



Talking Points: Personal Outcomes Approach

**Update report June 2010:
Focus on making use of information on outcomes
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Section One: Introduction and general update

At the heart of the Talking Points: Personal Outcomes Approach are the outcomes most important to service users and their unpaid carers. Talking Points seeks to achieve the best quality of life possible for people by doing the following:

1. By focussing on outcomes in interactions with people using services and their unpaid carers, including finding out from individuals what is most important to them in life and identifying how everyone can work together to achieve the best outcomes possible for that person. The information gathered can be recorded in outcomes focussed support plans. The circumstances of the person can be revisited at review, including checking out whether outcomes are being achieved, resulting in amendments to the plan as required.
2. Information on service user and carer outcomes captured during these interactions can be used to support service improvement; the planning and commissioning of services and performance management.

The Talking Points approach has been developed by researchers working with the Joint Improvement Team (JIT) and representatives from community care organisations across Scotland since 2006. A range of resources have been developed to support implementation. These resources are freely available from the JIT website: (<http://www.jitscotland.org.uk/action-areas/user-and-carer-involvement/>).

This document is intended to provide an interim update on Talking Points development and implementation with a focus on how information generated by the approach is being used in practice. However, although Talking Points data is the main focus of this report, a key message from practice is that there is a balance to be struck between supporting quality interactions between individuals, and data gathering imperatives. While recording of information is necessary to support a focus on outcomes and to influence service developments, attention should be paid to ensuring that information gathering requirements do not eclipse good practice. A significant culture shift needs to take place at all levels in an organisation to support the change in practice required – in most cases there is a need to unpick existing practice and redefine it. This needs to be supported through training and ongoing support and supervision, and at a strategic planning level within the organisation. Data gathering should support this shift rather than becoming the driver.

A second key message is that successful implementation of an outcomes approach requires buy-in at all levels of the organisation. Senior management commitment is required both to support the required culture change, including giving permission to staff to practice in a different way, and to ensuring that the information gathered is used at an organisational level so that the support that is available is re-oriented

around the outcomes that matter to people. Middle management also play a pivotal role in embedding an outcomes approach in the longer term, and in supporting the shift towards recording of outcomes rather than outputs. With regard to performance reporting requirements, it is critical that performance indicators and measures are consistent with, rather than conflicting with a focus on outcomes for individuals.

This update sits alongside existing materials, including previous data management guidance ([link](#)) and guidance on analysing qualitative Talking Points data ([link](#)).

UDSET to Talking Points: A shift in emphasis

When we started working with the JIT in 2006, the focus of the initial work on user and carer outcomes was on evaluation of services provided by partnerships in Scotland. This followed from the research we had undertaken for the Department of Health at Glasgow University, which evaluated partnerships from the user's perspective (Petch et al, 2007). In the early days with the JIT therefore, we worked towards developing an evaluation toolkit, which was called the UDSET, with an associated toolkit for carers called the CDSET. Just as the university research had focused on interviews with people who had already experienced services, the initial focus in the JIT work was on asking people about outcomes through reviews of their services. However, as we worked closely with partnerships through 2007, the limitations of producing a definitive standardised review tool for evaluation purposes quickly became apparent. We had to redefine the purpose for the following reasons:

- Practitioners welcomed the opportunity to have outcomes focused conversations, but informed that it did not make sense to review people in an outcomes-focused way when the assessment had been output focused.
- If people using services and carers are involved in defining their outcomes at the outset, this improves opportunities for meaningful engagement, supports the possibilities for recovery and re-ablement where appropriate, and for sustaining or improving quality of life for each individual.
- People using community care services include individuals with a wide variety of communication support needs. Although a standardised questionnaire or survey approach offers the advantage of high consistency of data, it does not offer the flexibility required when working with people with cognitive impairments and/or communication difficulties.
- It is possible to combine consistency and flexibility, in ways that permit the gathering of data which is 'good enough' to inform decision-making.
- Focusing on and recording outcomes through the various stages of service use journey allows the tracking of progress over time, with benefits for the person, staff and the organisation.
- It was imperative, given that staff already feel overwhelmed by data gathering and bureaucratic requirements, that outcomes should be built into existing processes and should not involve additional forms.
- Given the shift towards building outcomes into routine assessment and review, and the importance to partnerships and organisations of having ownership of their processes and tools, it was not possible to produce one definitive tool. It was agreed that the tables of outcomes were the core of the personal outcomes approach, and that there had to be some flexibility in how they were built into forms at the local level.

It became increasingly apparent during 2007/8, that refocusing on personal outcomes required a broader organisational shift than was initially appreciated, as

identified in the philosophy and principles and key messages documents. Despite this, most early implementers committed to continuing on the outcomes journey, and continue to invest considerable efforts in making the necessary changes.

Links with the Community Care Outcomes Framework and National Minimum Information Standards (NMIS)

Since 2007/8 effort has been invested on linking the personal outcomes approach with wider developments in community care. As new minimum information standards for shared assessment were being issued to partnerships in 2008, attempts were made to integrate a focus on outcomes in the standards. However, implementing both the NMIS and an outcomes approach does present challenges for partnerships, given the different origins and development of these approaches. Feedback indicated that practitioners found previous single shared assessment (SSA) tools to be onerous and prescriptive (Miller and Cameron, forthcoming). The guidance for the NMIS stated clearly that it is not necessary to include all the information standards in tools, and that some standards may be covered in associated guidance for staff. In practice, a variety of tools have been produced, ranging from those incorporating all of the standards, to more outcomes focused, less prescriptive models.

Alongside these developments, a new performance management model, the Community Care Outcomes Framework (CCOF), has been promoted to partnerships. The CCOF includes 16 measures, some of which are output and process measures, with four outcomes measures. The measures depend to a large extent on data gathered via shared assessment. To support data gathering requirements for the CCOF, four data standards were built into the minimum information standards for assessment. These standards, expressed as satisfaction measures, have been broadly implemented. The inclusion of outcomes measures represents a departure from existing measures. However, implementation of the measures on their own will not result in organisations becoming genuinely outcomes focused. This also requires investment in staff, organisational and service development on an ongoing basis.

Main uses of Talking Points

There are two main categories of use of Talking Points in Scotland.

Broad implementation

Whilst recognising the continuing effort that requires to be invested in culture, practice and systems, the seven early implementer partnerships have committed to continuing on the outcomes journey. Learning lessons from the early implementers, some of the newer partnerships who have become involved from 2009 are also beginning with plans for broad based implementation, recognising that this requires long term investment. Implementation has been found to be most effective when focusing on culture and practice first, with forms and measurement following. Some early implementers are now in a position to be able to use the information they are gathering and examples are included in Section 3 of this guidance. Some provider organisations are adopting Talking Points. It is likely that links between partnerships and providers will increase as work develops on outcomes-focused commissioning.

Evaluation exercises

Best value reviews, requirements for health and social care agencies to survey user and carer experience and evaluation of change programmes have resulted in use of Talking Points for a variety of evaluation exercises. As already identified, evaluation was the focus for the research on outcomes of partnership working which informed the development of Talking Points (Petch et al, 2007) and it is feasible to use Talking

Points this way. In practice however, we have found that tensions can emerge in some evaluation exercises. One of the advantages of a personal outcomes approach is that it is not service led, which means that the role of the person and other supports in their lives and communities are part of the picture, which supports more enabling relationships. Analysis of qualitative information gathered through use of Talking Points can develop understanding of how individuals, either supported by the organisation or independently, have worked towards achieving their outcomes. Where the evaluation exercise is very service led, this may mean that practitioners are required to focus on the impact of the service only, with no attention paid to the role the person or informal supports have played in achieving their outcomes.

It is also arguable that developing a broader understanding at the local level of what is working and not working in terms of outcomes for individuals is also potentially valuable information to support wider service developments. This fits with the current emphasis on outcomes at the strategic level, in relation to Community Planning and the Single Outcome Agreement.

Section Two: Capturing and analysing personal outcomes data

Using the Talking Points approach generates both qualitative and quantitative data on outcomes. Experiences from the pilot sites has shown that it is possible to capture both narratives and numbers as part of a dialogue, through including open and closed questions, and that both forms of data are needed to maximise the effectiveness of the approach. The content of the next two sections provides a summary and update of earlier material contained in the data management guidance.

Whose views?

Piloting of the Talking Points approach involved considerable discussion about whose views should be captured - the service user / carer or staff view of the situation. This included a concern to balance respecting the agency of the individual and their right to define their own situation, with the need to collect data as consistently as possible. Furthermore it is recognised that the approach must support workers to integrate information from a range of sources (the individual, carer, staff, own observations) that at times may be conflicting, in particular where someone may have limited insight into their situation.

Over the course of the pilots, a consensus developed that the record of whether or not an outcome has been achieved should be negotiated between the interviewee and interviewer, including where relevant the perspectives of carers and the interviewer's own observations. This fits with best practice in care management and respects both the views of the individual and the professional skills of the practitioner. As is also best practice in any assessment or review, a copy of any documentation should be left with the service user or carer. Space should be available in any forms used for the practitioner to document whose views were taken into consideration in the recording and where there was any conflict.

Maximising utility/quality of the information gathered

As already highlighted, it is only when data is of a good quality that all the added value of adopting the approach for an organisation can be captured. In this context a good quality record of the data will include:

- Information on whether an outcome is being realised / is an issue *and why* it is / is not being realised / is an issue, if possible including examples of specific events / aspects of service that impact on the outcome.

- There should be space for comment on the data collection process, highlighting any circumstances that may have impacted on the information given, who contributed to the record and how reliable the interviewer thinks the information gathered is. Any significant disagreement should be recorded.

Learning from pilot sites shows that if data quality is to be maximised, then it is important that staff understand why they are collecting the information and how it will be used, and that they receive feedback on use of the information they are generating. In addition, continuing opportunities for staff to discuss and share views of the approach and the information gathered enable a shared understanding of what different scores and ratings look like.

Maximising reliability and validity.

Maximising the reliability and validity of information on service user and carer outcomes is a key concern of all organisations implementing the approach.

The term validity describes the extent to which a tool or approach is meaningful, i.e. measures what it claims to be measuring.

The term reliability describes the extent to which a tool or approach is repeatable with the same results, i.e. if different staff were to use the tool on different days with the same sample population, they would get the same results.

The validity of Talking Points as a framework for understanding the outcomes most important to service users and carers has been rigorously tested over 15 years of research, development and implementation. This research and practice has consistently shown the validity of this framework, a key strength of the approach.

The reliability of the approach, whilst generally good, can be subject to some variation. In general, practitioners report being able to confidently appraise whether or not outcomes are being met and that service users and carers report issues consistently over time. In some instances getting reliable information is problematic. This may be due to a communication or capacity difficulty on the part of the service user or carer, or a difference of opinion between parties. Furthermore, information collected by practitioners new to the approach will be less reliable than that collected by practitioners who have time to gain confidence in discussing and recording information on outcomes. A number of strategies can be adopted to maximise reliability of data.

1. Support staff new to the approach to ensure they understand outcomes, why the information is being collected and what it will be used for.
2. Careful piloting and involvement of staff in development of paper and electronic tools to ensure that they are understandable to staff and prompt consistent recording.
3. Keep scale data simple and categories broad
4. Get regular feedback from staff about their use of the approach collectively and reach shared understanding of what kinds of experiences constitute outcomes met or not met. Talking through case studies can be useful.
5. Ensure that written reports or decisions made on the basis of the data are shared with staff, which in turn improves understanding of its purpose.
6. Be aware that data collected in the first months of implementing the approach will be less reliable.

Avoiding bias

Current policy emphasises the importance of including user and carer views in service developments. This involves including individuals who might be considered hard to reach, due to challenges to participation. The methods adopted for gathering views will influence inclusion. The flexibility required for inclusiveness can present challenges to very standardised methods of data collection. Although Talking Points offers the advantage of being a flexible approach, additional communication supports are required for individuals who face challenges in identifying their outcomes, and work is ongoing to develop support materials ([link](#)).

Some debate has been generated about who should be involved in collecting outcomes information, particularly in relation to process outcomes. As Talking Points has developed, it has become increasingly accepted that the most sustainable way to gather information about outcomes from people using services is via routine processes. Information used to make decisions in community care settings is already gathered through assessment documentation, so in some ways it is a natural progression for outcomes information to be collected in this way. Some staff have reported that where the conversation is successfully focused on outcomes rather than services, individuals find it relatively easy to talk about continuing concerns at review, as well as areas of progress. In an early pilot in Glasgow South West CHCP, a research company undertook 50 interviews with service users alongside the CHCP staff undertaking 25 outcomes focused reviews. In practice, the results were broadly similar, with individuals reporting both positive and negative outcomes.

With regard to process outcomes specifically, the question arises as to the appropriateness of staff asking for direct feedback from users about how they feel they have been treated, and this does require careful consideration. Over time, findings on this question are more mixed than was previously anticipated. Unlike many measures currently in use, the approach does not aim to measure a one off interaction. Rather, at the point of review, there is an underlying assumption that the responses will be informed by the overall trajectory of multiple service interactions. Within this, it may be well be that one individual member of staff or one incident, has a particularly strong influence on process outcomes for the person (Petch et al 2007).

In Midlothian, research showed that some staff remained uncertain about asking about process outcomes directly ([link](#)). In some areas however, staff have found discussions on this topic useful and informative. In the initial pilot undertaken by Glasgow Addictions Services, some individuals gave both positive and negative feedback directly to their care manager, including suggestions as to how the care manager could improve e.g. reliability and listening skills. More evidence is needed on this area. While there can be benefits in some situations to asking about process outcomes directly, consideration is being given in some settings to also including separate surveys for process outcomes.

Analysing information

For data to become information it needs to be subject to analysis, whereby key themes and trends in the data are extracted and summarised to answer key questions. In this case, analysis can be thought to occur at two levels, individual and service/organisational levels. In identifying the key themes for the individual, the worker is already conducting preliminary analysis. These key messages are also recorded for later analysis at a service and organisational level, which involves summarising key themes and trends in the data from across the organisation or locality and from specific sub-sets of clients depending on the questions being asked. Whilst data analysis at this level is likely to be initially quantitative, to identify overarching trends, particular issues or concerns can then be picked up by

qualitatively analysing small samples of data. Suggested questions for both levels of analysis are set out in the data management guidance ([link](#)). The following section describes some early examples of uses of Talking Points data.

Section Three: Use of Talking Points Data

This section includes examples of how outcomes data is being used in various ways.

Service improvement

Including a focus on outcomes in assessment, planning and review produces a significant body of evidence both in on individuals and for whole services. To date, partnerships and providers have tended to collate and act on this information at a service level. Indeed the potential of the approach to improve services is a key motivating factor for front line staff. A number of mechanisms have been developed by organisations to collate Talking Points information for service improvement. For example, in Edinburgh, practitioners from the Intermediate Care Service worked in small groups to reflect on each of the Talking Points outcomes and record:

- What difference they felt they were able to make to people's lives with respect to each of the outcomes
- The extent to which they were supported and hindered by the structures and systems they worked within.

The evidence collected during this session was written up and used by the service manager to influence decision making processes at a strategic level.

In Orkney, evidence from reviews showed a considerable number of cases where it appeared that the service user might benefit from intervention under the Adults with Incapacity (Scotland) Act 2000 to properly manage and protect their finances. This evidence contributed to the overall case for additional resources to be allocated to a dedicated AWI post, which was duly funded and appointed to.

Performance management and scrutiny

The context and emphasis for performance management in the public sector in Scotland has altered in the last few years. The SNP government's concordat with local government (2007) includes development of Single Outcome Agreements (SOAs), whereby local authorities have greater freedom to set their own priorities, with community planning partners (Scottish Government and COSLA 2007). The challenge to improve outcomes while delivering efficiencies in face of the economic downturn is significant. Against this context, local partnerships are moving towards outcomes based performance measures.

There is also a new performance framework for community care, consisting of 16 measures, including 4 outcome based satisfaction measures (see p4). A minority of partnerships have adopted the full suite of 16, with others adopting some measures. As yet, relatively few partnerships have reported on the outcome measures within the framework. Some partnerships have adopted these measures as tick box satisfaction measures within their assessment tools and early returns would tend to suggest very high satisfaction ratings by this approach. While high figures are heartening, some caution is required where outcomes data are collected through survey like approaches. While customer satisfaction surveys are now an almost ubiquitous means for organisations to gather feedback, and offer the advantage of gathering large amounts of standardised quantifiable data, there is a significant literature questioning some aspects. Concerns include inadequate conceptualisation of satisfaction (Carr-Hill 1992), underestimation of dissatisfaction (Carr-Hill 1992, Cohen et al 1996, Hart 1999) particularly with increasing age (Calnan et al 1996), sampling

and the treatment of non-response rates (Carr-Hill 1992) and adequacy for decision-making about allocation of health resources (Ryan et al 2001, Norquist 2009).

While quantitative analysis can indicate the typicality and range of responses, inclusion of more conversational, qualitative approaches also allows the respondent to reflect on their situation (with potential in itself for improving outcomes) and can yield a more mixed but valid picture (Hart 1999, Nicholas et al 2004, Norquist 2009). Ironically, early findings from the work on Talking Points indicate that in organisations where there has been less of a cultural shift towards engaging users and carers in defining their outcomes, there are likely to be higher summary ratings. Additionally, analysis and reporting of sub samples of qualitative evidence can ensure the validity of results and enable understanding of what influences outcomes in a given locale.

In East Renfrewshire, staff have been using a simple coding system of met, partially met and unmet for the range of actions recorded against personalised outcomes in outcomes focused support plans, which are then revisited at review. Early analysis of data from shared assessments and reviews in East Renfrewshire shows significant improvements in quality of life outcomes in particular, including feeling safe, having things to do, seeing people, staying as well as you can and quality of life for carers. A snapshot of this information has already been fed back to staff at a re-enablement event celebrating good practice in June 2010, both to keep staff informed of progress and to maintain the focus on improving outcomes.

Commissioning

Using outcomes information to augment existing data to inform commissioning has been identified as a key priority for partnerships. This coincides with increasing recognition of the importance of evidence based commissioning. Commissioning here is understood broadly as place-shaping activity, whereby commissioners in each locality are required to ensure that the range of services and support required for changing populations is available to support delivery of the outcomes that matter to people. This also means that the way services are delivered, both by directly provided and external services, will become more outcomes focused in time, as compared to the current tendency to focus on tasks and time. To date, activity has focussed in a number of key areas, with examples as follows.

Strategic decision-making

Evidence from the reviews carried out with service users who are placed out of Orkney was fed into the formal Best Value review of the Council's use of Out of Orkney Placements. This enabled the Department to show quite clearly that almost all people in out of area placements are happy and settled and do not wish to return to Orkney. This evidence played a key role in persuading local elected members that the overall use of out of area placements was appropriate and that returning those individuals to Orkney was not necessarily where the Council should focus its efforts.

Planning and reshaping services

A number of partnerships have used Talking Points outcomes as a basis on which to plan and reshape services. This work has been carried out using data gathered specifically for the purpose, with the Talking Points outcomes used as the basis of questionnaires and interviews with service users and carers about the services they receive. In response to reports of social isolation of older people living in care homes, which emerged from collated information from outcomes focused reviews in Orkney, a conversation club was set up in partnership with a local voluntary organisation.

Some partnerships have published reports on relevant areas of activity. North Lanarkshire used Talking Points to interview service users attending their new

integrated day service for older people in 2008. Family carers were also interviewed. The report of the initial review of Sinclair Integrated Day Services was produced in 2009. This first review was important in informing the rollout of integrated day care in localities across the partnership. The second review was completed early in 2010, and it is intended that this will inform continued rollout.

A recent evaluation of mental health services redesign in Midlothian involved service users and carers in selecting the approach to evaluation, which centred on Talking Points. The qualitative approach to the evaluation yielded mainly positive findings, and included quite specific information about what was making a difference to user and carer outcomes. The results were fed back to users and carers at an event, with further opportunities provided to feed into plans for remedial action ([link](#))

The Department of Health has recently published guidance on using information from individual reviews to inform commissioning. This report includes details of an inclusive methodology that can be used in the context of a workshop or meeting to bring together a range of partners to analyse qualitative data from users and carers. <http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/General/?parent=2734&child=5802>

Evidencing impact of provision on outcomes

There has been interest from providers, partnerships and scrutiny bodies in the potential of information gathered using Talking Points to be used to evidence the difference that specific care provision makes on outcomes for individuals. The approach is already being used by a number of provider organisations primarily to ensure that they are maximising outcomes for individuals, but also to evidence the impact of the support they provide. The preliminary work done in this area has confirmed the importance of analysing and monitoring qualitative and quantitative data on outcomes to develop an understanding of what is working and for whom. This work has also highlighted the importance of partnerships and providers working together to both take forward the outcomes agenda, and to understand how whole systems contribute to individual outcomes. Due caution is clearly required with respect to information sharing protocols and confidentiality, and as yet mechanisms to share this information between organisations are to be developed, but individuals from partnerships and providers have highlighted the importance of ongoing dialogue to maximise shared learning.

Evaluating quality of provision

There has also been interest in the possibility of using outcomes data to evaluate the quality of service provision. Qualitative analysis of information gathered during outcomes focussed conversations with service users and carers can yield valuable evidence regarding how aspects of a service impact on individuals. Depending on how discussions are conducted with individuals, and on how the information gathered is recorded, it is possible as evidenced in Glasgow SWCHP report, in the Mental Health report from Midlothian and in the GAS report to evidence links between features of services and outcomes for people. However, caution is required in considering the approach as a measure of quality per se. An individual's appraisal of how well their outcomes are being met will be influenced by a wide range of factors in their lives. As with other forms of evaluation, the temptation for the service to identify their input as the key factor, is significant, particularly where the data is summarised as a tick box only. Triangulation of data is recommended for quality evaluation.

Conclusion

Data management was highlighted as a particular concern by partnerships when the interim evaluation of UDSET (now Talking Points) was undertaken by the University of Strathclyde in 2008:

The majority of pilot sites indicated that they would be willing to mainstream the UDSET approach but that there were still challenges to this development, particularly around data management and the link to the commissioning and service design processes as well as integrating the approach into existing care planning pathways (Stewart, p5)

With regard to the latter point, in the two years since the evaluation was undertaken, many partnerships have integrated outcomes into their tools. With a performance management focus, some areas have integrated outcomes in so far as to incorporate the measures in the Community Care Outcomes Framework. Others have gone further in reshaping tools to support outcomes focused conversations, including most of the early implementers of the approach. With regard to the former point raised in the evaluation, about data management and use of outcomes information, this guidance demonstrates application of Talking Points data in different localities, including some innovative examples. Over the coming months, as increasing numbers of outcomes focussed assessments come online, this will increase the data base and enable review of outcomes based information on a larger scale.

One of the ways that the information is being used is in feedback sessions with staff, once analysis of and reporting on Talking Points data has been completed. There are several advantages to holding these sessions. One is that staff value the learning opportunities to hear about what is working well and less well in their locality, often finding that small things they are doing are having a significant impact. Additionally, a key challenge identified by early implementer areas is that it takes longer than anticipated for practitioners and managers to make the shift from focusing on outputs to focusing on outcomes. Feedback sessions with staff allow opportunities to share good practice examples and develop understanding of outcomes. Further, if staff understand how information is being collated, reported and used, this in turn encourages and supports improvements in recording outcomes based information.

This report also includes examples of how outcomes information is being applied to service improvements and early examples relevant to commissioning. Over the next year or so, there will be a focus on developing opportunities to combine personal outcomes data with other data sources to further develop these areas. As more agencies becoming involved in using Talking Points, there is also potential to compare outcomes based information from different parts of the system.

The evaluation of UDSET in 2008 identified that reconciling the improvement and performance management functions of the personal outcomes approach was a key challenge. While it is possible to do both, evidence would suggest that the improvement focus should remain paramount. Recent findings also suggest that staff engage with the approach in different ways according to their understanding of its purpose. Further to this, individuals' understanding of the principles of Talking Points is likely to affect its capacity to promote outcomes focussed practice and improve outcomes for service users (Hitchin, 2010).

Sharing learning from practice is critical to continuing the application of outcomes information in practice this and we are therefore keen to hear about any relevant developments to continue to develop the evidence base. We will review this guidance in 2011. If you have feedback or examples that you would like included in

a future update, please send to Ailsa Cook (ailsakrcook@googlemail.com) or Emma Miller (e.miller@strath.ac.uk)

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Appendix 1. Suggested Reading and References

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