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INFORMATION ON OBTAINING THE VIEWS OF USERS OF PRIMARY HEALTH CARE SERVICES

CONSUMER FEEDBACK RESOURCE

INFORMATION ON OBTAINING THE VIEWS OF USERS OF PRIMARY HEALTH CARE SERVICES

CONTENTS

INTRODUCTION

This information has been compiled primarily for the use of Family Health Service Authorities although it may also be of use to GPs or CHCs who wish to obtain the views of users of primary care services. The definition of Primary Health Care used encompasses all those services for which Family Health Service Authorities have direct responsibility – general practitioners, dentists, opticians, pharmacists and community nurses attached to general practices.

The purpose of this information is:

1. to give an overview of what has previously been carried out in this field
2. to give details of some of the current major projects
3. to give advice on use of feedback methods
4. to list some organisations which may be able to carry out research
5. lastly, to provide a checklist of what appear to be the most important issues to patients.

Details of any type of consumer feedback project using survey or non-survey methods are welcomed by the Consumer Feedback Resource so that we can develop the advice to FHSAs. Please send information to:

Shirley McIver
Consumer Feedback Resource
King's Fund Centre
126 Albert Street
London NW1 7NF Tel: 071-267 6111

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LITERATURE OVERVIEW OF CONSUMER FEEDBACK IN PRIMARY HEALTH CARE

Family Health Service Authorities

A series of government publications has made clear the need for Family Health Service Authorities to be more aware of the needs and wishes of their local population. Working For Patients, 'Implications for Family Practitioner Committees' Working Paper 8 (1989) makes clear that performance reviews of FPCs will be based on "a health profile of the population", whilst instructions from the Department of Health in 'Health Service Developments – Working for Patients: Medical Audit in the Family Practitioner Services (HC(90)15 states:

> *The views of patients and their degree of satisfaction with the general medical services may provide an indication of potential problems. The FPC's own assessments of consumer satisfaction could provide useful information to the MAAG. MAAGs should ensure that patients' views are taken into account as ultimately it is the interests of patients which are central to the process of medical audit.*

FHSAs offer some services directly to the public, including information on how to change GPs; a procedure for dealing with complaints about pharmacists, GPs and dentists; call and recall systems for cervical cytology, and certain certificates for payment of dentures and spectacles. FHSAs will want to know that these services are being used effectively. FHSAs also have responsibilities for improving the accessibility of GPs to the local population, improving surgery premises and medical audit. FHSAs need information from users to develop these services.

FHSAs are still in a stage of transition from bureaucratic paymasters to dynamic managerial organisations and some are further ahead than others. The need for FHSAs to settle into this role so that they can effectively explore the power they hold as developers of primary healthcare has been stressed recently (Huntington 1990). This has important implications for the collection of patients' views as this information can only be effectively used by an organisation which has clear ideas about its role and aims.

Recent studies of the role of the FHSA in finding out patients' views have focused on the relationship between the FHSA and the patient and stressed the need both to clarify and develop this. Currently FHSAs have a very low profile with users of primary health care services but they can develop their existing relationship by providing information about their role; improving the standard and availability of information about how to complain and about what different services are offered in the area by GPs, and by using their executive powers to increase the accessibility and effectiveness of services offered by GPs, dentists, community nurses etc.

Several new areas of responsibility for FHSAs in relation to users have emerged from the recent white paper on the health service (Working for Patients). These are as planners and developers of primary health care services, as the emphasis and resources in the health service shift from the acute sector to primary care (Huntington, 1990):

> *(FHSAs) must create clear primary care objectives and develop means of achieving them and of demonstrating that achievement.*

FHSAs also have a responsibility to advertise the local availability of services to patients thereby increasing the sophistication and ability of the patient to choose between services (Jefferson et al, 1989) A third role is that of protectors of patients' rights in the face of strong and organised professional interests and as organisations accountable to the local community who have a responsibility for empowering users to get involved in deciding the shape of their local services (Winkler, 1991). These new responsibilities all have implications for the way in which FHSAs choose to collect users' views of services in the future.

A review of surveys to obtain users' views of primary health care services reveals that many have been undertaken of users' satisfaction with GP services. These surveys are by a variety of CHCs and academic organisations and a few by FHSAs. Some population surveys have also included questions about primary health care services. The most recent are by North West Thames Regional Health Authority and Wandsworth Health Authority and Lincolnshire Family Practitioner Committee (1990).

Feedback on General Practitioner Services

A major piece of work in this area was undertaken by Cartwright and Anderson (1981). They used structured questionnaires to interview 836 patients and sent postal questionnaires to their GPs. The survey was carried out in 1964 and again in 1977 and showed that the attitudes and practices of doctors and patients are linked and that it is possible to relate the experiences and degree of satisfaction of the patient to the doctor's age, sex, size of practice, equipment, ancillary help and the doctor's views and habits. An example of this link is that the study found that patients more often thought their doctor had a well equipped up-to date surgery if a nurse worked there and were more critical of the doctor on this count if he or she did not have a nurse.

Questions were asked about the setting of the surgery, the nature of doctor/ patient contacts, the primary health care team, links with hospitals and variations between doctors. The study found that the proportion of patients who felt their doctor was "not so good" at giving information had increased over the ten year period. Differences in levels of satisfaction according to the patients' age, sex, and social class were also explored. The study found that younger people were more critical of the service they received from their GP whilst working class patients seemed more appreciative of the care they received although there were few class differences in the level of criticism of specific aspects of care.

Feedback on Doctor/Patient Relationships

Many surveys of patient satisfaction with GP services have revealed levels of satisfaction of 90 per cent and above. However, closer examination of the results has pointed out dissatisfaction with particular aspects. In a survey by interview of 177 mothers with young children, many critical comments were made about the difficulty of getting home visits, the attitude of the practice receptionist and the attitude of the doctors when making home visits (Williamson, 1990). Other surveys have gone into depth on one particular aspect of dissatisfaction with studies of the effect of time availability on the consultation. These surveys have demonstrated that patients' dissatisfaction increased with shorter appointments with the GP (Risdale et al 1989). Other researchers have investigated the effect of a GP's style on consultation (Savage et al 90). Recent work at Liverpool University has explored the preferences of different types of patients for consultation style (Al-Bashir et al, 91).

Feedback on Access to General Practitioners

Another area that has been explored in depth by researchers is access. The North West England Faculty patients' liaison group interviewed a random sample of 593 people with questions about appointments, waiting times, choice of doctor, telephone access, and out of hours calls. This research indicated that patients' satisfaction with the appointment systems was related to the efficiency of their own GP's system and that a large proportion of patients would like direct telephone access to their general practitioner (Allen et al, 1988).

Patient Participation Groups

Patient participation groups offer an alternative non-survey and participative method of obtaining the views of users which have been established in some GP practices. These started in the 1970s in new health centres with the broad aims of:

- giving patients a say in running the health centre
- improving communications between doctors and patients and to provide feedback from patients to doctors
- providing a way of dealing with suggestions and complaints
- promoting health education
- providing a base for voluntary community care
- campaigning for better provision of health services and improvements in the level of care available.

Most groups were set up by doctors and provided a forum for them to discuss the above matters directly with patients (ed Pritchard, 1981). A National Association for Patient Participation Groups was formed in 1978 and provides its members with a voice, a forum for sharing ideas and receiving advice. A patient participation group starter pack is also available from them, priced £2.00. (See Organisation Contact List section.)

Recent Research

The specific impact of the government white paper has encouraged researchers to look for a method of assessing patient satisfaction which is easy and quick to use and pinpoints those specific issues which cause dissatisfaction. One approach has been to explore the use of the critical incident technique in GP practices (Gau et al 1989). This technique involves using interviews to explore those issues which patients themselves identify as important. This provides a snapshot of how patients view the service and clearly show the patients' likes and dislikes. North Yorkshire FHSA has commissioned a survey of 500 patients to establish a cost effective way of measuring health service users' views of their GP (Jefferson et al, 1990). A project by Kent University reported in the *Health Service Journal* (17 January 1991) has set out to identify the specific criteria most strongly associated with overall levels of patient satisfaction. The method used was that of questioning 454 people about primary and acute health services. The key influences on overall consumer satisfaction with primary health care identified were:

- GP gives enough information
- like GP as a person
- GP spends enough time on consultation.

An interesting piece of research reported in the *British Medical Journal* (High-Smith, 1989) shows that those criteria of care rated most highly by the government were the least highly rated by patients - that is health education, being able to change doctor easily, and well decorated and convenient premises. The patients' most important criterion were all related to their relationship with the doctor. This underlines the importance of asking patients for their views of services.

Feedback on Practice Nurses

Few studies have been done of users' views of practice nurses but studies of users' views with primary care services as a whole indicate that users find practice nurses more accessible and punctual than GPs and find them easier to talk to (Kinmouth et al, 1989). Other studies have indicated that patients would be happy to see the role of practice nurses expanding and would for example be willing to be referred straight to practice nurses in specified situations (Williamson, 1990).

Feedback on Dentists

There have been a few studies of patient satisfaction with dental services provided by the Community Health Units and these have attempted to find out users' views of waiting time, choice of appointments, relationship with staff, environment and information (Sandwell Health Authority, 1988). Several American researchers have tried to isolate those factors which affect patient satisfaction, such as dentist and patient relationship, technical quality of care, accessibility, cost, facilities, availability, continuity of care, and outcome (Chapko et al, 1985). Recent work at Kent University has also isolated some criteria that affect overall patient satisfaction with dental care. These were 'competent dentist', 'spends enough time on treatment' and 'gives enough information' (Calnan et al 1991). Other studies have looked at the relationship between compliance with treatment and patient satisfaction (Zimmerman, 1988) and others the effect of receiving new dentures on patient satisfaction (Berg, 1988).

Feedback on Pharmacists

Studies of users' views of pharmacists have looked at why users go to pharmacists with a view to extending the role of the pharmacists to make better use of GP services. One study identified that patients attended pharmacists as part of the decision making process before seeing the GP. Pharmacists offer treatments for alleviation of symptoms and advice on the appropriate time to consult the GP and are more accessible for users (Cunningham-Burley et al, 1988). With a view to illustrating the full range of services pharmacists could offer patients if their role was expanded, the Pharmaceutical Services Negotiating Committee launched a 'Patients Charter' in 1987 (*The Pharmaceutical Journal*, 21 November 1987).

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CURRENT PROJECTS

The projects listed below are ones that are funded to develop good practice in the field of consumer feedback or quality improvement. They will be of interest to those FHSAs who are thinking through their strategy in relation to consumers.

"Ask the Patient"
College of Health and Kensington, Chelsea and Westminster FHSA

Contact: Nancy Dennis
Primary Care Adviser
College of Health
St Margarets House
21 Old Ford Road
London E2 9PL
Tel: 081-983 1225

The aim of this project is to develop a range of simple, practical methods which GP practices can use to monitor the quality of their service themselves by reference to the experience of their own patients.

Consumer Satisfaction with Healthcare
University of Kent Centre for Health Service Studies

Contact: Michael Calnan and Simon Williams
Centre for Health Services Studies
University of Kent
Canterbury
Kent CT2 7NF

First Stage: 1989-90

The aim of this study, funded by the DoH, was to examine which specific consumer criteria were of most importance for overall satisfaction with particular medical services – i.e general practitioner, dental and hospital care – and to assess the degree of congruence or divergence of consumer criteria across these differing medical care settings.

Second Stage: 1990 +

Empirically to test some hypotheses emerging from the first stage, such as how the White Paper will alter the relationship between the doctor and patient.

Consumer Surveys for FHSAs
University of Manchester Centre for Primary Care Research

Contact: Ralph Leavey
Research Fellow
University of Manchester
Centre for Primary Care Research
Rusholme Health Centre
Walmer Street
Manchester M14 5NP
Tel: 061-225 4214

Commissioned by DoH to produce postal questionnaires for FHSAs to use. A series of questionnaires has been designed, 14 for General Practice and others for dentists and pharmacists. The project report and a package of questionnaires is available from June 1991.

FHSA Quality Networks

These are being formed in some regions to exchange ideas about quality initiatives. Please ask your local Regional Health Authority contact for more information.

METHODOLOGICAL ISSUES

This section will cover the following areas:

- Deciding Which Method to Use
    - Types of User
    - Aim of User Feedback
- Methods
    - Quantitative
    - Qualitative
    - Informal
- Asking the Right Questions
    - User Judgements (satisfaction)
    - User Accounts (experiences)
- Acting on User Views
    - Planning the Project A Customer-Service Oriented Culture
- References

Deciding which method to use

There is no single, recommended or standard method for obtaining user views. The best approach to adopt will depend upon the types of user involved and the aim of the exercise.

Types of User

Users have different characteristics. Some will find it hard to complete a questionnaire themselves. These include:

- Elderly people, who often have arthritic hands, poor eyesight and find forms confusing;
- Children under about twelve years of age;
- Black and minority groups, who may not read English or the language they speak;

- People suffering from a mental illness, who may feel too threatened to fill in a form or may have difficulty reading because of the effects of prescribed drugs;
- People with learning difficulties, who may find it difficult to make decisions and so find some questionnaires confusing.

If the service area or section of the population includes many people who fall into one or more of these categories or who have characteristics which make it difficult for them to complete a questionnaire themselves, then an alternative to the self-completion questionnaire should be sought in order to obtain a representative sample of users.

Aim of User Feedback

User views can be collected for a number of different purposes. These include the following:

- Service planning – information to help planners to decide the form a service should take. This will include epidemiological and demographic information about health need, information about the style and mix of service that users prefer, and comments on existing services.
- Service evaluation – information about the way the service is being used, user views on service appropriateness, quality, etc., in order to assess how well the service is fulfilling its aims.
- Service monitoring – user views can be an important way of monitoring service standards as part of the quality improvement process.
- Measuring outcome – user perceptions and health state can be sources of information or variables in the assessment of different health and social care programmes and treatments.
- Different types of information from users will be needed to fulfill the different aims and this can influence the choice of method – primarily whether a quantitative or qualitative method is used.

As a general guide it is best to use quantitative methods for monitoring or answering 'how many?' questions, and qualitative methods for the exploration of issues or answering 'why?' questions.

Methods

The methods available for use mainly come from the social science tradition, although in some cases informal or 'quasi' methods can be adapted and may be more useful. There are two types of social science method: quantitative and qualitative.

Quantitative Methods

These involve the collection and analysis of information in numerical form. That is, incidence or rates of occurrences – death rates, accident rates, throughput figures, the number of people answering 'yes' to a particular question, etc.

The main way that quantitative information about the views and experiences of people is collected is by structured questionnaire. That is, a form with a list of questions, each having a choice of response.

There are three main ways that this type of questionnaire can be completed: a self-completion questionnaire either collected by the person or delivered by post; a telephone questionnaire; or an interview schedule.

The self-completion questionnaire

This type of questionnaire requires the respondent to tick or circle the appropriate response to each question and then return the questionnaire to the administrators. It has a number of **advantages** as follows:

- It is relatively cheap to run, although if a postal method rather than a personal distribution method is used, there is likely to be an initial low response rate and so the necessary chasing up of non-respondents adds to the cost (probably two reminders at two-week intervals will be necessary).
- The expertise required is located mostly at the initial state and not throughout – that is, a skilled person needs to design and pilot the questionnaire, but an administrator can collate replies, chase up non-respondents and arrange for computer coding and analysis.
- It is relatively quick to complete, although sufficient time must be allowed for at least two small pilots of the questionnaire to check that, firstly, questions are understandable and unambiguous, and secondly, that analysis of the results will answer the questions being asked or provide the information required.

This method also has a number of **disadvantages** as follows:

- Those who complete them tend to be the most well-educated and generally the higher income groups. Those who have difficulty reading, for whatever reason, are unlikely to respond.
- The respondent must work within the structure of the questionnaire and so is limited in the response she/he can give. This is not too much of a problem if work has been done to check that the questions asked are those the respondent finds important (through interviews at an early stage and during piloting of the questionnaires) and also if space is allowed for comments.
- The respondent is not allowed any participation in the decision-making process – she/he cannot help by suggesting solutions to problems.

Telephone questionnaire

There are similar advantages and disadvantages where the telephone format is concerned, with the following additional **advantages:**

- A higher initial response rate than to the postal questionnaire is likely.
- The respondent can query the question if it is not clear, and similarly the administrator can ask the respondent for an explanation.

However, there is also an additional **disadvantage:**

- Only those with telephones can respond and this may bias the sample towards those on a higher income.

Structured interviews

Using this method an interviewer completes the questionnaire for the respondent, either at home or another location.

The **advantages** are:

- A large amount of detailed information can be collected.
- More people are likely to respond, including those with reading difficulties.

The main **disadvantage** of this method is that it is costly and labour intensive. Large surveys of 400–500 respondents will require a team of trained interviewers, plus a supervisor or researcher to check questionnaires for systematic interviewer errors in order to eliminate them early, and generally to keep the standard of recording at a high level as well as to debrief interviewers about problems and emotional stress.

Further information about the questionnaire survey method in the context of health care can be found in Dixon and Carr-Hill (1989), Luck, Lawrence, Pocock and Reilly (1988), Cartwright (1988) and Cartwright (1989) and HMSO (1989). Information can also be found in general Social Science texts on methods, such as Moser and Kalton (1971).

Examples of recent large surveys are those carried out by North West Thames Regional Health Authority (report available from 30 Eastbourne Terrace, London W2 3QR, priced £20), Wandsworth Health Authority (see Raferty, Skingsley and Carr 'Preferential Insights', The Health Service Journal, 22 November 90, and East Dorset Community Health Council (460 Christchurch Road, Bournemouth, Dorset, GH1 4BA, priced £1.00).

Qualitative methods

These methods involve the collection and analysis of narrative information. The main social science methods are semi-structured and unstructured interviews, discussion groups, observation and keeping a diary.

Semi-structured and unstructured interviews

The degree of structuring during an interview refers to the extent to which questions are set by the interviewer. In semi-structured interviews, some questions are set and some left open for the respondent to bring up for discussion in their own way. In an open interview, no questions are formally set – people being interviewed talk about their experiences and opinions in the way they want.

Critical Incident Technique (CIT) is another approach to interviewing. It is directed at collecting information about what happened to a person and about what they liked or disliked about their experiences. Details on its use can be obtained from North West Thames Regional Health Authority (1986) and Pryce-Jones (1988; 1989).

Discussion groups

This method is not yet widely used within health or social research in Britain, but it is regularly used by market research companies, where it is commonly known as the group depth interview, focus group, or focused group discussion. In the USA, where it has been used extensively since the 1950s, the number of group interview projects commissioned each year far exceeds the number of surveys (Goldman and McDonald, 1987).

In Britain, the discussion group has been used extensively by Social and Community Planning Research (SCPR), an organisation which also runs training workshops on research methods, including the discussion group. The SCPR publication *Keeping in Touch with the Talking: The Community Care Needs of People with a Mental Illness* (1988) gives details of use of this method. Also the Department of Social Policy at Birmingham University is currently running a project using this method with Shropshire Health Authority.

Observation

Observation can be either qualitative or quantitative. It is possible to have a number of predetermined events written down and to tick a box every time this event occurs. It is also possible to write down what is observed in a narrative form, or to video record these events.

Both methods are useful, mainly when interviews or questionnaires may be too disruptive, or where events are more important than opinions or experiences. In some instances personal experience may be difficult to relate due to traumatic circumstances or unconscious actions and then it is more useful to watch and record (e.g. working habits can be 'automatic' and so below the level of conscious awareness).

An extension of this technique is that of participant observation, which is similar to 'shadowing'. Its aim is to obtain some experience of what it feels like to be involved in a particular activity, such as using a particular type of service. Some people may object to being observed in some situations, however. For example, clients in a study by Atkinson (1985) were happy to be observed at home but not outside it.

Keeping a diary

Some individuals can be encouraged to keep a diary of 'what happens to them during their visit...' and this can produce useful information, particularly if they are encouraged to record their thoughts and feelings as well as events which happen to them. Atkinson (1985) successfully used this method with people who had learning difficulties, which implies that use is not heavily dependent upon writing ability.

Further information about qualitative or non-survey methods can be found in Walker (1985) and McIver (1991), as well as general Social Science texts on methods.

Informal methods

There are a number of other ways to obtain information from service users, although as this is not their main task those involved may have their own agenda and the task of information provision will need to be negotiated.

Some of these ways are:

- Patient Advocates
- Patients' Councils
- Health Forums
- Advisory Groups
- Liaison Officers
- Public Meetings

For further details about use of these methods, see McIver (1991) Winn (1990) and Winn and Quick (1989).

Also useful are:

- suggestion boxes
- telephone help lines
- routine contact between service providers and users
- complaints.

Some examples are contained in McIver and Carr-Hill (1989) and International Hospital Federation (1988).

Asking the right questions

These are questions which focus upon the service user's agenda of importance, as well as that of the service provider. They are also questions which produce information which facilitates improvements in service quality.

There are two types of questions which can be asked: ones collecting user judgements about services – that is, how satisfactory they find services – and ones eliciting information about users' experiences of a service – user accounts of what happened to them.

User judgements

Asking users for their opinion about service quality assumes that they possess sufficient knowledge of services to compare them with an expected standard. Yet users are rarely informed about service standards or given enough information to know what to expect from a service.

If users are to be asked about their satisfaction with a particular service, or if they are to be asked about the style of service they prefer, then they should be well informed about standards aimed at, or about alternative service styles.

User accounts

Where service users are poorly informed about service standards and so where expectations might be low, unrealistic or confused, it is advisable to collect details about their experiences. Service providers can then match these accounts to their standards and make their own judgements about quality.

Currently within the NHS, service standards have been made explicit to users in very few instances and so asking users about their experiences is probably the best approach to adopt. Further details about how to do this can be found in McIver (1991a) and McIver (June 1991).

Acting on user views

Collecting accurate information from service users about their experiences and views is only part of the process. The information collected must be used to inform service development or improve service quality. This can be a difficult task but there are two ways to help ensure that changes take place: by good planning of the project and by developing a customer-service oriented culture.

Planning the project

A well planned project will include a number of different stages, of which the first is of key importance.

Stage One – Set up the project

- Establish the main aim.
- Be clear about the questions which need answering.
- Do a literature/activity search to find out what has been done before.
- Decide on the method, taking into account aim and type of user.
- Present an outline of the aim and method to the Ethical Committee if necessary.
- Draw up a project timetable, allowing sufficient time for analysis and writing up.
- Allocate tasks.

Stage Two – Collect the Data

Stage Three – Code and Analyse the Data

Stage Four – Write the Report

Stage Five – Disseminate the Results

There are a number of books which give advice on how long the various stages of user feedback projects are likely to take. See Morton-Williams (1985) for those involving qualitative methods, such as interviews and discussion groups; and Dixon and Carr-Hill (1989) for surveys. See McIver (1991) for further details of the different stages.

A customer-service oriented culture

A customer-service oriented culture is one in which the user is responded to as a person, with rights and responsibilities. It means a move away from a traditional public service approach where the service provider 'knows best' what the user wants and needs.

In order to change in the right direction, staff will need help to change their attitudes, knowledge and behaviour. This change is best brought about within an organisational atmosphere which is dedicated to total quality (for staff and service users), and one which is management led, but where staff are encouraged to think of initiatives to increase user dialogue and improve service quality from the user perspective themselves. It is also important that staff receive sufficient training in order that they understand the user perspective and change their behaviours and attitudes appropriately. Information from users can be an important part of this training.

Some of the important aspects of developing effective user feedback initiatives include:

- management leadership and support for user influenced service change
- staff ownership of user feedback initiatives
- staff training to change attitudes, behaviour and knowledge
- regular feedback activities to monitor service quality and explore user experiences and views
- well planned feedback initiatives
- obtaining expert advice and using trained staff where necessary
- adopting the right methods to suit the aim and service user – it is usually best to use a number of different methods
- increasing user knowledge of services by improving information provision
- where possible encouraging user involvement in service planning, review and monitoring.

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ORGANISATION CONTACT LIST

This is a list of organisations offering advice and assistance to those seeking to obtain information from users of primary health care services. This list is not comprehensive and inclusion does not imply endorsement by the King's Fund Centre.

Centre for Health Services Studies
George Allen Wing
University of Kent
Canterbury
Kent CT2 7NF
Tel: 0227-764000

Centre for Primary Care Research
Department of General Practice
University of Manchester
Rusholme Health Centre
Walmer Street
Manchester M14 5NP
Tel: 061-225 4214

College of Health
St Margarets House
21 Old Ford Road
London E2 9PL
Tel: 081-981 6719

Institute for Social Studies in Medical Care
14 South Hill Park
London
NW3

Tel: 071-794 7793

Department of Community Studies
Brighton Polytechnic
Lewes Road
Brighton BN2 4AT

Tel: 0273-600900

National Association for Patient Participation
50 Wallasey Village
Wallasey
Cheshire L45 3NL

Social and Community Planning Research
35 Northampton Square
London EC1V OAX
Tel: 071-250 1866

CHECKLIST OF IMPORTANT ISSUES FOR USERS

The most important issues to users of all primary health care services are staff attitudes, organisation of services and information. Access to services and the environment of the facilities are also important. There are a few issues which are specific to pharmacy, dental and opticians services. The following list is compiled from previous research into the views of primary health care service users but it is not intended to be exhaustive.

General Practitioner services

Staff attitude

- Friendliness and helpfulness of receptionist on telephone and in person.
- Patient allowed to feel comfortable about refusing to have students present.
- Approachability of GP.
- Consultations are not interrupted by telephone calls.
- Doctor does not 'rush' patient through the consultation.
- Patient leaves consultation reassured by the advice he/she has been given.

Organisation of services

- Confidentiality – the way a patient is called for appointment, care of records, general handling of information about patient.
- Availability of home visits – clear protocol so patients know when they are entitled to a visit.
- Efficient repeat prescription system.
- Continuity of care, ie same doctor or practice nurse seen.
- Holistic approach to care.
- Services available quickly and on premises, eg ear syringing, treatment for minor surgery.
- Telephone advice available.
- Choice of doctor – pre-registration meetings seen as acceptable.
- Efficient referral to other services.
- Telephone system or staff to cope with busy times, i.e a stacking system or message facility.
- Efficient appointment system.
- Treatment is effective.

Information

- Information is clearly displayed on noticeboards and regularly reviewed.
- Information about making complaints is clearly displayed.

- Information about standards to expect is clearly displayed.
- Information about services available in surgery is clearly displayed.
- Healthcare information on display, ie posters and leaflets.
- Information about other services, eg community health groups, interpreters, natural alternatives to drugs.
- Signposts in and outside surgery.

Access

- Accessibility of premises for prams, wheelchairs, etc.
- Parking facilities.
- Accessibility by public transport.
- Opening hours.

Surgery environment

- Quality and quantity of seating, ie high backed chairs for elderly, plenty for mothers with several accompanying children.
- Appearance of surgery, ie colour of decoration, pictures, flowers, etc.
- Facilities to occupy children.
- Standard of cleanliness in public toilets.
- Changing facilities for mothers with babies.
- Magazines and videos available on health topics.
- Cannot overhear conversations between doctors and patients.

Dentists

- Charges are reasonable.
- Charges are clearly stated before treatment.
- If work is being undertaken privately this is clearly stated.
- Treatment is effective – in particular crowns stay in place and dentures fit comfortably.

Pharmacists and Opticians

- Price paid for treatment is reasonable.

GUIDELINES FOR FHSAs ON CONSUMER FEEDBACK ACTIVITIES

- Consumer feedback activities should be part of the organisation's quality improvement programme.
- Involve all staff in making suggestions for the improvement of the services they provide to their users (either the general public, GPs, etc.).
- Provide customer awareness training for staff.
- Use quality circles to improve services for users.
- Use current data to improve services for users, eg complaints information, demographic information.
- Consider carefully the aim of any consumer feedback activities before undertaking them and the type of user you wish to get information from and choose an appropriate method.
- Make contact with community groups.
- Use facilitators to develop and maintain contact with various need groups, e.g homeless, elderly, mental health.
- Publicise FHSA role at community events, eg give talks.
- Involve users/user representatives on working groups.
- Give GPs an information pack on getting feedback from users of their services:
  - include guidelines about or examples of patient's charter or standards (e.g Association of Community Health Councils for England and Wales, Patients' Charter).
  - information on complaints procedures to be displayed in the surgery and suggest they display a suggestion box for those users who do not have a complaint.
  - information on setting up patient participation groups for GPs.
  - information on good practice for undertaking surveys.

The King's Fund Centre is a health services development agency which promotes improvements in health and social care. We do this by working with people in health services, in social services, in voluntary agencies, and with the users of their services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences and publications. Our aim is to ensure that good developments in health and social care are widely taken up.