Lay perceptions of the desired role and type of user involvement in clinical governance

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Abstract

Objective The aim of this paper is to explore variations in lay perceptions of user involvement in clinical governance.

Context The English National Health Service has sought to build a dependable health service through enhanced effectiveness, responsiveness and consistency. Clinical governance, a policy for improving service quality, is a key pillar of these reforms. It is a statutory duty of primary care organizations to ensure that users are involved in all service planning and decision making, including clinical governance. Yet surveys indicated that user involvement in clinical governance was underdeveloped and underutilized.

Design Focus groups were conducted with different types of lay people to explore their perceptions around public involvement in different aspects of clinical governance policy.

Results Content analysis of the transcripts reveals that different groups of lay people varied in their desired role perspective and preferred type of involvement in different aspects of clinical governance policy. Drawing upon existing models of user involvement, we identified three role perspectives that lay people could take in user involvement – consumer, advocate and citizen. We compared our findings regarding the desired type of involvement with existing models of user involvement, and identified a new type of involvement, overseeing, that is relevant to clinical governance policy.

Conclusions These findings suggest that to facilitate user involvement in clinical governance, it would be necessary to use different strategies to accommodate the differing role perspectives and types of involvement desired by different groups of lay people.

Introduction

The English National Health Service (NHS) has sought to build a modern, dependable health service through enhanced effectiveness, responsiveness and consistency.[1] Clinical governance, a policy for improving service quality, is a key pillar of these reforms. Donaldson and Gray[2] described clinical governance as a framework through which NHS organizations are accountable for continually assessing and improving the quality of services by creating an environment where excellence flourishes. From its inception, clinical governance was designed to be a top–down and professionally led initiative, with the aim of securing and maintaining professional standards.[3]

The Health and Social Care Act in England and Wales made it a statutory duty of primary care organizations to ensure that patients and the public were involved in all service planning and decision making, including clinical governance.[4] Yet surveys indicated that user involvement in clinical governance was underdeveloped and underutilized.[5] Anderson and Florin[6] found that public involvement was one of many competing interests for Trusts and often a low priority due to limited resources and knowledge. Pickard *et al*.[7] found that despite an organizational commitment, user involvement in Primary Care Trusts (PCTs) was limited to lay board representatives who were rarely involved in priority setting and clinical governance. Freeman and Walshe's[8] survey also highlighted that one of the greatest shortfalls in achievement by PCTs was in relation to user involvement. Recently, *Creating a Patient-led NHS – Delivering the NHS improvement plan*[9] acknowledged the difficulties of including users in service improvement, while still emphasizing its priority.

To assist with public involvement in decision making, several models have been developed that are explored briefly in the next section. The extent to which these can be used to inform user involvement in clinical governance has not been investigated. This paper explores lay perceptions of user involvement in clinical governance in order to identify their desired role perspective

and preferred type of involvement in the improvement of the delivery of health services. Comparison of our findings with existing models of public involvement shows that they do not completely accommodate the different role perspectives and types of involvement described by the different groups of lay people in this study.

Throughout the paper, we distinguish between the roles of 'patient' and 'citizen'. The term 'patient' is used to denote people who are identified as current users of health-care services. The term 'citizen' we use to refer to people for whom the state has an obligation to provide health care.[9] Unlike patients, citizens may or may not currently be using services and tend to speak from a broader perspective due to their lack of immediate personal experiences with services. Where we refer to both groups together – just as our informants do – we use the term 'users' as a catch-all phrase that covers both groups. We acknowledge that these categories are fluid and that at different times and in different discussions, the same people may adopt differing perspectives on services. The view people take depends very much on personal experience and the service that they are speaking about. A diabetes patient may adopt a 'patient' persona in discussing services that she is currently using, but may speak from more of a 'citizen' perspective when discussing (for example) mental health services.

Models of user involvement

To assist with user involvement in decision making, several theoretical models have been developed. Arnstein's Ladder of Participation[10] is one of the best known models where involvement is presented as a hierarchy of eight steps, each describing an increasing type of involvement people can have in decision making. The bottom steps are non-participatory, whilst the middle steps are considered to be 'tokenistic' forms of citizen involvement and power sharing. The final steps are classed as citizen power sharing and involve high levels of participation.

There have been critiques of Arnstein's model. Burton[11] questioned the assumption that higher

'rungs' represented progress towards an agreed goal and suggested that progression is not as linear as implied. At a more detailed level, Litva *et al.*[12] argued that Arnstein's concept of 'consultation' may not be as 'tokenistic' as implied. Based upon a study examining lay views of public involvement in different levels of health-care decision making, they found that lay participants wanted their involvement to be located somewhere in between 'consultation' and 'partnership'. They suggested the addition of a step called 'accountable consultation' whereby citizens contribute to the process of decision making are guaranteed that their views are taken into account, and the rationale for the ultimate decision is justified to them, particularly if it did not overtly reflect their views. Tritter and McCallum[13] felt that Arnstein's model treated user empowerment too simplistically and failed to consider other types of involvement, such as participating in the process, which can also be empowering. Feingold[14] reduced Arnstein's ladder to five rungs: informing, consultation, partnership, delegated power and citizen control; while Charles and DeMaio[15] developed a similar model based upon three similar themes: consultation, partnership and lay domination.

Whilst Arnstein and Feingold's models were designed to model the participation in different US government policies, Charles and DeMaio's model was specifically designed to model levels of participation in health-care decision making. However, Eyles and Litva[16] stressed that the modifications to Arnstein's model do involve the loss of some nuances of meaning.

Charles and DeMaio also distinguished between two role perspectives that can be brought to the decision-making context. The first role perspective they describe is that of 'user' whereby people respond in a concentrated or narrowly defined way as users of health service. The user perspective reflects an individual's narrowly defined interests such as a particular group that an individual feels a particular affinity for. The second role perspective is a 'policy' perspective where people give their views for a broader public or community good rather than being tied up in specific concerns.

Skelcher[17] drew upon Arnstein's work but presented involvement as a continuum with information provision at one end followed by seeking opinions, discussion of proposals, user exploration of issues, goals and choice, through to joint decision making and devolution of decision making at the other end. Like Charles and De Maio, Skelcher emphasized the importance of the *context* of decision making. What he added to the debate was the understanding that user involvement in certain decisions, particularly those concerned with questions of strategy or structural conditions, challenged statutory agencies' power over decisions, existing hierarchies in health care and professional control over the process of decision making.

Abelson[18] abandoned the ladder analogy and explored the role that different contexts played in shaping community decision-making processes. She asserted that the analysis of user involvement in decision-making processes has tended to ignore differing socio-economic, cultural, institutional or political contexts in which decisions are made. Abelson grouped these into predisposing influences that included the cultural and social context of the population, enabling influences including general attitudes towards participation, and the precipitating influences, which are the actions that lead to the initiation of involvement.

Methods

The research took place from June 2001–February 2002 in a city in the North-west of England. In order to access a maximum variation sample of lay accounts, we identified and accessed four different types of users (Table 1). The 'Citizens' in our study were people selected only because the state has a duty to provide health care for them.[19] Therefore, we randomly selected informants using the electoral rolls of a 'middle income' and a 'deprived' ward. They were included in order to gain a broader view – also described by Charles and DeMaio's[15] as the 'policy' role perspective – that would be less likely to be tied up in a specific concern and are more likely to make 'broader' comments about the health service based upon non-specific experiences of it. The Patient User

Table 1 Description of lay sample

Name of group	No. focus groups conducted	No. informants in focus groups
Citizens	3	Deprived ward Group 1 – 3 Middle income ward Group 2 – 7 Group 3 – 4
Patient User Groups	2	Group 1 – 11 Group 2 – 5
Health Interest Group	3	Diabetes Group – 9 Spina Bifida Group – 8 Young Stroke Victims Group – 6
Frequent Attendees	2	Luncheon Club – 2 Playgroup – 5
Totals	10	60 Informants

Groups consisted of existing members from patient user groups attached to a local surgery but from different parts of the city. The participants could include both patients and citizens. Patient User Group 1 had a history of activism, which arose out of the need to help a community that had poor health statistics and had been threatened with the loss of a local health centre. Patient User Group 2 had not been in existence very long and perhaps better reflected a 'typical' patient user group.

The next two groups were selected to reflect what Charles and DeMaio[15] called the 'user' role perspective but which we refer to as 'patients' because they were selected based upon their current use of health-care services. Health Interest Groups included individuals whose membership in the group was based upon living with a particular illness or disability that required they regularly use health-care services. Frequent Attendees were individuals who were likely to have sought primary health care more than twice in 6 months due to their stage in the lifecycle. This health care may have been part of routine health checks within a primary care surgery. Whilst again, they may provide the broader view like that of a citizen, their likelihood of recent attendance meant they would be more likely to speak from the position of patient. We focused upon older users at a

luncheon club and parents with young children who attended a playgroup. Table 1 provides an overview of our lay sample.

The concepts of 'clinical governance' and 'public involvement' were not easily accessible to most lay informants. Thus focus groups were used to allow lay informants to discuss their perceptions about public involvement in three key aspects of clinical governance: improving and assessing quality, dealing with poor performance, and education and training. These concepts were drawn from Campbell et al.,[20] which provides an explanation of why they are central to clinical governance policy.

Focus groups were conducted by either AL or KC and assisted by a note-keeper. Each focus group was transcribed verbatim then checked for accuracy. All identifying features were removed to preserve anonymity and groups were given an identifier. A descriptive account of each focus group was created and thematically coded by AL assisted by NUD*IST (version 6) software (QSR International Pty Ltd, Southport, UK). The quotes presented in this paper have been selected because they best articulate the shared ideas expressed within the group.

Findings

Improving and assessing services

The Citizens group felt that professionals should be left to 'sort out' issues around improving and assessment of services. However, they felt that 'ordinary people' like themselves could have some input by ensuring that decisions did not go off on 'tangents' and focused upon the needs of the community.

> Citizen group 2: I don't think that ordinary people can go on a board and make decisions …purchases and watching performances and thing like that. We can have some input.

> Citizen group 2: I think you've got to leave it to the experts. But you can have a voice to make sure they do not get off on tangents.

The Citizens groups felt that the appropriate type of involvement for users was to oversee

performance assessment. They described the purpose of an 'overseer' as someone who observed how decisions were being made, sometimes challenged the information being used to inform decision making and then fed back to the community.

> Citizen group 1: They [Community Heath Councils] just sit there and observe and occasionally they'll ask for an opinion. Whereas there needs to be some way of people getting reports of what's going to happen and being able to object.

> Citizen group 2: I think they should oversee… Um stand in the background and watch what goes on and say 'Well no, that's stupid' or, you know 'That's not how it happens'. Because I mean, we're paying these people to make the right decision so in theory they should know what they're doing.

The two Patient User Groups differed in their perceptions about involvement in this aspect of clinical governance. Patient User Group 1 felt that their role was to protect the wider interests of the local community because in the past, this had not been done and as a result local health-care services declined. While they discussed 'regaining' lost control over what happened to their community, their description of involvement was one of working in partnership with the local general practice to identify issues and concerns within the community and getting them investigated or changed.

> Patient User Group 1: We'd lost the control, so we set up the health forum, [we've] taken back the control… we need to keep in control for the benefit of ourselves, our kids, our families, our communities…

> Patient User Group 1: One time we had a problem with mums getting inhalers from the hospitals. Every time a child went to hospital with a chest infection, they come back out with an inhaler. And we wanted to know why a baby was getting an inhaler, you know, it wasn't right. So we've asked for it to be investigated.

In contrast, Patient User Group 2 felt their role was to provide and obtain information regarding health-care issues that affected either themselves or other users of the practice.

> Patient User Group 2: Well, we've got a patients' notice board in the front foyer and if there's anything anybody wants to put on it, you can put on

it. And most of the patients - not just us - most of the patients know, if they need to know anything, they can ask [the Practice Manager].

The Health Interest Groups indicated that their desire for becoming involved in the improvement and assessment of health services was to improve services both for their own use and for patients like them. Thus they felt that due to their own experiences and knowledge, they could work as advocates for others like themselves. They felt that by trying to improve services for users like themselves, it may ultimately have a wider impact on other types of users.

> Spina Bifida Group: Even if you only achieve that… your corner of the globe, for want of a better expression, then you've achieved something, haven't you? And hopefully there'll be like a roll-on effect in that. If you achieve something within your community or whatever, then that will have a knock on effect to other groups and other communities.

> Stroke Group: My doctor said to me 'You've had a stroke. You're the expert. Tell me what you would like and I'll see if I can get it.' I would be willing to take on something that helps other strokes [sic]. I don't want to run the health service; I just want the strokes to be given a fair deal.

Their comments suggest that although they wanted a similar level of involvement to that described by the Citizen groups, except that they would likely focus upon the specific concerns of their own community although these could have an impact on the wider community. By taking the role of an 'overseer', they could ensure that issues relevant to their community were being taken into account when dealing with quality issues.

> Stroke Group: Maybe see the areas that are going to be addressed by the [Primary Care Trust] to improve. And ensure that they feel all the problems they've had are covered by those areas that are going to be addressed. If you like, a secondary audit…a sort of quality loop.

The Frequent Attendees felt that any information produced as a result of conducting assessments of services would be useful to them in their role as consumers of health care. When asked if they felt practice performance reports

should be made readily available to them, they indicated that this type of information could help inform their own decisions about the practitioner they use or the surgery they attend.

> Playgroup: Oh yes. Definitely. I'd love that because then you can choose which one you go to can't you? [Laughs] And if my doctor's known as a tosser [sic] I'd be distraught.
>
> A: You would pick your surgery?
>
> Playgroup: You would, wouldn't you? You'd want the best. If you could go to change your surgery to the best one that got the best marks, you would, wouldn't you? Anyone would really.

There were differences in the role perspectives desired by the different informants wanted with regard to improving and assessing service provision. The Citizens and the Patient User Groups felt their role was to represent the wider community's interests. In contrast, the Health Interest Groups felt their role was to represent the interest of a specific community. The Frequent Attendees felt that their role was to inform their own consumption of health services.

The type of involvement also varied between the groups. The Citizens and the Health Interest Groups describe the most appropriate level of involvement as 'overseeing' the decision-making process. The Patient User Groups differed in their desired type of involvement, with Patient User Group 1 wanting partnerships with decision makers. The concept of 'partnership' is reflected in some models of involvement[10,14,15] and refers to a process whereby there is a shared responsibility for decision making. Patient User Group 2 and the Frequent Attendees described informing as their desired level. Whilst 'informing' has appeared on involvement models,[10,14] the assumption is that the information only goes in one direction: from the user to the organization. Although this use of the concept may be particular to clinical governance policy, it appears that 'informing' can go in the other direction and its use depends on the role the user is taking. Thus it may not be as 'tokenistic' a form of involvement as initially thought.

Dealing with poor performance

The Citizens group felt that the public had a role in ensuring that communities were protected and concerns heard when dealing with poor performance. They felt the type of involvement needed was for someone to oversee the process and feedback to the community, thus ensuring that problems were dealt with openly and ensuring greater accountability. Patient User Group 2 and the Frequent Attendees also expressed these views.

> Citizen group 3: Unless you have the public involvement then there are cover-ups galore… And I think you need the public involved in it to see that the work is being done, that it's being done properly and that the procedures in place for putting things right… I wouldn't want to be involved in trying the doctor, but I'd want to know that the procedures are in place and it's done properly… I think the public need to be involved there, almost as just seeing that there's fair play.
>
> Patient User Group 2: Well, he [the overseer] could keep an eye on things and pass the word… bring it back to the community.
>
> Playgroup: Just one person that's been picked by everyone and they go into everything… just look out for your interests… 'cause there's some doctors that have been charged for something or sacked because they've done something and then they could go and work in your surgery couldn't they?

Unlike the other groups, Patient User Group 1 wanted to be involved with issues around dealing with poor performance. They felt that by knowing about problems associated with poor performance, they could work in partnership with the practice in order to change them.

> Patient User Group 1: If he's not performing or if she's not performing, we'd want to know why and how and possibly change it.

The Health Interest Groups wanted greater openness about what the problems were and how they were being dealt with. Ensuring accountability was important to them because of having received poor care in the past and wanting to ensure others did not. The type of involvement they wanted was to be able to

identify problems with care or services, ensuring they were dealt with and then feeding back to the group.

> Diabetes Group: If this person went to the forum and said 'OK. Such and such a practice, this happened last week. We want to know that it's not going to happen again.' So that when we have the next meeting you could say to the GP involved 'Has anything been done about this situation so it won't happen again?' So in that way there would be accountability. Then they would feed back to the group; say 'OK, this isn't going to happen again. We reckon that there's a fault there' …there was some kind of error made so maybe there would be a bit more accountability because we could be saying we want results. We don't want this person struck off for no apparent reasons…

As with the previous aspect of clinical governance policy, the lay groups wanted different roles and type of involvement when dealing with poor performance. All the groups except for the Health Interest Groups felt that their role was to act in the interest of the community. The Health Interest Group wanted to speak from their position of having experienced services as a particular type of patient. However, the Health Interest group, Citizens, Patient User Group 2 and Frequent Attendees all felt the appropriate type of involvement was to 'oversee' the process and decisions. Only Patient User Group 1 wanted to work in partnership to solve problems. Like Lowndes *et al.*[21] has highlighted, we assert that it is the relative deprivation and previous dissatisfaction with authorities that shapes this groups desire for higher types of involvement. Thus it is their historical, cultural and political context, which Abelson's model[18] referred to as predisposing, enabling and precipitating influences that shaped the level of involvement these users want.

Education and training

All the groups were asked directly if they felt that public should have a role in the education and training of health-care professionals. The Health Interest Group was the only group who wanted to have a role. Their motivation comes from having personal experiences with practi-

tioners who were not aware of their health-care needs and thus having had their quality of care affected.

> Spina Bifida Group: Even if you've known the GP for a long time, they don't actually understand what your difficulty is. Because a lot of GPs, when they're going through their training, they skim over disability – like half a day.

> Stroke Group: There's some research done years ago that said you make most of your recovery in the first 12 months. And that's become the Holy Grail for doctors for some reason. Now if that'd been the case, I wouldn't like to think of the state I'd be in now. Because after a year, I couldn't do… I couldn't walk. I was in a wheelchair…

The Health Interest Groups felt that they had a role in sharing information about their experiences and how the implementation of clinical guidelines affected them. The type of involvement they describe is working in partnership with professionals in order to improve knowledge and understanding around specific illness and disabilities. The other groups saw it as an important aspect of a professional's job and essential to the provision of good care, and they did not want user involvement.

Discussion

Analysis of the findings (Table 2) revealed variations and similarities between the Citizens, Patient User Groups, Health Interest Groups and the Frequent Attendees regarding their perceptions of the role perspective and type of involvement that users should have in clinical governance.

Like Charles and DeMaio,[15] we have found that lay views about participation are not homogenous but include perceptions about involving different types of people in different activities and in different ways. This study highlights three roles that users wanted when being involved in clinical governance: 'consumers', 'advocate' and 'citizen'. Whilst other models[15,17] have suggested that user context affected the type of involvement desired, none have explored this in the context of clinical governance nor have the roles been considered in this way.

	Improving and assessing services	Dealing with poor-performance	Education and training
Citizens	Role: Citizen Type: Overseeing	Role: Citizen type: Overseeing	No desire to be involved
Patient User Group 1	Role: Citizen Type: Partnership	Role: Citizen type: Partnership	No desire to be involved
Patient User Group 2	Role: Citizen Type: Informing	Role: Citizen type: Overseeing	No desire to be involved
Health Interest Groups	Role: Advocate Type: Overseeing	Role: Advocate Type: Overseeing	Role: Advocate Type: Partnership
Frequent users	Role: Consumer Type: Informing	Role: Citizen Type: Overseeing	No desire to be involved

Table 2 Summary of lay perceptions of preferred role and type of involvement

We define the 'user-as-consumer' role perspective as users who are concerned with maximizing their own satisfaction and are involved only to improve their immediate situation. As Greenwall[22] has asserted, their involvement in decision making is self-serving and aimed purely at fulfilling personal need. They are information-seeking with the aim of improving access to the best resources possible. Yet we are aware users-as-consumers of health care cannot be true 'consumers' because they are not rational, dispassionate, economic decision makers who have maximize optimum control over their choice in order to gain maximum utility.[23] The health 'market' functions imperfectly and even with improved information, the consumer remains dependent on professional expertise and interpretation. Harrison and Ahmad[24] contended that whatever choice is available is negotiated with the provider and not through the process of exchange. Nonetheless, for some of the informants, public involvement in clinical governance was perceived as a strategy to improve their access to the best health care.

We define the second role perspective emerging from these findings as 'user-as-advocate'. In this context, the user draws upon their specific interests that are shaped by their own illness experiences. They used their specialist knowledge to seek to improve health-care services for the collective benefit of similar users. For many users, having knowledge and experience – particularly poor experiences – of the health-care system is a necessary requirement for being involved. This has been recognized by Hirschman[25] who stated that dissatisfaction is usually the most obvious motivation for user participation in decision making. Similarly, members of the user movement in mental health have characterized themselves as 'survivors'[26] motivated by their dissatisfaction with services, which have been seen as oppressive.[27] For some users, their illness may be constructed as part of their identity and their aims are sometimes wider than service change, extending to system realignment and political consciousness. Barnes[28] distinguished between those 'interest' groups who were transitory and service focused and 'identity' groups who had a common culture and purpose and seek political as well as service goals.

The third role perspective is the 'user-as-citizen'. The user's role is defined by their intention to seek to improve or protect the general community. This group included what Harrison *et al.*[29] have called the 'literal public'. They are individuals who respond to involvement without any special knowledge and are likely to be free of vested interests. Users in this role will act in their capacity as citizens and taxpayers with rights to use public services and will contribute to or participate with others collectively in the society in which they live.

We also found that the informants wanted different types of involvement in the different parts of the policy. The analysis reveals strong overall support for an 'overseeing' type of involvement for different groups in several aspects of clinical governance policy. This type

of involvement has not explicitly been included in any previous models of public involvement. It represents a call for accountability in public services that Sullivan[30] interpreted as a process for controlling the agencies of the state. Stewart[31] referred to accountability as being concerned with 'giving account' and 'being held to account'. The informants adopted both modes in their descriptions of overseeing involvement: where decisions are scrutinized by a member of the public who ensures the concerns and values of either the wider community (acting as a citizen) or the specific community (acting as an advocate) are examined and professionals held to account. They also described the 'overseer' as giving account by providing information about how decisions were made and concerns dealt with to the specific or wider community depending on the role. This type of involvement could be what one informant from the Stroke Patient Group called an 'audit loop'. It supports Tritter and McCallum's[13] assertion that sometimes user participation – not control – in decision making is the end goal.

Government policy has recognized the value of this process of user scrutiny or 'overseeing' as trusts have the duty to scrutinize health service decisions and to refer service change proposals to the Secretary of State for review.[4,32] Our findings suggest support for other research, which has shown that there remains a question regarding public trust in health service provision. For example, A MORI survey for the Audit Commission[33] found that the public did not rate public managers highly on indicators of trust such as honesty, competence and communication skills. In contrast, doctors persistently score highest (and politicians lowest) in surveys of trust in professionals.[34] Heenan[35] found that voluntary organizations were trusted more by people with disabilities to deliver services than public sector agencies. It also appears that the voluntary sector found trusting government difficult.[36]

These findings demonstrate that there was no desire on any group's part, to achieve control over decision making, but that there was a desire to be involved in the clinical governance policy.

We found predominant support for an 'overseeing' role, which carried with it the right to scrutinize process and decisions in order to ensure they took on board community concerns or values. This particular role may be a reflection of the nature of clinical governance, the full understanding of which requires some degree of technical knowledge. Most importantly, we develop current models of involvement by demonstrating the important inter-relationship between desired role perspective and preferred type of involvement. The desired role perspective partially determines the preferred type of involvement that is most appropriate. By showing how these vary between groups, we highlight why implementation of public involvement in clinical governance may be more challenging than it first appears. Furthermore, we suggest that it may be better to seek the specific involvement of particular users, at particular times and in specific ways, within the clinical governance process This is more likely to be productive than trying to design generic forms of involvement that will cover all clinical governance situations. This way, involvement could be designed to reflect users' desires in terms of both role and type of involvement.

This research draws upon the opinions of a wide range of health-care users living in a city in North-West England. Despite the qualitative rigour of our study, the findings may reflect that this city has had a strong history of public activism. Public involvement in clinical governance remains problematic only partly because of issues around the role and type of user involvement. What remains are matters around the acceptability of involving users in what have usually been 'professional' decisions.

Conclusions

The lack of understanding of public involvement by policy makers and their implementers has been highlighted by Shepherd[37] and Alborz *et al.*[38] We also feel public involvement in any health-care initiative remains highly problematic until it is recognized that different users will take different role perspectives and desire different

types of involvement in different aspects of the policy. Thus large, all-encompassing strategies of user involvement may only appeal to a limited range of users, and this could impact significantly on their use and usefulness.

Acknowledgements

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