual changes, but may be the setting up of a task force to consider the options that exist. Telling people about what is being done, what decisions have been made and why can all help to counter potential cynicism.

The report of the survey of users’ of the NHS in Scotland “What Users Think 1982” for example, includes some information on intended follow-up actions in the survey report.
It is hoped that those involved in seeking consumer views on NHS matters — Health Boards as purchasers and providers of health care, NHS Trusts as providers, general practitioners, local health councils as consumer representatives and other organisations — will find the information contained in this guide useful when embarking on new consultation exercises and planning consumer-centred health services. There is a great deal of rhetoric on the subject and the intention of this guide is to offer more practical guidance as well as outlining the broader issues involved.

Although providers have long been interested in finding out what people think about aspects of health services, there has recently been a firmer commitment to consumer consultation and public participation in the NHS in Scotland. This is partly due to an increased recognition that health service users are an expert resource. A knowledge of people’s experiences, attitudes and opinions can assist in the setting and monitoring of standards, inform health needs assessment and shape health policy.

Ascertaining consumer views, however, can be fraught with a number of difficulties. Health service users may be reluctant to criticise health services because they are grateful for the services provided — even if they are flawed — or are frightened of staff reaction to unfavourable comments. In addition, people may have difficulty in remembering the precise details of service provision once it is over. The extent to which these issues present difficulties will depend on the type of service under scrutiny, the people who are being consulted, and the issues to be tackled. There are many research tools to choose from, both quantitative and qualitative. It is important to define research aims and objectives before making an assessment of the most appropriate research method. It is essential to define very carefully the target population and make use of the best techniques to select an appropriate sample from that population.

When the information has been collected, an appropriate technique — manual or computer — must be used to analyse the information. The size and shape of this task will depend on the research method used; for example, quantitative results will probably need statistical analysis.

Much has been written about the volume of consumer consultative documents which end up gathering dust on a shelf. This is hardly surprising since the apparent lack of follow-up action is a source of frustration for many people. A commitment to follow-up action should, therefore, be firmly in place before the research gets underway. Telling consumers about what is being done, what decisions have been made and why, can all help to counter the cynical view that consumer consultations are token exercises.

There are three basic principles which can best sum up the key to successful consultation of NHS consumers: a high level of commitment to consumer consultation and its consequences, detailed attention to research design and to its suitability for the particular research aims, and effective communication of results and follow-up action.
appendix i — a short checklist

• Have you defined your research questions clearly?

• Who do you want to ask? Define your target population.

• Do you have commitment at all levels to the research findings? Who will ensure that follow-up action happens?

• Have you checked other research and published information? Can you find out what you want to know without doing the research? If not, can you learn from others’ experiences?

• Do you have the time, money, skills and equipment to use the method you have chosen?

• Have you allowed enough time for analysis and write up?

• How will you tell people about the results and what you plan to do about them?
<table>
<thead>
<tr>
<th>CONSULTANT</th>
<th>ADDRESS</th>
<th>USED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lethian Health Council</td>
<td>21 Torphichen Street, Edinburgh, EH18 9BX</td>
<td>Lethian Health</td>
</tr>
<tr>
<td></td>
<td>(031 229 6065)</td>
<td></td>
</tr>
<tr>
<td>Market Research Scotland Ltd</td>
<td>9 Park Quadrant, Glasgow, G3 6DS</td>
<td>Greater Glasgow Health Board</td>
</tr>
<tr>
<td></td>
<td>(041 332 5751)</td>
<td></td>
</tr>
<tr>
<td>MORI</td>
<td>96 Southwark Street, London, SE1 0IX</td>
<td>Management Executive</td>
</tr>
<tr>
<td></td>
<td>(071 298 6955)</td>
<td></td>
</tr>
<tr>
<td>Derek Mowbray, Management Advisory Services to the NHS</td>
<td>11 Royal Crescent, Cheltenham, GL50 3DA</td>
<td>Forth Valley Health Board</td>
</tr>
<tr>
<td></td>
<td>(0342 519009)</td>
<td></td>
</tr>
<tr>
<td>PA Consultant Group</td>
<td>Cambridge Laboratory, Melbourn Royston, Hertfordshire, SG8 6DQ</td>
<td>Fife Health Board</td>
</tr>
<tr>
<td></td>
<td>(0783 391222)</td>
<td></td>
</tr>
<tr>
<td>Price Waterhouse</td>
<td>Albany House, 56 Grosvenor Gardens, Edinburgh, EH1 3QR</td>
<td>Fife Health Board</td>
</tr>
<tr>
<td></td>
<td>(031 557 9500)</td>
<td></td>
</tr>
<tr>
<td>Ian Phillips, Digital</td>
<td>Mole Business Park, Station Road, Leatherhead, Surrey, KT22 7BA</td>
<td>Forth Valley Health Board</td>
</tr>
<tr>
<td></td>
<td>(0372 370077)</td>
<td></td>
</tr>
<tr>
<td>Quality Health Management Consultants</td>
<td>Sutton Manor, Poleterton Lane, Sutton, Scarisdale, S44 5UT</td>
<td>Greater Glasgow Health Board</td>
</tr>
<tr>
<td></td>
<td>(0246 865260)</td>
<td></td>
</tr>
<tr>
<td>Dr Margaret Reid</td>
<td>University of Glasgow SPORU, Dept. Public Health, 2 Lollybank Gardens, Glasgow, G12 9QQ</td>
<td>Greater Glasgow Health Board</td>
</tr>
<tr>
<td></td>
<td>(041 339 8855)</td>
<td></td>
</tr>
<tr>
<td>Scotsresearch Ltd.</td>
<td>5 Claremont Terrace, Glasgow, G3 7XR</td>
<td>Lanarkshire Health Board, Greater Glasgow Health Board</td>
</tr>
<tr>
<td></td>
<td>(041 339 2704)</td>
<td></td>
</tr>
<tr>
<td>Scottish Health Feedback</td>
<td>5 Leamington Terrace, Edinburgh, EH10 4JN</td>
<td>Argyll &amp; Clyde Health Board, Dumfries &amp; Galloway Health Board, Shetland Health Board</td>
</tr>
<tr>
<td></td>
<td>(031 228 2167)</td>
<td></td>
</tr>
<tr>
<td>SRU Ltd</td>
<td>78-80 St Johns St, London, EC1M 4HR</td>
<td>Management Executive</td>
</tr>
<tr>
<td></td>
<td>(071 220 1131)</td>
<td></td>
</tr>
<tr>
<td>Stirling University</td>
<td>Stirling, Scotland, FK9 4LA</td>
<td>Fife Health Board</td>
</tr>
<tr>
<td></td>
<td>(0786 73171)</td>
<td></td>
</tr>
<tr>
<td>System 3 Scotland</td>
<td>6 HHI St., Edinburgh, EH2 3JZ</td>
<td>Ayrshire &amp; Arran Health Board, Greater Glasgow Health Board</td>
</tr>
<tr>
<td></td>
<td>(031 229 1179)</td>
<td></td>
</tr>
<tr>
<td>Dr Sara Whiteley</td>
<td>Sorrell Health Care Research Consultancy, 2 Beresford Gardens, Edinburgh, EH3 3ES</td>
<td>Shetland Health Board</td>
</tr>
<tr>
<td></td>
<td>(031 552 2155)</td>
<td></td>
</tr>
</tbody>
</table>
Survey Design


Consumer feedback in health services:


International Hospital Federation (1988) And what would they know about it? The issues, options and implications of seeking the patient’s point of view, IHF, London.


appendix v — reference list