

A QUALITATIVE INVESTIGATION OF PATIENT AND STAFF
EXPERIENCE ACROSS MULTIPLE CLINICAL SERVICES: THE CASE
OF A REDEVELOPMENT PROGRAMME AT AN ENGLISH ACUTE
HOSPITAL NHS TRUST

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by

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Abstract

This study was a qualitative examination of patient and staff experiences within a redeveloping acute NHS hospital Trust in England. The aim of the investigation was to examine the current direction in government policy which places considerable emphasis upon delivering healthcare services structured broadly around increased patient involvement and choice. There is a need to address the gaps in the evidence for this strategic direction, which indicate an apparent lack of appreciation for the complexities involved. The qualitative methods applied in the study included the use of patient and staff interviews, observations and some documentary review. The research location was selected as an opportunity to assess and compare the perceptions and experiences of patients and staff in the context of a hospital redevelopment programme, from within three distinct clinical services. The three clinical services studied were accident and emergency, a paediatric ambulatory care unit and an adult respiratory outpatient clinic. Thematic content analysis was applied to the data. Findings indicated that generally patients were satisfied with their care and did not expect greater control or involvement. Some issues were raised by staff around uncertainty towards the change programme. Furthermore, there was a suggestion that staff and patients had differing perceptions of what constituted satisfactory care, with respect to technical versus functional quality. The notion of a 'model' of patient behaviour emerged. The conclusion is that given the current political agenda focused on the role of the patient, greater sensitivity in understanding towards terms such as patient-centred care, involvement and choice is required. Additionally, there is a need for greater awareness and appreciation of the discrepancy between staff and patient perspectives of what impacts the patient experience. Further research might focus upon the understanding of the patient processes and interactions involved with respect to patient-centred care and choice.

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List of abbreviations used:

A&E	Accident and Emergency
ACDU	Acute Care and Diagnostic Unit
BPR	Business Process Reengineering
CCC	Clinic Care Coordinator
CDP/CDNP	Chronic Disease (Nurse) Practitioner
COPD	Chronic Obstructive Pulmonary Disease
CPPIH	Commission for Patient and Public Involvement in Health
CVF	Competing Values Framework
DNA	Did Not Attend
ECC	Expert Consulting Centre
GDR	Gynaecological Direct Referral Service
GNP	Gynaecological Nurse Practitioner
GP	General Practitioner
GPSI	General Practitioner with a Special Interest
HO	House Officer
LINKs	Local Involvement Networks
NHS	National Health Service (England and Wales)
NICE	National Institute for Health and Clinical Excellence
NP	Nurse Practitioner
NSF	National Service Framework
NVQ	National Vocational Qualification
PACU	Paediatric Ambulatory Care Unit
PbR	Payment by Results
PCT	Primary Care Trust
PFI	Private Finance Initiative
PPI	Public Patient Involvement
SHA	Strategic Health Authority
SHO	Senior House Officer
SpR	Specialist Registrar
TQM	Total Quality Management

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1 Introduction

The current emphasis of governmental policy focuses on increased patient involvement and choice in healthcare. This not only currently underpins many aspects of strategic healthcare provision and development, but has also seen major financial investment. The trajectory of acute hospital redevelopment has been influenced by this approach. Much of the focal point of such redevelopment is structured upon implicit assumptions around what is 'best' for the patient and is formed on an arguably limited evidence base of this broad concept. There appears to be only a narrow awareness of what patient and staff perceptions of this agenda are, or what their interpretations of this direction in policy might mean in practice. This raises questions concerning the nature of patient involvement in the context of National Health Service (NHS) redevelopment. This research will, therefore, examine in the context of a redeveloping English acute hospital NHS Trust, the patient and staff views around such changes in the service. This study will take a qualitative approach in order to examine, at length and in depth, the issues across a number of diverse clinical services within the Trust. This investigation will address the gaps raised by current policy and will enable suggestions for future considerations to be made on the basis of novel empirical findings.

1.1 Background

The positioning of patients at the centre of healthcare, designing services both around them and in conjunction with their input, appears to have become increasingly regarded as the best-practice approach to the development and improvement of healthcare services. This is illustrated by the range of government policies and guidance for example the NHS Plan, (Department of Health, 2000) and Creating a Patient-led NHS – Delivering the NHS Improvement Plan (Department of Health, 2007a)

which specifically refer to the practice of patient involvement, consultation and choice, and also by the recommendations to and responsibilities of hospital trusts for patient and public involvement (PPI) stipulated by The Local Government and Public Involvement in Health Act 2007 (Department of Health, 2007b). A need has been cited for greater patient and public involvement to lead improvements in the patient experience (Department of Health, 2004) which are now a cornerstone of NHS policy (Sitzia, Cotterell & Richardson, 2006). The announcement in May 2008 that the government was to link pay to performance in hospitals by using patient experience (i.e. looking beyond physical aspects of care) to measure the quality of care illustrates the serious implications for NHS trusts in adhering to such guidance and policy.

A series of publicised inquiries in the NHS have identified service failings in relation to the patterns of behaviour, assumptions and values of working practices which have been affirmed over decades (Mannion, Davies & Marshall, 2005). These are represented by the seminal inquiry and report on children's heart surgery at the Bristol Royal Infirmary (Kennedy, 2001) and in other well-publicised cases such as Liverpool's Alder Hey Inquiry (Redfern, Keeling & Powell, 2001). There is growing evidence to suggest that organisational culture can affect the performance and quality of health services (Hyde & Davies, 2004). Incidents such as Bristol and Alder Hey have highlighted the importance of NHS culture upon patient care and experience. This has occurred through recognition of a need for appropriate internal operating and communication systems. Such systems should allow challenges to be made against the dysfunctional behaviour of staff in healthcare, where too much control is in the hands of too few. These high profile cases also bring into question patients' feelings of trust towards doctors, which, if not dealt with, could seriously damage public trust (Irvine, 1997). The extent to which this distrust is realistically in proportion with public perceptions, or is more due to a media machine highlighting such incidents is unclear.

The patient-clinician relationship has undergone major and increasingly rapid changes in the past 40 years (Balint & Shelton, 1996). The development of this relationship has occurred within the context of a continually changing and somewhat unplanned NHS, where initially patient choices and control was far more limited (www.nhs.uk). The structures and systems that have emerged for caring for and progressing patients through the NHS have evolved in a relatively ad-hoc manner to address contemporarily relevant issues. These processes mainly focus upon top-down clinical care, and have formally occurred through the continuous release of new government initiatives or policies. However, as suggested above, in recent years the focus has been upon creating an NHS which accounts for a greater degree of patient control and choice. Individually, patients are tiny elements of a hugely complex and voluminous organisation. Nevertheless, there has been a development in the position of the patient from a dependent receiver of care and instruction from medical professionals, to a consumer or customer at the centre of service provision (Newman & Vidler, 2006). However, the extent to which patients generally wish for such status remains open to discussion and limited attention is paid to the extent to which patients wish to be involved in elements of health service delivery (Thompson, 2007). Evidence suggests the traditional consumerist model underlying a policy of making comparative performance information available to the public to enable them to exercise choice in the case of primary care providers, may also not be appropriate (Marshall et al., 2006).

This research will address the suggestion that the breadth and rigour of the evidence, upon which the shift of the developing philosophy increasingly placing patients at the centre of all aspects of care is founded, is not adequate. This shift may be overly driven by external political influences which are raising patient expectations, resulting in anticipated perfection from the NHS. Websites aimed at patients such as 'NHS Choices' (www.nhs.uk) with the sub line of 'your health your choices' may be one example of how patient expectations are being heightened. The political perspectives and context underpinning the

focus on greater choice in public services in general and the health service in particular, were illustrated in a political pamphlet by Tony Blair whilst he was Prime Minister. Blair acknowledged that “Our public services, despite the heroic efforts of dedicated public servants and some outstanding successes, are not all of the quality a nation like Britain needs” (p. 1). Choice is one of the four principles of Labour public service reform (Blair, 2002) with the apparent belief that this would put pressure on providers to improve their services and make them more responsive to users’ needs. However, there is a perception in some fields that the current political dogma simply assumes that choice is inherently good (Bate & Robert, 2005) and that the scope of choices required by patients may be over-estimated by the present policy (Greener, 2007).

Due in part to its uniquely politicised nature questions arise for the NHS over the degree to which the increased involvement and control of the patient in the design and delivery of healthcare might be acting as a political tool. This is particularly the case given that the NHS Plan itself has been perceived as a response to media criticism of the government’s handling of the health service (Baggott, 2005). Apprehension from clinicians over the motivation for steering the development of healthcare in such a direction and the evidence upon which this strategy is founded is becoming apparent. Some clinicians have questioned why politicians are promoting choice, when arguably patients already have choices yet some have rebuffed them, preferring not to exercise their choice (Steer, 2006).

Patients may not want to make choices about where and what type of treatment they receive (Greener, 2007). There is a suggestion that the reaction of some patients to choice can be debilitating, with choices ranging from time, location and type of treatment. The effects of choice overload may be bewilderment and high levels of anxiety and stress (Bate & Robert, 2005). Where patients have been involved in healthcare development and delivery (through Public Patient Involvement schemes),

there have been worries expressed regarding the over-complex nature of the systems involved and lack of resources (Baggott, 2005).

There is an apparent disparity between the evidence base supporting and directing the continued movement towards patient involvement and choice, and the policy, which remains unaddressed. There is concern that many aspects of patient choice are still under-researched (Greener, 2007). The research reported in this thesis was designed and carried out in order to gain evidence of patient-doctor interactions from a patient perspective, focusing upon the reflection in clinical reality of issues of patient control and choice. Additionally, examination of inter-professional clinical and managerial interaction, in the context of the redevelopment programme, has been incorporated. The implications for the patient have been considered across three distinct clinical services operating with different medical specialities and at varying stages of service redevelopment.

1.2 Hospital redevelopment programme

With a focus upon patient experience, the research explores overarching questions about patient-doctor relationships, patient pathways, control and the impact on patients and staff of hospital change. The hospital Trust serving as the research environment for the studies is situated in London, England. The Trust comprises two major hospitals and a number of smaller satellite facilities spread across adjoining London boroughs. The two main hospitals merged in 1999, forming a union before the conception of this research project. The Trust provides care for an ethnically diverse population of more than half a million patients and treats high levels of associated culturally-specific illnesses (such as sickle-cell anaemia and diabetes). The Trust is a major local employer providing work to 4200 staff. The second of the two hospitals, positioned in the more deprived area of London than that of its sister hospital, has been experiencing a period of major redevelopment, involving a hospital

re-build and a redesigned clinical service model. The redevelopment programme has, and will continue to be a significant undertaking involving £85 million of investment through a Private Finance Initiative (PFI). PFIs with private consortia usually involve large construction firms who are contracted to design, build and in some cases, manage new projects. Contracts typically last for 30 years during which time the building, in this case the new hospital, will be leased by a public authority (www.dh.gov.uk, 2008).

The business case for the new hospital outlines strategies to “develop a hospital model with the appropriate structure and capacity to meet the pressures and demands of the modern NHS” (reference removed for purposes of anonymity) with what is referred to as a state-of-the art environment (reference removed for purposes of anonymity). In addition, individual service models are being developed, utilising the newly completed respiratory model as a template, with the overall model aiming to reduce inequality through hospital care which is underpinned by intermediate services, primary and self care all supported by diagnostics and IT. The overarching themes for the hospital redevelopment and new clinical models centred upon the fundamentals of business process reengineering (BPR), focusing upon improving efficiency and effectiveness. A key requirement of the development and implementation of BPR is teams (Choudrie, Hlupic & Irani, 2002). Hospital-wide, changes for staffing groups are being structured upon utilising fewer staff but increasing the qualification levels of those providing the service. The creation of more specialist multidisciplinary teams is one of the key features of this change process. This development will partially be reflected in a planned increase in responsibility for nurse practitioners in many clinical areas.

The hospital redevelopment programme is underpinned by an assumption from redevelopment programme and Trust managers, that the changes being made will benefit patients and staff. The assumptions will therefore, be intrinsically linked to aspects of staff working. These

assumptions contribute to the expectations placed upon staff from above, which may also fuel expectations of the patients regarding the care they receive. The research reported in this thesis aims to provide greater insight into how these assumptions of the change programme map onto the views and experiences of staff in their professional roles. Learning about the consequences of staff views and experiences in terms of the impact upon the patient perspective, as the redevelopment unfolds, is a key aim of this research.

1.3 Research focus

The newly developed hospital has been selected as the location of this research as it provides a current example of the trend in investment centred on patient choice, whilst the evidence base for this approach remains in its infancy. There appears to be no certainty in terms of outcomes in care or patient (or staff) experience of such investment programmes, despite the significant levels of investment being justified for this purpose. As a recent King's Fund review highlights, "It is too early to say whether choice at the point of referral has led to real improvements in clinical quality of services in areas such as clinical outcomes, complication rates or rates of hospital-acquired infections" (Robertson & Thorlby, 2008, p. 4). A review commissioned by the government examining the issue of choice of hospital at point of GP referral has concluded that despite its popularity as an idea with the public, more choice on its own was unlikely to improve quality (Fotaki et al., 2005).

The services within the Trust selected as locations for each of the studies in the programme of research have been chosen for their value in representing specific patient groups, clinical specialties and various stages of progress in the hospital redevelopment programme. Research questions relating to experiences of patients and staff during treatment will reflect upon issues of control, choice and the structures, culture and environment within which services function during periods of

redevelopment and change. The sample of clinical areas being studied will allow comparisons to be drawn between the various services with a variety of service boundaries, systems and respective stages of care. The following section outlines the detailed rationale for utilising particular locations for data collection; the paediatric ambulatory care unit, the accident and emergency department (A&E) and the respiratory outpatient clinic.

The research will initially focus upon the acute adult patient group, in the A&E department of the main hospital facing redevelopment. The newly developed, somewhat ambivalent clinical model makes A&E an interesting and desirable place to explore the issues at the focus of the research project. The A&E model outlines how patients should be seen more quickly by specialist multidisciplinary teams, aiming for less delay or repetition in stages of care. However, being newly introduced, the model has not been tested fully at the hospital. It is based upon a certain level of managerial and clinical assumption that systems and procedures will translate effectively and efficiently to clinical practice. This approach will enable the researcher to address questions regarding service models, team structures and staff and patient experiences through observations, interviews and mapping the patient in the clinical environment. Here information can be considered from a range of staff groups and acute patients within the accident and emergency department during the day, the night and for specific emergency patients utilising the gynaecological direct referral service.

In order to address questions of control or involvement for a clinically specialised service, the subsequent phase of investigation will be set within the sister hospital of the main hospital involved in the redevelopment programme, where a new service for children has recently been developed and established. The setting for this phase of the research will be a paediatric ambulatory care unit (PACU) with purpose-built facilities and dedicated staff. PACU is a referral only unit with restricted access. The specialist status of younger patients (Norredam &

Album, 2007) in addition to the specialist status of the clinicians who work in paediatrics, combined with the recent overhaul of this service contributes to making the unit an ideal place to examine patient experiences. The potentially unique levels of control or consultation of patients with respect to the fact that paediatric patients are commonly accompanied by their parents is the final factor which forms the case for focusing upon this hospital service, allowing an examination between this and the acute service experiences identified above.

As the paediatric and emergency adult patient services will enable the capture of data from two distinct patient groups and clinically acute areas, the final phase of investigation will be based in the outpatient respiratory clinic. This will enable the research to address the thread of issues from previous stages of choice, control and culture across a broad range of services. The rationale for focusing upon this outpatient service is due in part to the contrasting nature of the outpatient, commonly chronic, adult patient group. The chronic respiratory patients are unique in that they experience living with their condition which results in development of self management strategies and acquisition of some expertise in how their health condition is managed as supported in the Expert Patients Programme, (www.dh.gov.uk, 2001). The respiratory clinic is also facing imminent redevelopment, having adopted certain elements of the reengineering of services prior to the transfer to the new hospital building including changes in staff roles and the imminent introduction of additions to the service.

By considering this range of services a fuller picture will be gathered of experiences for staff and patients across the hospital Trust. It is intended that examination of the various interactions taking place, in conjunction with a reflection upon relevant literature will enable an analysis of factors identified as requiring more evidence, such as patient control and involvement. The objective of the thesis will be an output which advances the knowledge in this field and contributes towards addressing some of the gaps identified in the existing research evidence.

1.4 Thesis outline

Chapter 1 Introduction

The chapter presents the introduction to the research, along with the broad rationale and context for the study.

Chapter 2 Evolution of the NHS: Policy and Practice

The chapter provides the political and policy based context for the study, in the form of an examination of the background of the NHS, its organisational development, policy and practice over the past 60 or so years. The changing position of the patient within the NHS is also considered. In addition the chapter incorporates a review of the relevant literature broadly focusing on organisational and professional culture.

Chapter 3 Development of Methods

The chapter addresses the development of strategy and materials selected to answer the research questions posed by the research. Approaches to data collection are reviewed, with a rationale given for the three selected forms (observations, interview and some documentary review) of qualitative data collection. Issues of reliability and validity are addressed, along with the development of the analytical framework.

Chapter 4 Methods

The chapter builds on the foundations of the Development of Methods and provides details of ethical review and the research questions to be addressed. The chapter covers the study design and materials, inclusion and exclusion criteria, population, sample, setting and procedure for collection of the data within each of the three clinical services. This includes:

- 1) The acute service or accident and emergency department (A&E) of the hospital at the centre of the redevelopment programme spanning data from across patients and staff within the service

(Day time, Gynaecological direct referrals (GDR) and Night time services).

- 2) The paediatric ambulatory care unit (PACU). This unit, situated within the Trust at the sister hospital to the main site facing redevelopment, had recently completed a process of redevelopment itself and as a referral only paediatric outpatient unit presented an opportunity to collect useful comparative data.
- 3) The respiratory outpatient clinic based within the main hospital site awaiting redevelopment. The service was mid-way through aspects of the service redesign but awaiting the move to the new hospital facility at the time of data collection.

Additionally, the methods of analysis and limitations of the methods are described.

Chapter 5 Results

In this chapter the findings from the research process are presented, from the three services as outlined in the Methods chapter.

Chapter 6 Discussion of patient and staff experience in three NHS services

This chapter is a reflection of the findings from the three clinical services within the Trust at the centre of the research. It contains the discussions relating to the individual services, and raises and considers questions and issues which might be relevant from one service to another and to the overall discussion of the thesis. Limitations are also discussed.

Chapter 7 Main Discussion

Here the findings from each of the three empirical chapters are drawn together and critically analysed in relation to the research questions posed. The overarching emergent concepts are outlined and discussed. Suggestions are made for future research.

Chapter 8 Conclusion

This final conclusion summarises the process adopted to answer the research questions posed. The key findings are presented and the novel contribution offered by the research is highlighted.

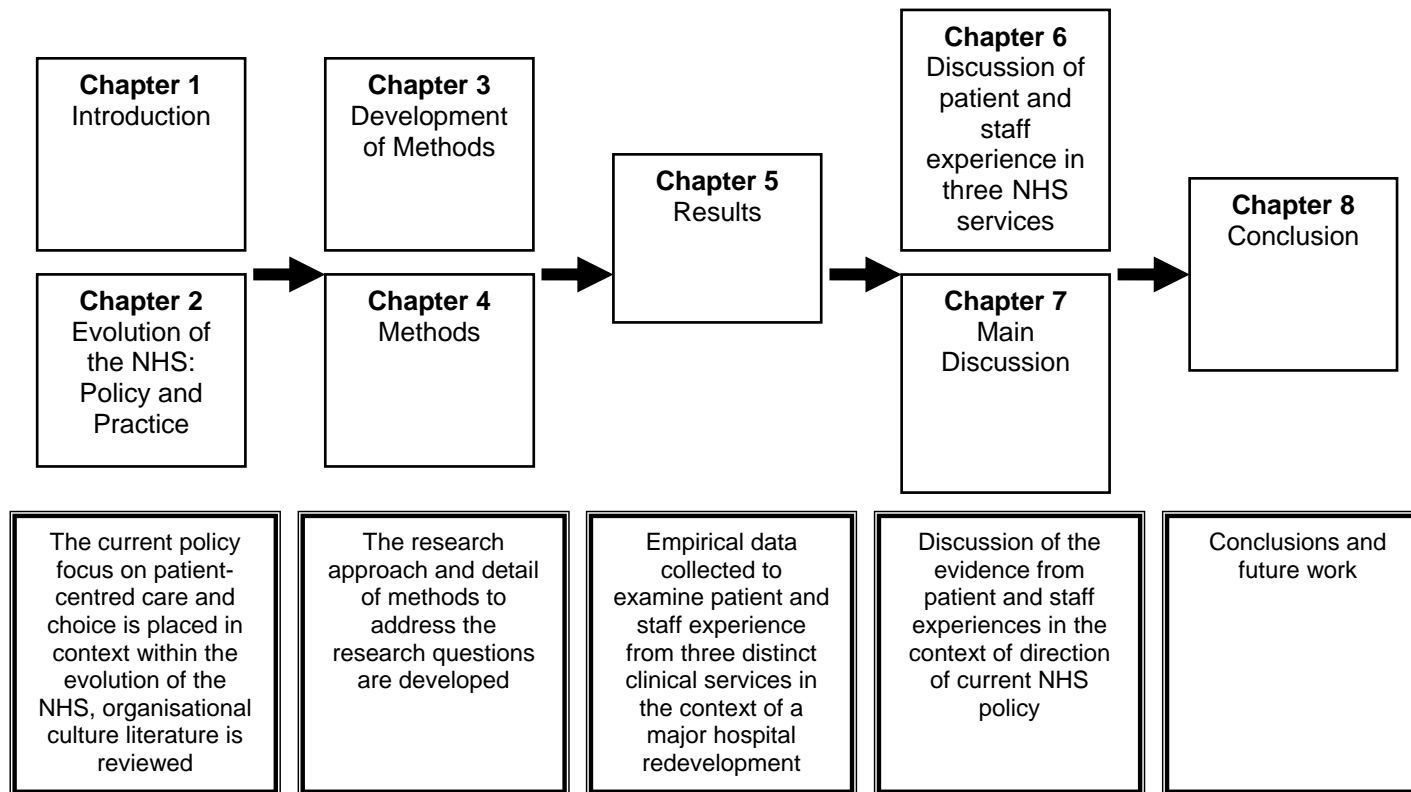


Figure 1.4.1 Thesis logic

2 Evolution of the NHS: Policy and Practice

2.1 Evolution of the NHS

2.1.1 Context

The organisational and developmental context of the NHS is important when considering how the service has been re-modernised and how the position of the patient may have altered over time. The National Health Service was created in 1948 under a new Labour administration led by Bevan, Minister for Health. The NHS emerged as a result of plans for a health service made during the years of the Second World War. Departing from the approach of previous systems, the new service was centrally managed and funded, (financed by the taxpayer) and free at the point of delivery (Delamothe, 2008). The “paternalistic, monolithic” NHS as it has been referred to by Klein (2006 p. v), was the first westernised health system to offer free medical treatment to the whole population (at the point of delivery).

This method of funding hospital services through the taxpayer (Chen & Feldman, 2000) influenced the public’s perception of their health service. The public were encouraged to view the NHS as an insurance against illness, thus helping to fuel the continually rising expectations (Rankin, 2006). Future iterations of the NHS have continued to be affected by this public perception. Whilst expectations can be important for example, in terms of holding politicians to account, they create a problem when they become unrealistic (Rankin, Allen & Brooks, 2007). Consequently, striving to manage expectations of the public has been an issue since the creation of the NHS and a constant debate has remained over whether it is sufficiently funded (Dixon, Harrison & New, 1997). The uniquely

politicised nature of the NHS has shaped and influenced all aspects of the service from its inception to the present day.

The founding principles of the NHS:

- The service was financed almost entirely from central taxation; the rich therefore paid more than the poor for comparable benefits
- Everyone was eligible for care, even people temporarily resident or visiting the country; anybody could be referred to any hospital, local or more distant
- Care was entirely free at the point of use, although prescription charges and dental charges were subsequently introduced (Rivett, 1998)

The creation of the NHS brought hospital services, family practitioner services (doctors, pharmacists, opticians and dentists) and community-based services all under the umbrella of one organisation for the first time. Brown (2006) identified how this was not without significant administrative difficulty; a difficulty in cohesion which continues today. However, any logistical difficulty at the time of the inception of the NHS was far outweighed by financial challenges, as demand for services soon exceeded estimates (Brown, 2006). Attempts to overcome financial tensions have led to actions such as the introduction of fees in some areas, for example for prescriptions, introduced in 1952 (Delamothe, 2008) which also served to deter frivolous demand for healthcare (Evans, 2008).

The social context at the time of the introduction of the NHS is also relevant to the consideration of how the service has subsequently developed. The pre-war period in Britain was poor, and the healthcare system somewhat disorganised. Baggott (2004) described how prior to the war, people had paid to visit the doctor but following the hardship of war time, were left unable to afford this. Voluntary hospitals existed in the private sector and municipal hospitals and community health services formed the public sector (Baggott, 2004). The Beveridge Report

presented to Parliament in 1942, aimed to make the best of the situation as a result of the War and “supported the idea of a comprehensive health service available to all” (Baggott, 2004, p. 84).

A British Medical Journal editorial from the time also raised the issue of a need to address the problem of multitudes of ‘housewives’ and children who had been left without their family bread-winners due to many men being killed in World War Two. These families were clearly unable to afford to pay for healthcare, but through Beveridge’s proposals would be accounted for and provided with the care they needed as a result of taxation (Beggs, 1942). So whilst not all recipients of the NHS provisions were working or paying for the service, they were to be protected by it.

The difficulty with the concept of an NHS offering ‘cradle to grave’ provision has been related to the misguided assumptions outlined by the Beveridge report. “It was...expected that expenditure would soon level off and even decline as people became healthier. In fact the reverse happened.” (Ham, 2004, p. 16) Initial predictions about capacity and demand of the NHS were clearly misaligned to the reality that transpired, as further illustrated by Dent (1995): “[there was an] original plan to free people from the burden of illness and disease, the premise however, turned out to be false and the hospital service grew rather than shrank in size.” (Dent, 1995, p. 880)

The complicated nature of the health service in the main has been identified as a result of the influence of politics and finance (Draper & Harrison, 1991). The subsequent battleground revolving around health issues is well established and cynicism felt towards the incentive for reform was, and remains strong:

“We are not all on the same side and the ‘war’ over our health is a ceaseless and complex affair of advances and setbacks. In the field there are friends and enemies, allies and supporters – and also referees whose whistles are often disobeyed or

blown too feebly or too late. Real motives of invading forces are usually hidden and extensive camouflage is in constant use. There are many deliberate diversions, obstacles and traps.” (Draper & Harrison, 1991, p. 144)

A number of Parliamentary Acts (Acts of Parliament which have been given Royal Assent) and Bills (legislation that is still going through the parliamentary process) have been introduced to develop and improve the health service. Many of these are relevant in considering the organisational and professional structures of the NHS. Often such policies have focused upon specific and direct implications for autonomy for professional groups within the NHS in their attempts to steer the development of the NHS.

The Professions Supplementary to Medicine Act (PSMA) was passed in 1960 after considerable debate and a degree of compromise. The Act regulated the initial training, fitness to practise, and the conduct of professions including: Chiropody, Medical Laboratory Science, Occupational Therapy, Physiotherapy and Radiography. The Act and the related statutory bodies operated in a complex area which has witnessed substantial policy and practice change since 1960 (J M Consulting Ltd., 1996). The Act provided effective powers to control qualification leading to State Registration which qualifies and regulates the conduct of the healthcare professional in this field.

A review commissioned by the Department of Health and published in 1996 highlighted flaws in the working of the PSMA including lack of cross-professional strategy and significantly, in considering culture within the NHS, an over dominance of medical representatives. A Bill building upon the Act, but with more flexibility, was recommended in the review (J M Consulting Ltd., 1996). This reflected the changing structure and responsibility of certain professions within the NHS, which is traditionally viewed as a domain ruled by medics (Gair & Hartery, 2001).

Structures within the NHS are significant to the direction and development of the service. The Porritt Report (1962) criticised the separation of the NHS as it was in three parts - hospitals, general practice and local health authorities. The report called for a simpler structure comprising a relatively small number of single health authorities encompassing a wide range of medical and welfare services (Macpherson, 1997). In 1962 the Hospital Plan (Great Britain Ministry of Health, 1962) was also produced to address the uncoordinated building of hospitals in an attempt to give clear strategic direction. In England the incentive for change emanated from local government, which finally resulted in reorganisation in 1974 based upon the 1973 NHS Reorganisation Act (Department of Health). Regional Health Authorities covering in theory all three parts of the NHS replaced Regional Hospital Boards. However, return of the health services to local government continued to be rejected, although less confidently so than in 1948 (Webster, 1995).

A lack of political agreement over the reorganisation of the NHS and the mounting concern of the roles of managers, clinicians and culture within the health service are reflected by Crossman (1972), who described the new cultural shift within the health service as being dominated by a “managerial philosophy” resulting in a service operated by “men of managerial experience”, (Crossman, 1972, p. 23-4) rather than decisions being determined by healthcare based ambitions.

The creation of the district general hospital in 1964 has been described as resulting in services being far more concentrated “into a single, monolithic provider serving a district, the predominant model or ambition of almost the entire NHS” (West, 1997, p. 9). The development of district general hospitals threatened the existence of many of the smaller ‘cottage’ hospitals, as they often were at the time. However, part of the 1974 reorganisation saw the Department of Health issue a paper setting out its vision for community hospitals which according to Ramaiah (1994) had yet to be formally superseded.

“The suggestion was that community hospitals were needed to provide medical and nursing care, including outpatient, day patient, and inpatient care, for people who do not need the specialised facilities of district general hospitals and cannot be properly cared for at home or in residential accommodation. General practitioners were expected to provide the day to day care of patients. As a result of this guidance several former cottage hospitals were adapted to meet these new requirements, and in many health districts new community hospitals were developed” (Ramaiah, 1994, p. 487)

By the late 1960s, attempts at resolving some of the issues facing the NHS had already turned to the need to address staffing issues. In particular, the balance of skills mixes for different professional groups were considered. The Salmon Report (1967), prior to the 1973-4 reorganisation, had produced detailed recommendations for developing the senior nursing staff structure and the status of the profession in hospital management. The report outlined that nurses should have equal status with medicine and management. The need for nursing leaders to continually press the Department of Health to guarantee places for nurses at all levels of decision-making in the NHS is, however, something which was not fully resolved and has continued to be an issue for the modern NHS (Redman, 2008). In addition to the Salmon Report, the first report on the organisation of doctors in hospitals was released the ‘Cogwheel Report’ (1967), to arrange clinical and administrative medical work more logically, into speciality groups.

A number of factors have been identified as being responsible for this increasingly negative impact upon service provision. The post-war era was a time which experienced a peak in the birth rate; a cohort commonly known as the ‘baby boomers’ (Williamson, 2008). This increase in birth rate had obvious consequences in terms of the pressures placed upon healthcare services.

Despite the attempts at unity of the NHS seen under the 1973 NHS Reorganisation Act, efforts were not entirely successful. As Ham (2004) made clear, comprehensive unification was not achieved as GPs “remained independent contractors” (p. 22). This was an indication of the continual divisions between GPs, hospital counterparts and government. Further criticism of the reorganisation during this period related to delays in decision making, and a perception that there were too many administrators. Ham (2004) referred to “considerable unrest in the NHS” (p.26) with challenges faced from high costs, specifically in terms of staff morale. Baggott further reflected upon the original structure and accountability of the NHS as “flawed” with “botched attempts” at reorganisation (p. 89) and continued problems of funding “and a growing sense of crisis in the NHS” (Baggott, 2004, p. 97).

By the advent of the late 1970s it was clear that the NHS faced increasing turmoil. As Klein indicated, “the foundations of the NHS are set in the concrete of popular support...the NHS has become a cherished national monument”. He continued, however, “successive governments have over the decades struggled to cope with the flaws of the 1948 model, itself the product of political controversy and compromise” (Klein, 2006, p. v).

During its youth, the function of management had not been explicit in the NHS, with the consultant and matron responsible for running hospitals. However, this position soon altered particularly as a consequence of the introduction of general management based on the recommendations of the Griffiths Report (1983). As a result of this development nurses and therapists were concerned that their status diminished, as doctors gained increased managerial responsibility (Levitt, Wall & Appleby, 1999).

The next stage in the evolution of the NHS has been referred to as the most significant cultural shift in the NHS since its inception; the introduction of the internal market. This is where government separated the responsibility for purchasing services from the responsibility for providing them (Chen & Feldman, 2000). This was outlined in the 1989

White Paper, Working for Patients, and which passed into law as the NHS and Community Care Act (1990). The Conservative Government saw the internal market as a means for addressing problems such as growing waiting lists, which had arisen in the 1980s as a result of a mismatch in capacity and demand in the NHS. In the 1980s smaller cottage hospitals had been deemed uneconomical (Bamji, 2004).

There was a degree of controversy surrounding the legislation of the Community Care Act including opposition from professional groups as well as trade unions (Baggott, 2004). Klein (2006) suggested that the internal market was a by-product of the shift in NHS dynamics which aimed to give providers more autonomy. Draper (1991) provided a highly critical account of the introduction of the internal market, as a preparation for “extensive privatisation...a recipe for soaring accountancy and other bureaucratic overheads not contributing to clinical care” (p. 21). Despite this backlash governmental drive to pass the Act was successful. In response, public outcry against the changes introduced by the NHS and Community Care Act in 1990 was fierce (Filinson, 2002). The Act brought about some of the most radical changes in the NHS (Walsh, Stephens & Moore, 2000). There was a direct impact upon other NHS services as a result of the introduction of care in the community, which saw the closure of hospitals and mental health facilities.

The state of the NHS in the late 1980s, including the significant under funding which forced staff shortages and ward closures, has been poorly reflected in the official records from government sources from the period. Draper (1991) referred to this time of reform: “instead of a little more of our taxes, the NHS got a glossy government White Paper” (p. 21). This commentary indicated that the health of the NHS was not as positive as the politicians might have hoped for.

In 1990 significant changes were also made to General Practitioner (GP) contracts (who contract out their services to the NHS). This placed emphasis upon consumer choice and the promotion of health, but also

allowed for an element of competitiveness and increased opportunity to be involved managerially.

The Health of the Nation White Paper (1992) attempted to counter claims that the NHS did not give enough attention to promoting health (Levitt, Wall & Appleby, 1999), whilst at the time the government attempted as much as possible to reduce the size and cost across the public sector to allow market forces and competition to drive efficiency (West, 1997). The reasoning for not doing the same with either health or education were plain, “since consumers receive education and health care free at the time of use – a policy too sensitive to permit a changeover to substantial, new direct charges – there was and remains, no private customer income to attract a private operator” (West, 1997, p. 3). A key issue here was political sensitivity. Contracting out certain services such as hospital catering, on the other hand, was far easier to do. This issue of political sensitivity remains highly relevant to contemporary service provision.

Healthcare providers became trusts in order to be ‘providers’ in the internal market and by 1995 this was the case for all provision of healthcare. Trusts were, and remain today as semi-autonomous, non-governmental organisations which have taken on assets previously held by the state, for which they are required to make an annual repayment (Levitt, Wall & Appleby, 1999). Denunciation of the NHS as it operated at this time was vehement, and internal market operation was regarded as “perversity” (Hutton, 1996, p. 15) “with results difficult to assess” (p. 212).

Private Finance Initiatives (PFIs) introduced in 1995 hold particular relevance to the issue of hospital reorganisation. PFIs were viewed as an alternative source for capital funding, whereby the private sector effectively loaned on a long-term basis to the NHS. PFIs have been particularly popular for financing new hospital building projects. This movement towards the implementation of PFIs occurred at a time when the public sector in general was criticised for functioning as an environment where “employees are poorly rewarded and its services under-resourced” (Hutton, 1996, p. 9).

In 1997 the NHS Primary Care Act allowed GPs to be employed by an NHS trust, an option which has proved beneficial to those GPs not wishing to enter into their own practice (Levitt, Wall & Appleby, 1999). At this time many GPs were also given their own budgets. Whether or not this helped to address what Ham (2004) termed the “gulf between GPs and their consultant colleagues” (Ham, 2004, p. 18) which had become apparent early on from the inception of the NHS, is unclear.

Following their election in 1997, the new Labour government pledged to alter what had previously failed in the NHS, but to build upon areas of success. The Labour party had been particularly critical of the market approach of the previous administration. They aimed to remove competition but maintain the purchaser-provider split (Levitt, Wall & Appleby, 1999). The approach by the Blair government to commit to bring an end to internal markets was viewed as “eclectic and pragmatic.” (Ham, 2004, p. 54)

NHS Direct was launched in 1998. The service was designed to reduce some of the pressure faced by GPs and A&E departments. The aim was to offer a telephone triage service (Florin & Rosen, 1999) through which patients could access advice from qualified healthcare professionals without unnecessarily clogging up clinic or hospital services. However, the effectiveness of the service has been questioned. For example, a cluster randomised controlled trial found patients in the NHS Direct group were less likely to have their call resolved by a nurse and were more likely to have an appointment with a general practitioner, compared to those patients dealt with by usual on-site nurse telephone triage in general practice (Richards et al., 2004). Findings such as this have fuelled concerns over some duplication of effort.

The 1997 White Paper, *The New NHS: Modern, Dependable*, set out the new approach which was formed on partnership and integrated working and driven by performance. This created the basis for further NHS reforms outlined and initiated in *The NHS Plan* (Department of Health, 2000) and followed by subsequent iterations. Efforts were made to give

greater authority and decision making power to patients and frontline staff. Ham (2004) outlined how the policies to deliver the NHS Plan, whilst offering important differences, had similarities to the policies that lay behind the internal market, and this was particularly the case with offering greater patient choice and payment by results.

The National Health Service Reform and Health Care Professions Act (Department of Health, 2002a) reformed the distribution of functions between strategic health authorities and primary care trusts. A significant change was the creation in 2002 of locally-based primary care trusts (PCTs). PCTs are the organisations which control 80 per cent of the NHS budget and have the role of running the local NHS and improving the health of people in their areas. Concurrently, 28 new strategic health authorities (SHAs) replaced the former regional health authorities and took on a strategic role in improving local health services, while also making sure local NHS organisations were performing well. By 2006 further reorganisation took place and the number of SHAs, PCTs and ambulance trusts was significantly reduced. This was part of what the government described as its drive to create a patient-led NHS (Department of Health, 2006a, 2006e).

In contrast to the pressures placed on healthcare services by increases in birth rates shortly after the war, today the implications of a growing ageing population are exposing healthcare services to greater demand. This is seen particularly to be the case where there has been a continual lack of preparation for the changes in demand placed upon services (O'Dowd, 2008, Butler, 1997). A second issue related to the role of technological and medical advances, which although beneficial in theory, in practice were seen to pose severe financial implications (West, 1997). Rising expectations of the public (Gray, 2008) were potentially fuelled by this. This extreme shift of pressure from high birth rates post-war, to a growth in elderly population more recently, highlights the impact of changes of environment and population under which the NHS has had to operate.

The health service is a complex 'organisation of organisations' which has continually faced significant challenges in maintaining its original core objectives. The complex nature of the NHS is something which has continually challenged successive governments. Attempts to resolve or work around the complexities have been compounded by factors including introduction of market issues to the NHS, resulting in raised public expectation. Successive governments have restated the founding principles of the NHS (Baggott, 2004, Ham, 2004). However, the complex nature of the organisation has remained and some expert commentators feel that politicians have consistently failed the NHS (Davies, 2008).

2.1.2 Current NHS governance

There are a number of broad practices and policies in place which operate to govern the work of the NHS. As a consequence of the Griffiths Report (1983) into the working of the NHS, recommendations were made for a Department of Health management board to be responsible to the Secretary of State for implementation of government policy (Levitt, Wall & Appleby, 1999). There are a number of bodies which currently have responsibility for governing and auditing the NHS and feed back into this process. Ongoing changes in the structure and existence of these organisations reflect the transient nature of the NHS, for example the cessation of the Modernisation Agency in 2004 and alteration in the 'star' scoring system previously employed to assess hospitals.

Clinical governance was at the centre of government agenda for quality, but there was a perception of a need for some evolution of the role of clinical governance (Lakhani, 2005). The aims of clinical governance were to improve quality whilst aiming to prevent service failure particularly for less successful providers who should learn from services of excellence (Baker, 2000). Many new central bodies and regulatory authorities have been established in more recent years in addition to

existing operations, with the rationale of improvement in the quality of care.

In terms of national bodies, the National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE was created as an important element of ensuring national standards (Evans, 2008). It operates producing guidance in three areas, namely public health, health technologies and clinical practice which form the three centres of excellence. The guidance produced by NICE is developed by a number of independent advisory groups consisting of health professionals, individuals working in the NHS, patients, their carers and the public.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act (2003a). It has a range of functions and took over some responsibilities from other commissions when it was formed. This included the responsibilities of the Commission for Health Improvement, which ceased to exist on 31 March 2004. The Healthcare Commission took over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on 31 March 2004. In addition, it picked up elements of the Audit Commission's work which related to efficiency, effectiveness and economy in healthcare.

Following a consultation and review, the Healthcare Commission introduced a new system for monitoring the health of NHS organisations. The current system first applied in 2005/2006 provides each trust with two ratings on a four-point scale of 'excellent', 'good', 'fair' or 'weak'. One rating covers the quality of their services, measured against the government's core standards and national targets; the other relates to the use of their resources, measured against how well they manage their finances.

It is important to note that such auditing measures are relatively recent in the history of the NHS, and for the early NHS “devising measures to assess whether objectives have been met is beset with difficulties...outcome indicators are rarely employed and it is therefore difficult to judge whether policy is having an impact on the health of the population” (Ham, 2004, p. 187). The preoccupation with targets such as waiting times is a continued criticism of healthcare systems. It has been suggested that some of the new systems of audit are “features of the discarded internal market...in a new guise” (Ham, 2004, p. 213). Despite steps being taken to overcome what some perceive to be the limitations in audit, the English healthcare system in particular has been labelled as groaning under regulation and audit (Bevan & Hood, 2006).

On an individual trust basis, the governance of these organisations has also evolved in recent years. NHS foundation trusts were set up, also under the powers in the Health and Social Care Community Health and Standards Act (2003a). The bill abolished government control of NHS trusts, turning them into competing independent corporations (Pollock et al., 2003). The aim of NHS foundation trusts was to give more power and a greater voice to local communities and front line staff over the delivery and development of local healthcare. NHS foundation trusts have members drawn from patients, the public and staff and are governed by a Board of Governors comprising people elected from and by the membership base. NHS foundation trusts are inspected by the Healthcare Commission for compliance with healthcare standards and targets in the same way as all other NHS trusts. In addition foundation trusts are also overseen by an independent regulator called Monitor. Monitor has statutory powers to authorise NHS trusts as NHS foundation trusts and oversee compliance (Department of Health, 2006c).

National service frameworks (NSFs) are long term strategies for improving specific areas of care for a range of conditions and patient groups. NSFs were launched in 1998, and there were 10 NSFs in operation by 2007 (Evans, 2008). They are at the centre of modernising

the health service and improving patient care. They set national standards, identify key interventions and put in place agreed time scales for implementation. These frameworks contribute to forming the basis for the series of policy documents on reform of services, procedures and workforce structures. Their transient nature makes any comprehensive evaluation difficult.

The process of setting and obtaining targets for NHS organisations has not been an entirely smooth one, but targets and standards have been used by politicians in an attempt to meet public expectations (Evans, 2008). Gulland (2003) reported that some NHS staff resorted to cheating figures on government reports in an effort to meet certain targets and goals established by the government. In contrast to this view, concern has been voiced that a lack of targets has led to underperformance in certain NHS services, for example patient satisfaction and maternity care (Mayor, 2005). The process of aligning policy, structures and practice is obviously not straightforward or clear cut, despite the strategy and expectation outlined in government publications.

Staffing issues have consistently posed challenges to the NHS and the way it has been governed. The financial problems facing the service have inevitably impacted staffing. Medical staff have reported concerns over the issue (Eaton, 2008) and this has also led to significant media coverage, which undoubtedly impacts on public expectation (Rankin, Allen & Brooks, 2007). As highlighted by Ham (1997) “the long term underfunding of the NHS continues to present a major challenge to policy makers” (p. 103). A common accusation against the government has been that ministers who make decisions affecting the NHS rarely have the same level of social exposure to the local population as the professionals responsible for providing direct services such as healthcare (Draper & Harrison, 1991). The Agenda for Change review worked to assimilate employees’ pay scales and has resulted in pay increases for many, although difficulties have remained. Such difficulties have been

taken up by the media, with coverage having potential negative impact upon public perception.

A final but crucial aspect of NHS governance structure relates to the role of the patient. This has significantly altered over time, in line with the move towards patient-centred care. In the pre-NHS era patients paid to see doctors and a doctor's salary would have been directly associated with patients accessing healthcare. Following the introduction of the NHS, this all changed and patients received free healthcare at the point of delivery. With this change, the power dynamic also evolved. Patients have developed from 'passive' recipients of NHS care to 'active' participants, particularly in aspects of governance. More recently the position of the patient has developed into assessors via evaluation of services, which capture both the voices of patients as groups and individuals. For example the Commission for Patient and Public Involvement in Health (CPPIH) appointed patient public involvement (PPI) forums (replaced by Local Involvement Networks (LINKs) in 2008 to also cover social care services). These bodies which consist of patient and public members have the role of monitoring and reviewing the services provided by NHS trusts. They gather views of individual patients, users and carers and make reports and recommendations on this basis back to their trust.

2.1.3 Professional autonomy

Having outlined the role of governance of the NHS, it is also important to acknowledge the influence of professional autonomy in the NHS and how this has altered in line with policy, thus impacting upon patient control. Autonomy has been stated as one of the key features of the medical profession (Ham, 2004). Baggott (2004) reflected that the power of clinical autonomy gave "doctors an advantage over both patients and other health professionals in clinical setting" (p. 47). Doctors traditionally have fought to retain their independence. This has posed a challenge for politicians who want to bring in change, whilst concurrently making

changes in resource allocation and so on (Ham, 2004). Only in the late 1980s were real attempts made by government to employ monitoring of standards and disciplinary procedures, which could remove or suspend doctors, and offered managerial control over consultant appointments (Baggott, 2004).

As Baggott (2004) outlined, “medicine has been organised by a range of self-governing institutions which take responsibility for education, licensing, the maintenance of standards and the representation of interests” (p. 40). Baggott illustrated the dominance of the medical professions over allied health professionals “which have successfully been excluded in the past by the orthodox medical profession” (p. 41).

There are also significant and powerful bodies which support the clinicians and influence policy. Not only do medical bodies serve to represent their members, but they can perpetuate the hierarchical traditions for the health professionals. Such bodies have included the Porritt Committee (medical profession) the British Medical Association, especially post-war (Baggott, 2004), the General Medical Council and the Royal Colleges of Medicine.

Medicine has been classically identified as the ultimate example of professional dominance by Freidson (1988). However, it has been suggested that medical dominance in the UK has experienced a slight decline in the past few decades (Harrison & Ahmad, 2000).

The nursing profession is the primary example of inequality in levels of autonomy. In terms of conflict between nurses and doctors the “latter has invariably dominated” (Baggott, 2004, p. 42). Baggott reported that it has been suggested that the status for nurses along with other healthcare professionals improved in the last century as a consequence of factors including registration and licensing. Significantly, however, this is seen not to have gone any way towards weakening the dominance of doctors (Baggott, 2004). Yam (2004) referred to a “transition of nursing from

vocation to profession...the essence of nursing has changed considerably,” but also that “the professional status of nursing remains elusive to many nurses” (p. 978) which clearly indicates that the shift in views towards this occupational group is one which is not complete.

There has been a major shift in that registered nurses do now undertake technical work which traditionally was performed by doctors (Iley, 2004). This is evidence to suggest that increased registration has removed barriers in practice for some professional groups. For example, recent years have seen a real shift in the traditional roles undertaken by healthcare professionals such as the development of non-medical prescribing (Cooper et al., 2008).

Education and development of professionalisation is something which has shifted since the inception of the NHS and which is intrinsically linked to the development of professional autonomy. Historically, much of the training and learning of healthcare students was hospital based, but this has evolved over time and the emphasis today is more upon theory and gaining status as a professional. Previously skills were learned through observation and practice, but today it would be expected that a healthcare provider is trained and qualified to carry out a particular procedure.

Colyer (2004) discussed the developments in healthcare professionalisation, and was somewhat cynical in reflecting the governmental motivation for such changes, whose impetus, it was argued:

“appears to have come from economic and staffing considerations exemplified by the new deal for junior doctors...reduced their working hours and created opportunities for nurses and others to fulfil roles previously undertaken by them. Shortly after, a number of high profile

reports were published which identified serious deficiencies in care delivery” (p. 406).

With an emphasis upon multidisciplinary teamworking and flatter hierarchies, modern NHS reforms have supported the professionalisation of healthcare professions. However, it could be argued that through insisting that all health carers are qualified professionals, this has the opposite affect as it creates a homogenous group of staff who are no different from one another, thus undermining the professionalisation process. As Parkin illustrated; “professionals become subordinate to the corporations for whom they work with consequent loss of expertise, status and power...challenging the experts is now seen as being normative rather than deviant” (Parkin, 1995, p. 565).

The structure and governance of the NHS has radically changed in many ways since its inception over 60 years ago. Despite such developments the complexity of the health service as an organisation and its uniquely political nature have ensured that it remains at the forefront of public debate and continues to challenge those who attempt to tame it. As Draper (1991) outlines, “the common jibe that the NHS is really the National Sickness Service” (p. 20), would best be addressed by approaching healthcare services hand in hand with public health (poverty, unemployment etc) in general.

2.1.4 Recent policy and reform: patient-centred care and patient involvement

The NHS Plan (Department of Health, 2000) set out how increased funding and reform aimed to redress geographical inequalities, improve service standards, and extend patient choice. The Plan outlined a new delivery system for healthcare, adaptations for social services, and changes for NHS staff groups. It also set out plans for cutting waiting times, clinical priorities and reducing inequality. Above all, the heart of

the NHS Plan outlined a vision of a service “designed around the patient” (NHS Plan, 2000, p. 10).

The NHS Plan was concerned with patient choice, information and involvement in the service. The Plan outlined an extension of the Expert Patient Programme aimed at capitalising on the common observation of patients with particular chronic diseases like diabetes, who often have greater understanding of their condition than clinicians. The concept revolved around empowering the patient and giving them more say and higher levels of participation in healthcare (Lilley, 2001). These patients’ knowledge and experience, assumed to be superior to that of the healthcare professional, was seen as an untapped resource (Department of Health, 2000).

The NHS Improvement Plan (2004) along with the range of plans presented since 2000 (including for example, *Shifting the Balance of Power*, (2002b)) have attempted to put into action the strategic directives indicated by the NHS Plan. Such government publications have focused upon placing patients at the heart of the NHS and giving greater authority and decision making power to patients and frontline staff. The plans have proposed new targets centred upon increases in workforce and new structures within both the NHS and the Department of Health which form part of a ten-year reform process (Department of Health, 2006c). However, there is a certain degree of scepticism relating to the viability of the NHS Plan itself. “As 2002 dawns, it is abundantly clear that the targets set in The NHS Plan and its subsequent implementation programme are not being met although Government would argue to the contrary” (Bradshaw, 2002, p. 1).

One view is this shift of the patient status from passive recipient to fuller involvement may be explained because of the extent of what they are prepared to do, “patients are more willing to complain and seek redress. They desire more information and increasingly use sources other than their doctor, such as the internet” (Baggott, 2005, p. 45). The biomedical

model of health is to a degree, being placed on the back burner in certain respects. The patient as a consumer or customer of a service or product is evolving (Colyer, 2004). The mindset of consumerism is one where patients' expectations are higher (Gray, 2008). However, the evidence to support appropriateness of this view, despite its popularity, requires greater attention. The extent to which this patient-centred service has actually been adopted in reality, and the degree to which patients are comfortable with the level of responsibility and choice which they are being presented with, have not been fully evaluated.

In 2006 two White Papers: *The Our Health, Our Care, Our Say White Paper* (2006d) and *The Choosing Health White Paper* (2006b) set out visions for reform to provide people with good quality social care and NHS services in the communities where they live, and principles for supporting the public to make healthier and more informed choices with regards to their health (Department of Health, 2006d). This is the political context within which the issue of re-engineering and development of hospitals has occurred.

The wealth of information to support the public making informed choices relating to NHS performance has grown exponentially. This ranges from ratings of hospitals achieved as part of national auditing processes undertaken by the Healthcare Commission, to more specific hospital metrics focusing upon data around waiting lists or performance on infection control.

A number of systems have been introduced in recent years to facilitate the development of the NHS in achieving the ideals of the NHS Plan, particularly in terms of patient choice. Choose and Book is a system whereby it is intended that patients have the option to choose where and when they visit a doctor. Choose and Book represents one of the government policies aimed at putting patients at the centre of care. This approach was based on the notion that the offer of more power and choice is what patients wish for. However, many clinicians' perception of

the system has not been supportive. In some cases, Choose and Book has been viewed by clinical staff to be unfair and limiting (Midgley, 2005, De Kare-Silver, 2005).

The remuneration system in the NHS has also experienced change. Payment by Results (PbR) was introduced in English trusts in 2004 with the aim of providing a transparent, rules-based system for paying trusts. PbR was viewed as a way of paying providers a fixed national price for each case treated, replacing block contracts and locally agreed prices (Godfrey, 2005). The intention was that PbR would reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Under the changed system, payment was linked to activity and adjusted for case mix. The aim of PbR was a fair and consistent basis for hospital funding, rather than being reliant principally on historic budgets and the negotiating skills of individual managers. The response to PbR has been mixed, with auditing of PbR having indicated a relatively high level of clinical coding error (Audit Commission, 2006).

Growing evidence supports the notion that the patient-centric focus of much healthcare policy is not necessarily as straight forward as it might appear, given the processes underlying patient and doctor relationships. This is a proposition which finds its literary roots in the classic work of Szasz and Hollender (1956). According to Szasz and Hollender's view, the interaction between patient and doctor may take the activity-passivity form, which bears similarity to the parent-infant relationship. Alternatively, it may take the form of guidance-cooperation where the doctor tells the patient what to do and the patient follows instructions. The third form of interaction is the mutual participation model where the doctor effectively helps the patient to help themselves. Parkin (1999) presents a taxonomy of collaboration and partnership between patients and professionals and a semantic hierarchy which is a useful guide to the wide range of interactions from shared ownership and 'citizen control' to 'manipulation' and neglect.

When referring to patient choice, involvement or patient-centred care there is a danger of policy or literature making sweeping statements which lack clear meaning or definition. The future strategic direction for the NHS was set out by Lord Darzi in his 2008 review of the NHS (Darzi, 2008). Darzi was careful to be specific in reference to issues of choice or public involvement. Darzi highlighted the importance of: extending the choice of GP practice, ensuring wherever it is relevant to them that patients are able to make informed choices, the introduction of personalised care plans for those with long-term conditions (agreed with a named professional), piloting of personal health budgets and access to the most clinically and cost effective drugs and treatments. The focus here is upon empowering patients with the aim of improving quality, in conjunction with empowering staff.

Darzi summarised the importance of achieving an NHS which provides patients and the public with both more information and choice, but that most importantly has quality at its heart. Darzi noted the call for a greater degree of control and influence over health and healthcare, but he specifically distinguished with respect to this “If anything, this is even more important for those who for a variety of reasons find it harder to seek out services or make themselves heard” (p. 9). This is an indication that placing the patient at the centre of care should occur in a collaborative manner and one which is driven by clinicians. It should be focused upon patients who are willing or able to be more collaborative in terms of healthcare. However, in practical terms, fears have already been expressed in reaction to Darzi’s report over where the financial resources for the plans he outlined will come from (Tiwari, 2008).

2.1.5 Approaches to service redesign

Throughout the evolution of the NHS, initiatives based on policy and reform aimed at improving the quality of service provision have been observed. The NHS has experienced phases of redevelopment and

service redesign based on a range of strategic approaches, and in the context of the contemporary political climate. Often such methodologies have had a history of being successfully applied in industry outside of the healthcare sector, where this learning has then been transferred to the NHS.

Total Quality Management (TQM) is one such approach which emerged in the 1950s and 1960s, originally in manufacturing in Japan. By focusing upon new management approaches, service quality in Japan became regarded as the best in the world (Øvertveit, 2001). These management processes were differentiated by the creation of a 'culture' (Tuckman, 1994). This notion of a culture was one which supported the pursuit of excellence and of valuing all employees. TQM placed much emphasis on the approach that continuous process improvement could be applied using data. Using TQM to achieve the pinnacle of an organisation-wide shared belief in total customer satisfaction required pervasion across every aspect of the organisation (Taveira et al., 2003).

TQM initiatives in the public sector have experienced an upsurge in the last couple of decades (Taveira et al., 2003, Saint-Martin, 2001, James, 1997, Li, 1996, Quist, Skalen & Clegg, 2007, De Bondt & Zentner, 2007). Examples of this in relation to healthcare can be found in the application of the Baldrige Award framework for managing quality in healthcare which has been associated with 'traditional' TQM (McAdam et al., 2008). This is in addition to a range of initiatives which have emerged for application within organisations to improve performance (Hasin, Seeluangsawat & Shareef, 2001) and in direct response to increased public awareness and accountability.

One key aspect of TQM is the Japanese concept of 'Kaizen' (otherwise known as rapid improvement exercises). Øvretveit (2001) has illustrated how Kaizen relates to the continuous improvement of work processes as a means of responding to the customer's expectation. These Kaizen events or rapid improvement exercises would be an organised team effort

to improve reliability of a process, streamline a process, or rapidly implement or re-layout a work centre (Harms, 2007). There is a perspective from some sectors of the literature that Kaizen and TQM more generally fail to fully consider employee satisfaction during the search for continuous improvement (Hoque, 2003). Hoque also suggests that whilst TQM is effective in certain contexts from an organisational perspective, because of limitations from an employee's view, it may not be the most appropriate philosophy for staff. Additionally, there is a weakness in the lack of evidence relating to the notion that non-financial performance measures have any impact on financial performance for organisations within a TQM framework. This is particularly relevant to an NHS which has suffered continued financial challenges. Generally the results of the application of TQM to redesigning healthcare have been fairly mixed (Ham, Kipping & McLeod, 2003).

An example of an approach to service redesign which has emerged more recently in alignment with the TQM movement is the concept of Lean thinking. Lean originally developed from improvement of the processes involved in production of manufactured goods and services (Ben-Tovim, 2007). Lean was also pioneered by the Japanese manufacturing industry, in particular by the Toyota Company (Womack & Jones, 2003, Womack, Jones & Roos, 1990) and has seen some growth in popularity in the healthcare sector.

However, whilst Lean management has a track record of being applied successfully in the private sector particularly in manufacturing (Womack & Jones, 2005), the approach has been less frequently applied in the public sector. There is limited empirical research evaluating success of transference or impact on productivity or service quality (Radnor et al., 2006). Whilst application of the model to healthcare has become increasingly popular, Lean had not commonly been applied on a hospital-wide basis prior to 2005 in the UK (Fillingham, 2007). Much of the literature supporting Lean remains purely descriptive (see Balle & Regnier, 2007), or is mainly developmental in nature (see Radnor &

Walley, 2008). Therefore, whilst it is relevant to note the emergence of the Lean philosophy, it is also important to acknowledge the difficulty in critiquing the methodology. Furthermore, Lean is beyond the scope of this research, and emerged in healthcare after the inception of the hospital redevelopment project at the centre of this research.

Total Quality Management (TQM), is structured around initiatives that have emphasised incremental improvements over an open-ended time period (Patwardhan & Patwardhan, 2008). In contrast to this, and following closely in the wake of TQM (Ham, Kipping & McLeod, 2003) is the philosophy of Business Process Reengineering (BPR), the key text for which was written by Hammer and Champy (1993). BPR tackles defined, discrete initiatives to redevelopment and improvement of work processes within a defined time frame. Bowns and McNulty (1999) defined the characteristic feature of BPR as “the radical redesign of all of the key processes or systems of an enterprise, with implementation leading to discontinuous improvements in service or product quality and cost effectiveness” (p. 5). In the 1990s BPR came to prominence as a means of transforming health services (Powell & Davies, 2001). Learning from this concept was drawn upon by the redevelopment programme focused upon in this research.

Some BPR protagonists assume that healthcare systems and practices are flawed and need replacing (Patwardhan & Patwardhan, 2008). There is a large volume of evidence relating to the use of BPR and of BPR having been used within specific healthcare services. These have included programmes with the goal of increasing the amount of time pharmacists spend providing pharmaceutical care to patients (Al-Shaqha & Zairi, 2000), scheduling of operating theatres through tracing patient pathways from referral to discharge (Buchanan & Wilson, 1996), and in Day Surgery (Corlett, Maher & Sidman, 1998). Additionally, BPR has been used on a larger scale to achieve whole systems redevelopment of hospital services (Anderson et al., 1996).

The two key demonstrative case studies of application of BPR on a cross-organisational scale come from pilot studies at King's College Hospital (KCH) (Packwood, Pollitt & Roberts, 1998) and Leicester Royal Infirmary (Bowns & McNulty, 1999, McNulty & Ferlie, 2002).

Packwood, Pollitt and Roberts (1998) evaluated the impact of a business process reengineering inspired project which took place at KCH. The situational context within the hospital was relevant to the change attempt. The hospital was experiencing a period of uncertainty (as was facing many equivalent hospitals) over the potential impact of the internal market which was emerging at the time. As a consequence of this anxiety, the levels of clinical support towards the proposed change programme were improved. Packwood, Pollitt and Roberts found that the initial enthusiasm for whole systems change evolved into focusing upon more realistic targets for change. The results of the evaluation indicated that it proved very difficult to make real change quickly. The responses of staff, therefore, to the change programme were variable between services and success was more apparent within services which were coherent, with less interfaces with other services and which had concise and clear objectives. The report from Packwood, Pollitt and Roberts documents for example, the difficulties faced by some senior level managers who struggled to maintain the time commitment necessary for the change programme over a long period.

McNulty and Ferlie (2002) provided a detailed account of a business process reengineering programme which took place at the Leicester Royal Infirmary, drawing parallels with respect to the context and objectives of the changes outlined above which took place at KCH. The impetus for Leicester Royal Infirmary was pressure to achieve impressive performance targets whilst maintaining the support of the clinicians. McNulty and Ferlie describe the contributory conditions supporting the implementation of the change programme which included stable top-level leadership and a developed pattern of cooperation between managers and clinicians. However, the authors go on to detail how the impact of

the BPR change was more variable than might have been predicted. Specifically, the process of change had been contested and results were inconsistent between services. The reason given for this inconsistency was that doctors had retained a large degree of control over work practices which had been difficult to shift over a short space of time. In fact medical dominance was apparently still observable and un-shifting during the BPR programme.

McNulty and Ferlie also reflected upon the impact of context on attempting and achieving change, including the role of assumptions and the range of preconceived ideas towards change programmes from staff which spanned from perceived threat to opportunity. The complexities of NHS political power appearing to have shifted from the Cabinet Office to the Treasury were reported as significant in understanding the climate within which redevelopment of hospitals was embarked upon. The growth in the role of audit and regulation such as the introduction of National Service Frameworks and the role of the (subsequently disbanded) Commission for Health Improvement were also examples of factors influencing attempts and results of hospital redevelopment

The vast literature regarding BPR has resulted in assessment of the progress of the methodology being less than straightforward (McNulty & Ferlie, 2002). Criticism has been raised of BPR relating to some of the problems experienced during programmes of redevelopment at hospitals which had applied the approach. Findings indicate that success depends on senior level leaders playing a fundamental role in the process (Guo, 2004), that introduction of change from a top-down approach is limiting, particularly without engagement of physicians (Ham, Kipping & McLeod, 2003), and that such large scale change can be a costly risk (Davies & Walley, 2000) . What has become clear from the evidence relating to BPR is that such attempts must take account of the range of potentially influencing factors such as different professional groups and organisational sub-units. The reengineering of business processes

requires an appreciation of people behaviour and culture (Al-Mashari & Zairi, 2000).

2.2 Culture

Irrespective of which philosophical approach has been taken, the success or failure of the continual redevelopment of the NHS has been entrenched in culture. Whilst academics continue to debate what constitutes organisational culture, (Davies, Nutley & Mannion, 2000) definitions fairly consistently encompass aspects of shared assumptions, beliefs, values, norms and actions. Culture is an acquired body of knowledge of how individuals behave, shared symbols and meanings, both tangible and intangible which exist in all organisations.

Inattention to social systems in organisations in the past has led researchers to underestimate the importance of culture in how organisations function (Schein, 1990, 1996). Deciphering patterns of interacting elements is fundamental to understanding what culture is. Importantly, the forces that matter in culture are not easy to categorise into typologies due to the fact that they are organisationally unique (Schein, 1990, 1996).

“Culture is the pattern of shared basic assumptions that the group has invented, discovered, or developed in learning to cope with its problems of external adaption and internal integration, and that has worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.” (Schein, 1985, p. 9)

“Anyone who has spent time with any variety of organisations, or worked in more than two or three, will have been struck by the differing atmospheres, the differing ways of doing things, the differing levels of energy, of individual freedom, of kinds of personality. For organisations are as different and varied as the nations and societies of the world. They have differing cultures – sets of values and norms and beliefs – reflected in different structures and systems. And the cultures are affected by the events of the past, and by the climate of the present, by the technology of the type of work, by their aims and the kind of people that work in them.” (Handy, 1993, p. 180)

“The culture metaphor points towards another means of creating organised activity: by influencing the language, norms, folklore, ceremonies and other social practices that communicate the key ideologies, values and beliefs guiding action.” (Morgan, 1986, p. 135)

These statements broadly reflect the essence which underpins or illustrates culture from the core theoretical perspectives, namely; culture as invented and developed by a group, culture as systems and structures and culture and organised activity. Fundamental to gaining an understanding of the concept, it is through organisational culture that an appreciation of the working world around is reached, and meaning apportioned to organisational experiences (Brown, 1998). Concern has been expressed with regard to the over usage of the term culture, to the point that it may be viewed as “analytically empty” (Savage, 2000, p. 230). The approach taken in this thesis reflects upon organisational culture in its broadest sense.

Whilst it remains a complex and elusive concept, interest surrounding organisational culture in the NHS is unremitting. Culture can also have a dramatic effect on efforts to change specific procedures or processes within an organisation (Boan & Funderburk, 2003). Many previous policy

reforms in the National Health Service have invoked the notion of cultural change (Davies, Nutley & Mannion, 2000). The evolution of the NHS, its policy, reform and governance are all intertwined with the culture of the organisation. It is in this respect particularly that the NHS is uniquely challenging.

2.2.1 A background to organisational culture

The popularity of analysis of organisational culture is something which can be traced back to the latter part of the 20th century. At this time, addressing the underestimation of the importance of culture in how organisations function began in earnest (Schein, 1996). It has been suggested that there is such a diversity of approaches and definitions of culture, partly as a result of the overlapping intrigue in culture from several disciplines including anthropology, sociology, social psychology and organisational behaviour (Schein, 1990).

Brown (1998) made the distinction between what he viewed as the two basic definitions of perspectives of culture. Firstly, were those who viewed culture as a metaphor to help understand how organisations work (for example Morgan, 1986). Secondly, was the more common perception that culture was an objective entity. This approach was split into looking at the organisation as a whole, or looking at the organisation as a set of behavioural and or cognitive characteristics (for example Schein, 1985). Smircich (1983) also made a distinction between two common branches in the approach to organisational culture. The two can be identified as what the organisation 'has' and what the organisation 'is' (Mannion, Davies & Marshall, 2005).

Davies et al. (2000) scrutinised the conceptualisation and analysis of organisational culture. They viewed much of the management literature as prescriptive advice aimed at organisations which assumes that "cultures are an attribute of organisations that are open to manipulation" (p. 112). The interest in organisational culture is something which has

continued to stimulate much debate as a significant shaper of organisational behaviour. This popularity is something which has been fuelled by analysts hoping to apply cultural knowledge to effectively manage organisational conflict and change (Forsythe, 2005). Explaining varying performance in organisations has also been believed to be facilitated through study of culture through the reflection and application of the various approaches (Brown, 1998). This positive view of culture should be balanced with the converse argument that organisational culture can also be an encumbrance, which may conflict with the business or ethical needs of the organisation (Sathe, 1985).

2.2.2 Expressions of culture

There are a variety of classic expressions and models found from within the academic field which address culture. One of the most popular protagonists is Schein, who asserted that culture exists on three levels. Schein's first level relates to artefacts which are visible structures, for example physical objects or the written aspects of culture. This according to Schein (1999) was the easiest level to observe within an organisation. It included everything that "you see, hear and feel as you hang around" (p. 15). The notion of artefacts encompassed one's observations to one's own emotional reactions to being in an organisation, based on how people behaved towards one another.

Schein's second level of culture is espoused values. These values govern artefacts, such as strategies, goals and documents describing a company's values. It was, according to Schein, important to ask deep questions particularly about things which were unexpected or puzzling. It is likely that espoused values are not actually employed in practice. The final level of culture is that which defined whether or not an organisation truly supported what it said it did at the deepest level; the basic underlying philosophies. These philosophies are unconscious, taken for granted beliefs and it was, according to Schein, only by examination at

this deeper level that organisational culture could truly be understood (Schein, 1985, 1991b).

Culture is deep seated and complex, change is difficult due to basic underlying assumptions acting as a cognitive defence mechanism which once established is stubborn to change. The implications for this upon leaders attempting change are significant. Leaders must always be open to culture change in order for others to be able to embrace it (Schein, 1991b). Dialogue is necessary for understanding organisational subcultures (Schein, 1993). Schein stated that culture is a result of learning in a group and so will only be found where there is a definitive group which has a considerable history. Schein (1990) concluded that culture is the property of the group and is what that group has learned over a period of time. Despite acquiring broad support (Davies, Nutley & Mannion, 2000), Schein's work has received some criticism for being too integrative, as culture is continually changing (Meyerson & Martin, 1987).

Handy (1993, 1989) proposed a straightforward framework for categorising culture which was based upon a reworking of the ideas of Harrison (1972). This approach makes references to Greek mythology and proposes four main types of organisational culture: Power, Role, Task and Person. Handy has highlighted that individuals will probably not be able to identify themselves completely with any of the four, and that similarly, organisations will probably include aspects of all four of the cultures.

The Power culture is structured best as a web, where the organisation's culture depends on a central power source which spreads out and influences from that central figure (the "spider" in the web). Connection is through functional or specialist strings but with the power rings being the centres of activity and influence. Communication is dependent on personal conversation, whilst effectiveness depends upon trust (as faith is placed in the individual), and empathy. If the central figure chooses people correctly, they can be left to get on with the job. Handy (1993)

has indicated that potential problems may arise with size in power cultures. The web can break if overstretched and the only way to grow and remain a web is by “spawning other organizations, other spiders” (p. 184). There are few rules and little bureaucracy. These cultures tend to be proud and strong. However, some organisations with power cultures are tough or abrasive and can be as bad as they are good.

It is recognised that the Role culture works by logic and rationality. Such cultures tend, according to Handy, to be stereotyped as bureaucratic, based on functions, departmentalised and co-ordinated by a narrow band of senior management. As the name suggests, the role a person plays is more important than who it is performing a particular function, often a range of individuals could fit. Performance beyond expectation of a role is not required and may even at times be disruptive. Communication tends to be via committees, rules and job descriptions. Position is the main power source and personal power is frowned upon, expert power is tolerated only in its proper place. Role cultures are, according to Handy, slow to change even if the need is seen.

Task culture is said to be job or project orientated and emphasises getting the job done. This culture has been represented by Handy as a net, where some of the strings of the net are stronger and thicker than others. A significant amount of power and influence resides in the ‘knots’ of the net. Emphasis is based more (although not completely) on expert power than position or personal power. In task cultures, the influence tends to be more dispersed – a team culture. Handy has stated that these cultures tend to be very adaptable. Individuals have higher levels of control over their work which is judged by results. There are “easy working relationships within the group with mutual respect based upon capacity rather than ego or status” (Handy, 1999, p. 188).

Person culture is the least common. The individual is the focal point in organisations with a person culture. The structure of such a culture is as minimal as possible, and has been termed by Handy as a ‘cluster’. The reason for so few organisations having this culture is that it does not

invite objectives or allow for control mechanisms (except by mutual consent). Influence is shared. Hospital consultants would fit into this culture type.

Handy's four types of culture framework is generally referred to as an accepted approach in a number of publications relating to organisational culture (Mannion, Davies & Marshall, 2005, Brown, 1998, Pheysey, 1993). However, Watson and West (2001) identified the potential flaw in Handy's approach and the assumption that change is a linear process which can be directly controlled and managed. Watson and West's study captured the flux and unpredictability so characteristic of the context (a residential child care staff in a large Scottish local authority) which was experiencing considerable changes in working environment which did not adhere to Handy's theory.

Deal and Kennedy (1988) suggested that "the biggest single influence on a company's culture is the broader social and business environment in which the company operates. A corporate culture embodies what it takes to succeed in this environment." (Deal & Kennedy, 1988, p. 107) Therefore, culture would tend to reflect how a particular organisation responded to the market place. The approach to culture taken by Deal and Kennedy was based upon their examination of hundreds of organisations. From studying these organisations, Deal and Kennedy developed four typologies of culture: the tough-guy macho culture, the work hard/play hard culture, the bet your company culture and finally the process culture.

The tough-guy macho culture is defined as a world of individualists who often take significant risks at work and search for quick feedback on their actions, and Deal and Kennedy give examples of which types of professionals would fall into this category:

"...the most gruelling of all business cultures. Police departments are the essence of this type of culture since the

stakes are often life and death. The same is true for surgeons”
(Deal & Kennedy, 1988, p. 108)

Fun and action are the key aspects of the work hard/play hard culture. In order to succeed in such cultures a high level of lower-risk working activity is encouraged. For example, a company which needs to be able to sell a non-branded product would develop this type of culture to maintain the momentum of the sales team. The bet-your-company culture tends to mean high stakes decisions where feedback may take years in this high-risk environment. This would tend to be companies who spend a great deal of research and development money on something before knowing the final outcome. The fourth type, process culture, sees little feedback if any and workers are not able to easily measure what they do; rather they concentrate on how it is done. Individuals who are likely to thrive in this type of culture are punctual and organised. Deal and Kennedy (1988) have pointed out that when this type of culture gets out of control it becomes a bureaucracy.

Deal and Kennedy (1996, 1983) saw cultural rather than rational factors playing an increasingly more important role in the functioning of organisations. They argued that every organisation has a distinctive culture that has evolved through trial and error and that includes shared values, heroes (story-tellers and stories) that embody these values, and symbols which have significant meaning to the people who work there.

There are clearly some parallels between Handy’s ‘Person’ culture (Handy, 1989), with its minimal structure and focus of the individual within the culture, and the tough-guy macho culture of Deal and Kennedy. The placement within the four typologies, of surgeons in the tough-guy macho culture is interesting, considering the authors also indicate that the:

“...intense pressure and frenetic pace of the culture often burns people out before they reach middle age. The all or

nothing nature of this environment encourages values of risk-taking.” (Deal & Kennedy, 1988, p, 109)

The level of risk and potential burnout Deal and Kennedy outlined in surgeons is something which warrants further consideration in relation to the implications for quality and safety of patient care.

Deal and Kennedy’s definition of culture has regularly been utilised as a point of reference by many other researchers looking at the area of organisational culture (Brown, 1998, Zollers, Ramanathan & Yu, 1999, Silvester, Anderson & Patterson, 1999, Lomas, 1999, Lewis, 2002, Chapman, 2001, Nahm & Vonderembse, 2002).

The correlation of 'strong culture leads to good performance' promoted by Deal and Kennedy has not always been supported in its entirety. Evidence from Scott et al. (2003b) showed a more uncertain relationship, in that those aspects of performance valued within different cultures may be enhanced within organisations that exhibit those cultural traits. Ideas about the importance of strong, homogeneous cultures in healthcare have also been rejected elsewhere (Davis, 1996). There is, however, limited research beyond this which empirically examines the application of the four typologies of culture proposed by Deal and Kennedy.

Assessment of organisational culture has been tackled in various ways. Correlations are made by researchers between strong culture and performance and so naturally, various approaches to the assessments of culture have evolved. Whilst not the main focus of this research, it is important to acknowledge the literature on this topic. Techniques have ranged from the general approaches to named instruments utilised in the measurement of culture. Non specific tools have included interviews and questionnaires which may be useful to form an impression of beliefs, values and attitudes (Brown, 1998). However, they are also time consuming, labour intensive and subjective (Brown, 1998). Schein

(1999) also argued that cultural questionnaires were unable to reveal cultural assumptions as they were unable to ask the right questions, and that asking individuals about a process which is shared was fruitless and invalid. Specific tools amongst many others, includes the Competing Values Framework (CVF) which although supported for its face validity (Mannion, Davies & Marshall, 2005) is said to have a narrow classification of organisational types (Scott et al., 2003a).

Traditionally, organisational culture has been focused upon commercial businesses contexts. However, consideration of culture in other organisational settings, particularly in the public sector, such as education and the health service, is growing, as reflected in more detail in the following section.

2.2.3 Organisational culture in the NHS

A series of scandals has forced issues of quality and improvement to the forefront of UK NHS policy (Davies, Nutley & Mannion, 2000). Fostering cultures of excellence are said to be critical to this improvement, but as the authors pointed out, this is a recurring issue which has appeared in various guises. In order to be able to move forward in practical terms, Davies et al. (2000) argued that the distinction of culture was crucial. However, it is clear that exploring aspects of culture is not easy (Stanley & Swann, 2005). Cultural change in healthcare faces many difficulties (Worthington, 2004). The complexity of culture and lack of consensus has led to an unresolved status which continues to pose complications and raise challenges:

“...if culture is something that an organisation has, then it may be possible to create, change, and manage culture in the pursuit of wider organisational objectives. However, if organisations simply are cultural entities, then their study may help us to understand the processes of social construction at work but offers less in terms of shaping change or assisting

with management control.” (Davies, Nutley & Mannion, 2000, p. 112)

Despite academics’ battles to clarify issues of culture, the experience of healthcare professionals on a day to day basis leads them to being entrenched in the culture of their workplace. In order to successfully propagate change in organisational behaviour, an understanding of the collective thought processes informing that behaviour is required. This is where a deeper analysis and understanding of organisational culture may be productive (Scott et al., 2003b). Professor Halligan, former Deputy Chief Medical Officer for England with overall responsibility for the quality agenda, made the following statement whilst giving a lecture to members of staff from the Royal Liverpool Children’s NHS Trust, recognising staff’s familiarity with the concept of culture:

“I have come to believe, more clearly than ever before, that achieving excellence in the NHS is about establishing the right culture, and about finding the leadership necessary, at all levels, to foster it. When I said these things I felt that they had real resonance [with the audience]; that I was articulating ideas already familiar from their experience.” (Halligan, 2003: taken from website)

This statement from Halligan reflects the fact that professionals working in the NHS are already aware of the importance of a culture to providing the best service possible. This is despite the fact that service shortcomings continue to occur. Kennedy (2001) in the Bristol Royal Infirmary Inquiry, a seminal report on the failings of the organisation and people in relation to children’s heart surgery at the hospital, placed NHS culture at the centre of patient experience. This report also highlighted how in the NHS, cultures, for example, of nursing, medicine and management are so distinct and internally closely-knit.

Kennedy surmises that his report is:

“an account of a hospital where there was a ‘club culture’; an imbalance of power, with too much control in the hands of a few individuals. It is an account in which vulnerable children were not a priority, either in Bristol or throughout the NHS.” (p. 2)

This statement is important as it clearly indicates that the issues faced, though identified there, were not unique to Bristol but apply to the NHS as a whole. This consideration of balances in power and different roles has particular resonance in the light of current NHS developments which are seeing the roles of staff evolve. For example, the increase in nurse practitioners or GPs with a special interest (GPSIs), and the potential implications of such for service delivery and impact upon the patient. Heiskanen (1988) has also illustrated that work culture is related to how challenged staff feel at work within different types of hospital.

Fulop et al. (2002) and Fulop et al. (2005) have illustrated how perceived differences in organisational culture were an important barrier to bringing together two or more organisations where hospital mergers take place. The merging of hospitals is not uncommon and there may also be some parallels with redevelopment programmes where aspects of independent services are brought together.

Patient experience potentially may be negatively affected well before an event as serious as that at the Bristol Royal Infirmary arises. In the wake of Peters and Waterman's (1984) work few NHS managers are unaware of culture management as a tool for shaping organisational change (Davis, 1996). However, exposure to cultural variations between and within hospitals not only impact NHS staff. There is evidence in the literature that cultural variations can have real impact upon the type of experience the patient has during their time within the hospital (Carter, 1994). The implications are that the effects of culture reverberate at all

levels and may be far more subtle than some of the more highly publicised cases.

Given the complexity within the NHS; the range of professional groups (management, nursing, doctors etc), the individual clinical services, the interactions of the various trusts, the interplay of clinicians with the patients, and the overarching control of government, understanding the culture(s) within the NHS and their impact on any change are daunting. However, as Parkin describes:

“There are...robust arguments that practitioners who plan to implement change must pay close attention to understanding the strength and character of their prevailing organizational and professional culture to determine what actions, initiatives and outcomes are desirable and possible.” (Parkin, 2009, p. 115)

The following section will, therefore, address the literature in this area, from three main streams of NHS work cultures: management, nursing and medical culture.

2.2.4 Management culture

A need for change in culture within the NHS was outlined by the now disbanded Modernisation Agency's Pursuing Perfection document (2004). Here, change in culture was referred to as critical for improving quality of care. This approach endorsed culture which had a new patient-centred approach, empowered staff and sought out new evidence to learn from failure. This, along with the plan for reform identified in the NHS Plan (2000) is clear indication that the government felt some pressure to make improvements to service delivery. Given the developments brought into force in the wake of the Griffiths Report (1983), the position of management, its culture and the relationship with clinicians became highly pertinent.

Savage (2000) has been far more cynical in approach to the conceptualisation of culture, arguing it has been used as a tool of manipulation, "to validate the imposition of values and beliefs by management" (Savage, 2000, p. 230). This perhaps implies a more devious utilisation of the term culture in relation to healthcare, which has no apparent patient focus. With so many government reform papers and inquiry reports, if correct, this manipulation is occurring on a grand scale. Savage's work also made clear not only are management cultures themselves of significance in relation to healthcare, but so too is the application of the term itself within this professional groups' culture.

Worthington (2004) has also indicated that as a result of recent government reforms there has been a shift in the role of NHS management, but without offering such a negative interpretation:

"Prior to the Griffith Inquiry in 1983, the main function of management in the NHS was to provide support for nurses and doctors...following the Inquiry, NHS management was to play a much more active part in planning, decision making and cost

control over the use of resources and the training and development of healthcare professionals...their responsibility today is to work with, not for, doctors to help modernise the NHS...This clearly amounts to a radical departure from the traditional organisational frameworks and working practices within healthcare.” (p. 57).

It has been suggested that the cultural change for the NHS promoted in government policy reforms has not translated to the organisational context (Currie, 1997). This view implies that attempts at manipulation by management are either failing or being rejected outright. Currie suggested the reason for this failure in application was a mismatch between the expectations and desires of managers who are the participants in the management development programme and other stakeholders in the process, such as those facilitating it. This is perhaps no surprise as friction between medical staff and management has been apparent for some considerable time (Drife & Johnson, 1995).

Some of the tensions between professional groups in the past centred upon clinical governance and focused on the view that as clinicians are at the core of clinical work, they must be at the heart of clinical governance. There has been some recognition of the importance of an appropriate balance as “central to re-establishing ‘responsible autonomy’ as a foundation principle in the performance and organisation of clinical work” (Degeling et al., 2004, p. 679), suggesting the direction of any resolution.

Some attempts at altering the culture from management downwards within hospitals have been made. TRAIL, a model developed within Leicestershire Partnership NHS Trust's City Adult Mental Health Services, reported by Armitage (2005) is an example of such an attempt. The aim was to facilitate

incident reporting and active learning from adverse events. The model provided the service with a framework for identifying how lessons learned could be shared to raise awareness of individual and team responsibilities for maintaining safer services. The Trust successfully implemented a risk management strategy that encouraged staff to report adverse events, but as the paper highlighted, this had not guaranteed that all staff were aware of why incidents should be reported, and that efforts to progress away from the 'blame culture' continued to pose a challenge. This article indicated that despite identification and acknowledgement of factors which, (as in the case of the Bristol Inquiry), have potential to ultimately adversely affect patients, making improvements to 'blame culture' was a complex task. This was a task which despite some degree of change was still a long way off (Lilleyman, 2005).

However, whilst much of the literature endorses approaches to attempting change, there is a contrasting perspective that caution must be applied when considering cultural change, (Holland, 1993, Freshwater & Biley, 1998). For example, there is potential danger in the assumption that change of culture is beneficial. This is particularly the case in the context of what is a strong but ineffective culture where it is apparent that strong does not equal good and change is not always best:

“...conscious removal or significant change to a ceremony, such as the early morning drugs and drink round, or closure of the porter's pool, holds more than token significance. It is symbolic of wider change as it weakens the reinforcing mechanisms that maintain existing ways. Managers have to reconcile the potential unknown effects of removing or manipulating ceremony with the preserving and reinforcing effects of their remaining in situ” (Brooks & Brown, 2002, p. 348)

In their study from the US Meterko, Mohr and Young (2004) indicated a significant and negative relation between bureaucratic culture and patient satisfaction for inpatient care. This adds weight to the argument that where management forces staff to 'jump through hoops' to fit the values of the culture, this can adversely affect the patient. Gerowitz et al. (1996) found in an international study, that political economy influences the distribution of culture types in healthcare. The dominant cultures of the hospital management teams studied were positively and significantly found to be related to organisational performance.

There has been some sympathy for and recognition of the trend that NHS managers are in an unfortunate position and have in the past been easy scapegoats for any blame relating to change:

“The system of health service delivery creaks under the weight of Government reform and when things go wrong there is one particular target group to blame: that is NHS managers who are already reeling from target fatigue arising from the volume and pace of the current reforms” (Bradshaw, 2002, p. 1)

Goodwin (1996) proposed that clinicians utilise a coping strategy whereby they project unacceptable aspects of themselves into managers and that managers develop defensive social structures involving projection into clinicians. Goodwin argued that current NHS culture exacerbated the reliance on these defensive structures, resulting in particularly difficult collaboration problems between clinicians and managers, but significantly, in increased anxiety for those who occupy the dual role. This is particularly relevant to those doctors who have such roles, and may have implications for future approaches to managerial structures.

2.2.5 Medical culture

Dent (1995) indicated that it has been doctors, and not 'higher' powers, who have most control, including for example budgetary control. Dent described how not only in the UK, but also US and European literature suggests the dominance held by doctors in influencing the structure and provision of healthcare services:

“within the NHS, many hospital consultants have been incorporated within the new organizational arrangements as clinical directors, thereby avoiding erosion of their status whilst at the same time changing their professional role within the hospital” (Dent, 1995, p. 881)

There is a contrasting view in the literature which argues that medical dominance in some services may be fracturing in part as a result of the managerial reorganisation of the health service (Samson, 1995). However, there continues to be a clear supposition from the literature that inclusion of managerial status has increased the power consultants have:

“In theory...NHS management [has been taken] from a relatively subordinate to an essentially superordinate position in the organisational structure of the NHS. In reality, however, this is not the case. The UK health services are steeped in a tradition dominated by the medical profession, which is evidently reluctant to relinquish the power of its position within healthcare” (NHS Confederation, 2002) (as cited in Worthington, 2004, p. 57).

Jorm and Kam (2004) reflected that aspects of medical culture are antagonistic to improvements in quality. This is further indication of how entrenched culture in the NHS appears to be in favour of control for senior

doctors, and that the implications for the service overall are not necessarily positive. Research in the field has indicated that by reducing the level of medical dominance it might be possible to encourage the contributions of all team members working in a clinical setting, and thus enhances patient care (Gair & Hartery, 2001). This is supported by the popular view of consultants 'owning' their beds in hospital, and having complete control which they may be unwilling to relinquish to others, the cost of which not always being clear. "For too long now there has been a climate of fear and intimidation within the NHS, which has led to consultants being treated like 'gods.'" (Meehan, 2000, p. 3). Kennedy (2001) makes it clear the current medical culture has an imbalance of power "Consultants enjoyed (and still enjoy) what is virtually a job for life. Their relationship with the trust that employs them makes it difficult to bring about change." (p. 3). The fact that consultants work alone for periods of time is likely to have an impact upon their autonomy and culture.

Concerns have been expressed within the medical profession about attempts to resolve issues with a colleague's performance, where blame culture is rife. Beecham (1998) and Faugier and Woolnough (2002) have both highlighted some gaps in this respect. Medical culture has not been particularly conducive to expression of concern about others' performance. Beecham (1998) also indicated that trainee doctors fear victimisation and that self-regulation must be taken seriously by all. Whilst there is some recognition of this need to be able to reduce the barriers posed by culture, there is also an acknowledgement that this can be successfully achieved by working with the existing strengths of individual cultures to attempt to address problems (Carroll & Quijada, 2004).

Waring's (2005) paper explored attitudes of medical doctors towards adverse incident reporting in healthcare. It was recognised that there were major barriers to medical reporting, including the 'culture of blame'. This

comes despite the UK government and doctors' agreement to end 'blame culture' (Wise, 2001). The findings suggest that blame does impede medical reporting, but other cultural issues were also significant. For example, discouragement by anti-bureaucratic sentiment and rejection of excessive administrative duties were identified. Doctors indicated they were apprehensive about the increased potential for managers and non-medics to be involved in the regulation of medical quality through incident data. The paper argued there was a need to address the 'culture of medicine'. This two year qualitative case study in the UK, based on 28 semi-structured interviews is clear evidence for the unique culture of the medical profession, with clear tension between management.

Whilst it would appear that much of the literature relating to medical culture suggests doctors hold the most power, less attention has been paid to how medical culture has altered as a consequence of the change in patient responsibility, involvement or choice. It is also important to note the potential variation between subcultures not only within medicine, but also the various professions working within a hospital. The reality of the situation within which doctors find themselves is likely to be one where any autonomy they do hold can only operate within the restricted framework of various regulatory body approvals such as NICE or managerial allowances and what the trust has finance for.

2.2.6 Nursing culture

Traditionally, nurses have been seen as subordinate to doctors. For some time scholars have called for changes in nursing in order to address the "subjugated position of nurses within health care" (Robinson, 1995, p. 65). Attempts have been made to change this perspective. Moving the nursing culture from one of co-dependence to one of professionalism was regarded by Berger et al. (1999) as crucial to achieve state-of-the-art patient care, so it

is necessary that it is considered in context with the attempts to reform the NHS. With emergent roles such as nurse consultants and nurse practitioners there is some evidence of changes beginning to happen within the NHS in this respect. It is worthy of note that issues of working culture for Allied Health Professionals does not receive the same level of attention within the literature as nursing, medicine or managerial groups.

Bolton (2004) discussed how nurses, as the largest occupational group within the NHS, have attracted considerable management attention. Bolton reflected how the task of changing hospital culture and making service provision more efficient in relation to controlling nursing work has been accounted for in two distinct ways. Firstly, that it is firmly in the hands of hospital management, and secondly that cultures have been successfully orientated towards consumer care and that talk of 'quality' is achieving some success as a control device. Bolton showed how nurses have developed ways of reinterpreting management's desires but argued "management is likely to continue to rely on nurses' traditional autonomy in the delivery of health care in recognition that nurses may resist some but accommodate many of the demands made of them" (p. 317).

It has been reported that the long hours being worked by senior nurses was indicative of a 'presentism' culture, something viewed as detrimental, in which staff believed they had to be seen to be present (Lipley, 2006). This is something which is in stark contrast to the situation for some doctors as a result of the recent European Working Time Directive. This directive was intended to protect junior doctors by ensuring that they would become legally subject to restrictions on the overall number of hours they could work on average per week (maximum 48 hours) as well as the length and timing of their rest breaks (Department of Health, 2003b). This is suggestive of significant differences between what is viewed as acceptable or normal between the cultures of nursing and medicine.

Reynolds and Timmons (2005) examined the organisational culture in theatres, focusing on the doctor-nurse relationship. This study provided evidence that doctors and nurses are able to get on in a friendly, informal and efficient atmosphere, as a stark contrast to the multidisciplinary team relationship on hospital wards. Despite being based upon the experiences of only one person (one of the authors), this difference is interesting, encouraging, but also indicative of the wide variation and complex nature of cultures in just one hospital.

Tonuma and Winbolt (2000) identified that traditional Australian nursing culture, in consisting of a task orientated perspective involving rigid hierarchical structures and consequently disempowerment of staff, was an impediment to delivery of patient-centred care. This is a finding which echoes some of the frustrations expressed from within the NHS, particularly in terms of hierarchies applied to nursing (Davies, 2000, Cummins & Stern, 1995).

Brooks and MacDonald (2000) explored night nursing sub-culture which is struggling to survive in the context of the NHS in the UK. This exclusively female group within an organisation numerically dominated by women was found to evoke hostile reactions from other cultural groups within the NHS. This paper highlighted the issue that cultural male dominance persists in the NHS.

Coeling (1992) highlighted the importance of culture when fitting into a work place, and in fact, saw this as the key. Her paper offered nurses advice on how to determine what kind of unit they will fit into and enjoy working with. These included assessment of a unit's work style; aspects of a unit's working style that nurses should consider; supportive attitude of the group; encouragement of professional growth and development and independence

of nurses in the decision-making regarding the proper care to give. This is an interesting argument, however; insufficient information was presented within the paper to assess the basis for the claims made. The patient was external to any consideration of culture given by the author.

Senior nurses have been seen by Pollard, Ross and Means (2005) as well placed to promote and support substantive change in NHS culture. Through developing inter professional collaboration they were viewed as particularly well placed to help students across disciplines gain the experience needed to develop the requisite skills for delivering care within multi-disciplinary services. Further, the implementation of roles and initiatives which support senior nurses in developing appropriate leadership skills has been perceived as a key component underpinning the past modernisation agenda. This is evidence for the significant role which nurses play in relation to the culture of the NHS.

Brooks and Brown (2002) have tackled issues of culture and change which are particularly relevant in the current context of NHS reform. Their research utilised semi-structured interviews and observations with a range of NHS employees from chief executive to non-managerial level. They identified aspects to aid change in relation to the culture of healthcare professionals generally. Organisational change can be more successfully facilitated through the elimination of ritualistic ceremonies which perpetuate the barriers between subcultures and preserve the negative areas of a particular group, particularly in this case, nurses. Brooks and Brown (2002) suggest that changes which confront such unnecessary demarcation, whilst maintaining professional integrity, can create real benefits for NHS hospitals. It follows then, that reinforcement of positive aspects of ceremonial can lead to more adaptable, team centred change. Brooks and Brown (2002) have termed these approaches as 'ceremonies of preservation' and 'ceremonies

of change.’ The following quotation illustrates their ‘ceremonies of preservation’

“The daily drugs and drinks dispensing round at 6:00 a.m., which often involves waking patients prematurely...each clinical profession's insistence on collecting the same personal data from patients, all take on ceremonial significance...medical professionals argued that ‘it's always been done that way’ and that to do anything about it ‘means changing a lot of people's preconceived ideas about how to do things’...As a ceremony, however, it serves a purpose, not least in reducing potential sources of conflict between night nurses...and their day colleagues and those medical consultants who like to start their rounds early. It also serves to identify a specific and meaningful role for night nurses, and is, in the words of a nurse manager, ‘a very tender issue’.” (Brooks & Brown, 2002, p. 346)

It is relevant to note at this stage, that nursing practice may contain a range of ritualistic behaviours which affect nurse-patient interaction, but certainly, not all aspects of ritual are negative (Martin, 1998). “The dismantling of many nursing rituals might seem fine based on rational analysis”, but something valuable is often lost (Wright, 2001, p. 24). It is clear that caution needs to be exercised in this respect.

Hospital environments featuring a strong organisational culture was one resource found by Manojlovich and Ketefian (2002) to promote improved patient outcomes. The ability of nurses to practise in a professional manner may be influenced by the organisational culture of their work environment. However, this Canadian study did not precisely define what was meant by ‘strong’ culture as opposed to weak, and the patient was only considered as external to any culture.

Hewison (1996) questioned the widespread use of organisational culture as a way of explaining all 'soft' organisational issues and recommended more clarity is necessary if the concept is to retain its usefulness. The author examined culture and its application to healthcare organisations and nursing in particular. This demonstrated how the concept can be effectively utilised without losing an appreciation of its inherent complexity. It is argued that, when clearly defined and appropriately applied, culture can be a useful concept for nurse managers in that it increases understanding of, and thereby contributes to, the effective management of complex healthcare organisations.

Kennedy (2001) in his report on the inquiry into the scandal at the Bristol Royal Infirmary suggested steps needed to be taken in relation to culture for all staff in the NHS;

“the culture of the future must be a culture of safety and of quality; a culture of openness and of accountability; a culture of public service; a culture in which collaborative teamwork is prized; and a culture of flexibility in which innovation can flourish in response to patients' needs” (p. 13)...“All employees should be treated in a broadly similar manner. Doctors, nurses and managers must work together as healthcare professionals, with comparable terms of employment and clear lines of accountability, in order to provide the best possible care for patients.” (p. 3)

The final excerpt from Kennedy's report emphasises that whilst patient-centred approaches are important, there is a potential risk in balancing the power;

“a patient-centred service does not mean, and should not be taken to mean, a patient-dominated service, in which doctors, nurses, managers and other healthcare workers are regarded merely as functionaries.” (p. 257)

Kennedy’s report summarises some of the key issues facing the future of the NHS. He captures how areas for development and improvement must focus upon the working cultures of all professional groups together: managers, doctors and nurses. However, maintaining and respecting the professionalism of individuals working in the service whilst effectively challenging ingrained traditions, cultures and power within the NHS, presents an extremely complex undertaking.

2.3 Conclusion

The founding principles of the NHS at the time Bevan introduced his plans for the nationalised health service in 1948, were based upon free healthcare for all at the point of delivery. In the subsequent years the NHS has witnessed many challenges to maintaining this promise. In addition to the complexities faced as a result of the uniquely politicised nature of healthcare; continual financial pressures, obtrusive staffing issues and meeting the needs of local populations have all contributed to the demands upon the NHS.

Approaches to service redesign have evolved in conjunction with the development of the NHS as an organisation, to enable hospital trusts and other healthcare providers to adapt and apply the changes to services introduced by new policy. Methodologies for this purpose have varied, although learning taken from industries outside of healthcare have proved

popular. These have included initiatives structured around incremental improvements over an open-ended time period (Patwardhan & Patwardhan, 2008) such as TQM. This was followed in quick succession by BPR which despite some limitations has proved popular within healthcare. None of these approaches to redesigning services can be considered in isolation from organisational culture, which despite its complex nature has some fairly accepted features based on the theoretical perspectives available.

Healthcare reform in more recent years has brought into greater focus the involvement of the patient. This movement towards a consumer culture for patients had emerged by the 1990s (Warden, 1990) and consequently transformed into a more entrenched approach where the patient was at the centre of improvements to service provision for example Creating a Patient-led NHS - Delivering the NHS Improvement Plan (Department of Health, 2007a). This perspective also impacted and has been linked to governance structures within the NHS, where the role of the patient has developed from 'passive' to more 'active'.

A wealth of political documentation clearly indicates that current government policy favours choice, involvement and patient-centred care. Considering the public interest and politicised nature of the NHS, there is room for more extensive dialogue relating to this strategic direction. However, with a limited empirical basis for such an approach, the need for fresh debate arises. Greater sophistication is required regarding exactly what is meant by the use of common terminology such as 'patient involvement' and 'patient-centred care'. Whilst some choices in healthcare are cost neutral, (Elwyn & Edwards, 2001) public involvement can be costly and getting this wrong would be an expensive mistake leading to cynicism and mistrust (Evans, 2008). It is important to assess just how appropriate (or not) the current approach is, from the patient perspective.

3 Development of Methods

3.1 Introduction

This chapter outlines the rationale and development of the qualitative methods to be applied to the collection, presentation and analysis of data for the purpose of this study. Qualitative research has gained increasing recognition of being able to challenge assumptions and norms in areas of clinical practice (Bower & Scambler, 2007). In addition such methodologies have also gained precedence as valid and useful in more traditional areas of systematic reviewing and evidence based medicine (Murphy et al., 1998). Lewis and Ritchie (2003) suggest that qualitative research findings may be generalised when done so within a clearly defined framework. Lewis and Ritchie's principles are embraced and their approach, as detailed in Ritchie and Lewis (2003) has been applied in this research study. In keeping with this perspective, therefore, the rationale for the use of the qualitative methods of observations, interviews and some documentary review to address the research questions will be presented. In addition, and of equal importance to adhering to the notion of a clearly defined framework, the decisions around the analytical framework and use of thematic content analysis will be accounted for.

3.2 Design issues

It will be of utmost importance during the developmental stage to clearly define the purpose of the study to ensure quality of design. Efforts to achieve this include cohesion between research questions which are

focused and relevant (Lewis, 2003), methods used and a flexibility of approach. This will enable a certain level of adaptability to cope with unanticipated issues, both in terms of methodology and focus.

Defining the research questions in this study has followed a structured process. Initially, areas of interest included patient and staff experience, redesign of NHS services and organisational culture. Through review of existing literature and research, a more specific interest has developed towards issues of patient-doctor relationships, patient control and the impact on patients and staff of hospital change. Consideration of these issues and how current NHS policy is reflected or diverges from clinical practice or patient expectation is a focal point. The conceptual framework which has evolved from this stage of the research has contributed significantly to the design. As a result, the overall focus of the research is set within the context of various clinical services selected within a specific acute hospital Trust (the location of data collection), in order to fully and appropriately explore the overarching themes.

As previously highlighted, the statement by Lewis and Ritchie (2003) that qualitative research findings may be generalised, requires application within a clearly defined framework, and is a key principle of this study. They also note that individual studies which cannot be generalised do have potential value, for example in hypothesis generation. Reliability and validity in the context of generalisation are especially relevant, where the sustainability and well-grounded standing of research contributes to assessing the strength of the evidence.

It is useful to highlight that in relation to qualitative work in particular, the concept of validity itself is not always perceived as the most appropriate approach to what Lewis and Ritchie (2003) refer to as “the ‘correctness’ of qualitative evidence” (p. 273). There appears to be a certain degree of

overlap between elements of validity (internal or external). However, “continual interrogation of methods is needed throughout a research study” (p. 274) in relation to issues including sample coverage, identification, interpretation and display. A number of factors relate to validity and reliability in this study for sample design/selection, fieldwork, analysis, interpretation and opportunity for all perspectives to be covered (Lewis & Ritchie, 2003). The development around the line of thought as it is applied to these considerations is outlined in the following chapter.

3.3 Development of strategy and materials

The literature reporting the benefits of qualitative research methodologies is abundant and varied (Ritchie & Lewis, 2003, Breakwell, Hammond & Fife-Schaw, 2000). This section explores the role of the researcher along with the rationale for determining the appropriate methods to use in this research.

3.3.1 Philosophical stance

There is much debate around the various philosophical perspectives in research. The approach taken here has not been one fixed stringently within a particular domain, although a moderately realist ontological position has been taken, in so far as it is accepted that reality exists independently of the observer. In terms of epistemology, the most important factor has been to be as objective and transparent as possible in dealing with all aspects of the research. A degree of pragmatism was used to select the most appropriate method for answering the research questions posed. The adoption of the Framework methodology developed by Ritchie, Lewis and colleagues (2003) was a significant factor during the conceptualisation, design and analysis of the study, which was chosen to support and reflect this stance. The

methods selected to answer the research questions posed, given this position, are expanded upon in the following sections.

3.3.2 Reflexivity

It is important at this early stage to highlight the integral nature of the researcher to all aspects of data collection. Sensitivity through reflexivity is important in helping to present valid and reliable research findings. Through directing a critical gaze back upon the research process, reflexivity enables greater insight (Finlay, 2003). Prior experiences and assumptions are known to have the potential to be inadvertently influential (Mays & Pope, 2000). The presence of the researcher will facilitate data collection at times where otherwise there would be none. This might be the case for any patient or staff data which is triggered or created in direct response to the researcher's actions. However, this effect will not be applicable to data collected from pre-existing sources such as patient medical notes. In order to clarify the situation, where variations apply to the type of data being captured, this will be discussed individually within the methods section of the relevant clinical service, along with any processes followed for the purpose of any adaptation to tools. In order to address the research questions, data must be obtained from staff and patients in three ways. These approaches will relate to examining what has happened (observations), what was said or views of those involved (interviews) and what was documented (medical records, other records). The following three sub-sections are a review of the three methodologies which will be used in this research.

3.3.3 Observations

Observation is regarded as "one of the hallmarks of the qualitative research tradition" whereby the researcher may be "alongside the members of the group, interacting with them and in effect learning their culture" (Murphy et al., 1998, p. 99). There is support for the application of observational work

within the field of healthcare and specifically accident and emergency departments (Dingwall & Murray, 1983). Observational techniques are useful due to their immediacy “the major strength of direct observation is precisely that it is direct...there is virtually no time delay” (Wilkinson, 2000, p. 224). One of the strengths of qualitative observation studies lies in their ability to study process rather than merely to record outcome (Murphy et al., 1998). This effect has the potential to result in interesting findings with regards to areas of managerial, staff and patients’ expectations compared to actual behaviours in the hospital, which through more quantitative approaches are difficult to uncover. However, there are differing approaches to carrying out observations.

Ethnographic methods such as participant observation involve researchers immersing themselves in the research environment (DeWalt & DeWalt, 2002). This enables the recording of events that occur as they arise and from the perspective of experiencing the events firsthand. However, there is a view that this method is not otherwise of use for the scientific aim of theorising (Jorgensen, 1989), due to the potential impact on objectivity and logistical issues in terms of the sample population being patients. For this reason, it was concluded that this participant observation approach would not be suitable for the current study.

3.3.3.1 Direct observation through patient mapping

For the purpose of addressing questions around patient experiences and control it will be necessary to capture details of patient journeys (throughout the accident and emergency department and within PACU). In order to achieve this objective a more structured and formal approach of non-participant observation will be appropriate to allow for enhanced comparison and in depth understanding. Observations of this manner are particularly useful in investigating both processes involving several people and

behavioural consequences (Ritchie, 2003). As a result, the patient mapping tool outlined by the Modernisation Agency (as captured from the now discontinued Modernisation Agency website and documented in their Process Mapping, Analysis and Redesign Guide, 2005) will be expanded to suit the purpose of this research in conjunction with part of the wider evaluation programme under which this study fell, led by Gore (2004). This expansion will be carried out in order to incorporate the key elements of the Modernisation Agency recommendations, such as looking at stages in the patient journey, whilst also reflecting specific issues around the focus of the research, such as a consideration of patient views and experiences within the stages.

The mapping tool will allow basic demographic information about each patient, who agrees to participate, to be recorded. The main focus of the tool is to enable a chronologically structured recording format of the events which take place during an individual patient journey, whilst noting times, individuals involved and patient views. In this way, the 'stages' of a patient journey can be comprehensively captured. By combining the elements recommended by the Modernisation Agency for mapping patients with the capacity to capture patient thoughts, the result will be a more efficient single table observation tool to allow for ease of data collection (see Appendix I for patient mapping tool). This technique will be used consistently for all occurrences of patient mapping (i.e. acute and paediatric service users). See 'Methods' for detail of precise processes.

The expansion of the mapping tool will allow for two levels of data to be captured. Level 1 will represent generic data, for example the physical environment of a clinical area or staffing levels. Level 2 will reflect additional researcher observations, data which are the result of the researcher's presence in the field, for example, observations of differences in staff views of the redevelopment of a service. This representation of levels will ensure

provision of elements of both the original data set, as well as the interpretative commentary (for more details refer to 'development of the analytical framework').

3.3.3.2 Use of field notes/observation guide

It will also be necessary to record observations outside of the formal context of the mapping tool. Widely used and long established methods to achieve this are field notes and observation guides (Bryman, 2004). Field notes are popular as a means of non-judgementally recording information during qualitative research (Marshall & Rossman, 2006). Field notes are useful both as primary data sources, but can also be used to record "information acquired outside the immediate context of an interview or focus group, or ideas for analysis" (Arthur & Nazroo, 2003, p. 137). They have been used particularly effectively in a healthcare context where incorporating the patient and service provider perspective was important (Peconi, Snooks & Edwards, 2008).

The strength of field notes and qualitative observation is that they are both sources of data which are relatively independent from the analysis, in so far as subsequent cross references for inferences can be made where such notes are made available (Strong, 1979). However, the content of field notes or observations made are limited to what a researcher sees or is exposed to. There is a risk that the types or manner in which information is recorded could be influenced by the researcher's interpretation. Having said this, field notes and the use of observation guides provide a valuable systematic yet flexible means for capturing general information from the environment within which the researcher is working.

3.3.3.3 Development of the topic guide

The process of development of the topics contained within the observation guide for both patients and staff will be informed from two sources. The first source is evidence gathered from the literature, where topics of interest are supported as relevant or important. The second source of evidence for the guide is information gathered from the hospital programme redevelopment managers and other key stakeholders such as senior clinicians. Table 3.3.1 presents a summary of the development process and highlights in bold those issues which are specifically focused upon patient experience.

Table 3.3.1 Topic guide for observations

Topic	Sources of Evidence	
	Literature	Programme Managers/key stakeholders
Reduction of repetition and waiting; focus on stages of the patient journey	This was supported in general by the NHS Improvement Plan (2004), and specifically by the 4 hour A&E target for patients in A&E was outlined in the NHS Plan (2000).	A reduction in delays, waiting and stages of the patient journey were promoted as an expected improvement of the patient experience, intrinsic to the new hospital model.
Patient control	The Expert Patient Programme (2001) outlined moves towards increasing recognition of the role of the patient. For other patient groups too, changing expectations around patient control have emerged (Street et al., 2003).	The new hospital model incorporated a reduction in bed numbers, as a result of greater care being provided in the community and some recognition of the impact of policies such as the Expert Patient Programme (2001).
Professional group involved	Previous research has indicated that patients are not always aware which professional is treating them (Gore et al., 2004). Prestige of medical professionals shifts depending on speciality (Norredam & Album, 2007), with potential impact on the patient.	A reduction in staffing levels coupled with an increase in more highly qualified and specialist clinicians were outlined as key aspects of the new hospital model.
New Teams / roles and working cultures and service boundaries	The importance of the role of service redesigns and culture in healthcare have received significant coverage (Mannion, Davies & Marshall, 2005, Kennedy, 2001, Hyde & Davies, 2004, Fulop et al., 2005).	A new night team being introduced represented what senior managers hoped MDT working would align to. The new hospital model reduces bed numbers and expects to increase care for patients in the community.
Communication and information	Evidence has suggested that patients appreciate information and good communication to the extent that it can improve satisfaction levels (Billing, Newland & Selva, 2007, Maguire & Pitceathly, 2002, Coiera & Tombs, 1998).	The business case for the redevelopment of the hospital incorporated the position that improvements in service model and environment would foster enhanced information and communication systems for patients.
Environment and equipment (incl. the Private Finance Initiative)	Improvements in environment through rebuilding hospitals experienced some growth in popularity particularly with the advent of Private Finance Initiatives (Warden, 1995).	Much of the promotion of the new hospital by key stakeholders reflected the benefits of a new build and expected change in environment between from the original Victorian hospital building, both for patients and staff.

Topic	Sources of Evidence	
	Literature	Programme Managers/key stakeholders
Patient choice and involvement in treatment /care decisions	This approach was a cornerstone in the government policy at the time of the redevelopment, which remains today (Department of Health, 2000, Department of Health, 2000, Blair, 2002).	Involving patients in consultations regarding the new hospital service model and the change programme itself were both high priorities for the redevelopment programme team.

3.3.3.4 Limitations of observations used in this study

The patient mapping is developed and based on an existing valid approach proposed by the Modernisation Agency previously outlined, in addition to being formed on information from the hospital Trust managers and senior clinicians. However, it is acknowledged that the mapping tool functions as a framework which may shape data to a certain extent. More general limitations such as observer bias must also be acknowledged which apply to all observational methodologies (Wilkinson, 2000). Through highlighting an awareness of such potential bias and the use of triangulation of evidence from other sources it is possible to reduce bias.

3.3.4 Interviews

There are two common approaches to formatting interviews; structured and unstructured. A structured interview consisting of pre-defined ordered questions allows little scope for adapting to the unexpected or giving the participant the opportunity to volunteer information they may feel is relevant (Breakwell, 2000). This account has been expanded by Britten (1995) who defines qualitative interviews as ranging from structured to semi-structured and depth.

However, there are alternative methods available for collection of data through questioning participants. The most common of these are questionnaires (Fife-Schaw, 2000) which may be administered in a range of ways, including electronically over the internet or via postal survey. Questionnaires are popular for their apparent ease of use and low cost. In terms of content, questionnaires can vary from open-ended (qualitative) to closed (quantitative) questions. However, there are obvious limitations to the use of a questionnaire when attempting to collect rich and detailed

information relating to interactions between staff and patients, or in getting a sense of the climate of a clinical service.

Interviews are a popular means of data collection within a healthcare research setting. They have been used for a plethora of purposes which have synergy with the current study including: examination of patient characteristics relevant for physicians' clinical decision making (Lutfey et al., 2008), investigating habitual aspects of nurse working (Brown et al., 2008) or the development of consumer led services (Emslie et al., 1999) and researching patient experiences of doctor communication (Tobin & Begley, 2008).

On the basis that this research study wishes to capture in depth information, face to face interviews should yield greater return than the use of questionnaires, or telephone interviews which would prevent concurrent observation from taking place. Crabtree and Miller (1991) advocate the use of qualitative interviews in a healthcare context, particularly for investigating patient perceptions and clinician's understandings. Therefore, the semi-structured approach which has a more flexible structure and contains open ended, amendable questions would be the most appropriate for this study as a means of gathering content rich information from participants. This flexibility of the semi-structured interview will be useful in aiming to achieve a more equalised overall methodology, in conjunction with the observational framework provided by the patient mapping tool.

Topic guides for interviewing patients will be applied in a consistent manner in the acute and paediatric services. The topic guide will, however, be adapted for use within the respiratory clinic. This adaptation will involve more focused questions which are appropriate to the type of health conditions or care received by the respiratory patient group. The intention is that this adaptation will enable the capture of comparable retrospective

patient journey data from the respiratory outpatient clinic patient who by nature of their purpose for attending the hospital cannot have their 'journey' traced in the same manner as patients who attend A&E or PACU (see Table 3.3.2 for sources of topic guide development). Issues such as waiting times or communication are generally of interest within all areas of service provision; however, focus will also vary as appropriate across the different patient groups, for example, the child friendly environment in PACU and having access to specialist clinicians.

Interviewing (of both patients and staff) is perceived as an important phase of data collection which will be employed in order to drill down deeply to investigate issues and gather opinions from participants. The range of the topic guide will apply for staff as well as for patients. It accounts for a generic theme focusing on staff views towards their service, issues they raised in relation to patient care and more general views concerning their professional roles. This core guide will be adapted specifically according to the service which is being studied at the time, such as the impact of the introduction of a new A&E 'night team' as outlined in Table 3.3.2. In addition questions regarding any recent changes in service delivery will be incorporated. Flexibility in approach will be useful in dealing with any responses outside of the researcher's line of questioning. Care will be taken to ensure the length of interviews for both patients and staff are comprehensive enough to cover the relevant issues, whilst not causing extensive interruption for those participating.

3.3.4.1 Development of the topic guide

The process of development of the topic guide for both patient and staff interviews was informed from two sources in the same manner as the observations guide. Again, the first source was evidence gathered from the literature and the second source was information gathered from the hospital

programme redevelopment managers and other key stakeholders such as senior clinicians. Table 3.3.2 presents a summary of the development process of the topic guide for interviews and highlights in bold those issues which are specifically focused on patient experience

Table 3.3.2 Topic guide for interviews

Topic	Sources of Evidence	
	Literature	Programme Managers/key stakeholders
Perceptions of the focus on stages of the patient journey and impact on waiting	Supported in general by the NHS Improvement Plan (2004), and specifically by the four-hour A&E target in A&E outlined in the NHS Plan (Department of Health, 2000).	As these were promoted as an intrinsic aspect of the new hospital model, it was important to examine staff and patients awareness.
Views of the redevelopment programme	Mixed views of the approach, with opposition to PFIs reported in some quarters (Beecham, 2002) and support in others (McGinty et al., 2000).	Also of interest were the interactions with staff and the redevelopment programme on a local level.
Communication (incl. Awareness of which professional involved for patients and information flow around the redevelopment for staff)	Gore et al. (2004) found patients are not always clear who is treating them. Young et al. (2003) indicated that there can be difficulties particularly around appropriate communication with children.	Redevelopment managers reported that they had committed a significant amount of time and effort (through staff information sessions and health impact assessments) to involve, consult and inform staff of the imminent changes.
Views of the physical environment	It has been reported that sustainable healthcare environments are supportive of patients' health and recovery (Douglas & Douglas, 2005).	Much promotion of the new hospital reflected the benefits of a new build comparative to the original Victorian hospital building.
Perceptions of interactions between clinical teams (where appropriate) and service boundaries	Poor teamwork has been shown to negatively impact on patient care (Callum et al., 2002), and lead to greater risk of error (Sexton, Thomas & Helmreich, 2000).	The new night team, amongst other areas of changing multidisciplinary teamworking, was reported by programme managers to be expected to develop and improve.
Perceptions around opportunities for patient involvement or decision making	Questions have emerged around the cost and feasibility of the patient choice agenda (Appleby, Harrison & Devlin, 2003) and whether or not choice actually improves health outcomes (Appleby & Dixon, 2004).	Patient involvement in both the redevelopment programme and treatment were both promoted by the new hospital model (ranging from the Trust consultation with patients regarding building plans, to training around the 'Expert Patient').

3.3.4.2 Limitations of interviews used in this study

One of the limitations of standardised interviews that present consistent questions to all participants is that questions may not have had consistent meaning to all those taking part and that interpretation of questions has an influencing role upon responses (Murphy et al., 1998). The semi-structured interview goes some way to attempt to counter some of this through being more adaptable to the individual, for, amongst other reasons, purposes of probing or clarification. Researcher biases also impact upon interview methodology (Luce-Kapler, 2006), for example where face to face contact has occurred. Biases will be addressed through raised awareness and taking all possible steps to maintain consistency between patients in addition to triangulation of methods where possible. Using the same interviewer to conduct all of the interviews is also seen as a way to eliminate some of the potential bias (Breakwell, 2000).

3.3.5 Documentary analysis

Documentary analysis is said to have been relatively neglected as a form of qualitative research, when in fact, there are many research settings which cannot be adequately investigated without reference to the use of documentary materials (Atkinson & Coffey, 2004).

Furthermore, for NHS-based research it is important to appreciate that socially constructed documents are “a pervasive feature of healthcare settings” (Murphy et al., 1998, p. 125) despite the relatively little attention given to them by researchers. In addition researcher-formed documents such as researcher diaries or other written formats “can offer the researcher the opportunity to study aspects of social life that might otherwise be inaccessible” (Murphy et al., 1998, p. 125). There is a well established track

record for the use of documentary review in a healthcare context, including for examination of the introduction of shared electronic patient records (Greenhalgh et al., 2008) the impact of NHS trust mergers (Fulop et al., 2002), variations in health policy (Exworthy et al., 2001) and assessing the prominence of user involvement in healthcare (Fudge, Wolfe & McKeivitt, 2008, Brooks, 2008). Therefore, the documentary analysis approach will be used where appropriate, to supplement the approaches of observation and interview in answering the research questions posed. In particular it will be applied in reviewing the hospital Trust literature and policy regarding individual services and the redevelopment programme. Additionally, the documents created within the services surrounding patient care, such as patient records or notes will also be reviewed where feasible.

3.3.5.1 Limitations of documentary analysis

The most obvious limiting features of documentary analysis relate to the fact that consideration can only be given to what is contained within a document, where it is clear and easy to read, and where the document itself is in existence (Ritchie, 2003, Ritchie, Spencer & O'Connor, 2003). Information which is omitted, missing or illegible cannot be incorporated into the analysis. However, this is a limitation only in so far as one using the technique needs to be aware and clear about what it is being used for. Documents are not transparent representations of organisational routines, though this is no justification for downgrading documentary data (Atkinson & Coffey, 2004). Learning may also be gained within the clinical environment by establishing whether certain documents are not available as expected because, for example, patient records when they have been mislaid. The limitations in the scope of documentary analysis will be negated in the research as far as possible through the process of triangulation of evidence.

3.4 Validity and reliability

Reliability and validity are important considerations in research, as in their broadest sense they address the issues of the quality of the data and appropriateness of the methods used in carrying out the work.

Validity is commonly referred to as having two main dimensions (Lewis & Ritchie, 2003). The first dimension, internal validity, is the degree to which what is observed is what is purported to be observed (Robson, 2002). The second is external validity which is sometimes known as the generalisability of the findings made (Lewis & Ritchie, 2003). Further sub-dimensions of validity include content validity which asks whether the content of the collection tool is relevant to the characteristic being measured. Face validity is a subjective evaluation of the relevance of the tool (Hammond, 2000). Whilst many researchers do address the issue, there is an argument that rejects the framework of validity as inappropriate in the field of qualitative research, and suggests the focus might instead shift towards credibility and transferability (Lincoln & Guba, 1985).

Internal validity will be tackled here in a number of ways. The justification of the appropriateness of the methods applied, in this case observation, interview and documentary review, have been carefully addressed and are illustrated in this chapter, along with evidence from comparable use of these tools in research elsewhere: in observations, (for example Gore et al., 2004), interviews (for example Crabtree & Miller, 1991) and documentary review (Fudge, Wolfe & McKevitt, 2008). The function of both the literature review and initial discussions with the redevelopment programme managers (as summarised in Table 3.3.1 and Table 3.3.2) is to enable an awareness and understanding of the local environment and political context from which to form solid interpretations of findings.

Maintaining a link to the context of the data, as advocated by Richards and Richards (1994) is an essential element to maintaining the validity of analysis. In order to achieve this, it will be important to provide a detailed description, based on field notes of the hospital service from within which a participant has been recruited and to continually incorporate reference back to key parts of the raw data. Additionally, the focus upon ensuring internal validity through checking accuracy of fit (Glaser & Strauss, 1967) will be reflected in the data collection, where theory or policy has been considered in a specific area of the hospital service and then checked and compared in other areas of the hospital with a different set of participants at different times.

External validity will be addressed as far as possible by ensuring that data will be collected from a range of clinical service areas and with appropriate sample coverage of 'typical' patients from within these services and throughout different times of the day.

Reliability is generally understood to concern the replicability of research findings, although as with validity there is some debate over the application of the term 'reliability' to qualitative research (Lewis & Ritchie, 2003). Where research might hope to have some relevance to application to policy, this replication would be important.

Lewis and Ritchie outline the importance of internal checks on quality of data and interpretation and also that sufficient information around the research process is provided. The consistent use of multiple methods of observations, interviews and documentary review in this research, in order to corroborate data sources will be used to improve the reliability of the data and increase the likelihood that the aspects of the data found would reoccur outside of the study population. Internal reliability of interpretations will be enhanced by the detailed description of the development and application of

the methodology (in this chapter and the subsequent one). Furthermore, reliability will be addressed in the research process in so far as the same researcher will carry out all data collection and analysis, (followed by a rigorous process of discussion with colleagues not involved with the data collection). Any potential bias, for example from the researcher in the field or from participants who might give socially desirable responses (Fife-Schaw, 2000) will be considered and addressed in the following chapters.

3.5 Sampling rationale

The approach to the selection of samples for this study centres on the notion of being able to provide the most relevant, rich and varied information to answer the research questions. The rationale for the location chosen for data collection within the hospital will therefore be developed carefully. Agreement from a selection of service areas which reflect a range of typical patient groups is a primary concern. Ensuring that participants are typical to the service, and broadly represent the local population in gender and ethnicity as far as possible is also important for generalisability of findings. It is established that access to three service areas which offer valuable service specific information are most informative.

The aim of the research is to gain understanding and make comparisons, where possible, between different services within a hospital based on patient and staff data. Opportunistic sampling is defined by Ritchie, Lewis and Elam (2003, p. 81) as “the researcher taking advantage of unforeseen opportunities as they arise during the course of fieldwork, adopting a flexible approach to meld the sample around the field work context as it unfolds.” This sampling strategy will be employed as data collection takes place

across a range of services with the aim of representing different pockets of experience throughout the hospital's services as they are occurring.

These areas are: Acute Care (day, night and gynaecological services), a paediatric service (PACU), and the respiratory outpatients clinic. This specific range of services is important in that it allows inclusion of evidence from services at varying degrees of change within the redevelopment programme. Additionally, having access to the different types of patients across individual clinical services is important to establishing whether findings are consistent across patient groups. A patient arriving at A&E will probably have differing needs and expectations from one attending a chronic condition-based outpatient clinic. The nature of A&E admissions is unpredictable and therefore, opportunistic sampling of patients attending and being seen by A&E staff was most appropriate and practical. In the context of policy moves towards patient choice and control, particularly in terms of initiatives such as the Expert Patient Programme (www.dh.gov.uk, 2001), chronic condition patients are felt to be a particularly important group to approach. In turn, the experiences of paediatric patients in a specialist unit, accessible by referral only also have the potential to highlight their own unique issues.

Beyond patient participation, the aim of capturing a cross section of clinical and professional staff groups is also of importance. Logistical issues will unavoidably play some part in selection of services, although effort has been taken not to simply opt for the most convenient service (for example the night team service will be studied as well as day, but more clinically delicate intensive care units will not be approached). Data collection from a range of staffing roles is factored into the design, including administrative staff, managers, technicians, nurses, junior doctors and consultants.

The arrangements for gaining access to each of the clinical service areas will be specified in the methods section. Briefly, this will involve contacting the appropriate service manager or clinical lead and agreeing that a specific number of days will be involved in data collection. For security purposes and for the benefit of staff awareness for those working on a particular shift, it will be necessary to agree in advance when the research will take place. There may be some obvious but unavoidable implications to this method of access. This may include service managers limiting data collection to times when services are known to be quiet (or busy) for example.

3.6 Development of the analytical framework

The development of an analytical framework has evolved in a manner which aims to incorporate each of the types and sources of evidence in an appropriate and transparent manner. The strategy which has evolved for dealing with the information which will be collected is outlined in the following sections.

3.6.1 Framework for analysis

3.6.1.1 Levels of data

In order to maintain transparency and clarity, it is anticipated that the data collected within the study will conceptually be considered in different 'levels' which are reflected in the results sections for each service area. Level one will relate to the facts as they are observed and documented. This level of data will be reported as what actually happened, for example, a patient being seen by a specific doctor or being taken for an x-ray. Level one data will

also include a visual diagram which represents the factual aspects of the patient pathway in each of the clinical service areas.

It is important to acknowledge the difference between basic factual data and data which are more interpretive in nature. Therefore, level two data will incorporate the data which are the result of the researcher's presence in the field. This includes factors which would not be recorded if the researcher were not present, and which are in the context of the research questions (for example, data collected from interviews with staff). Through representation of two levels of data, this framework for analysis contributes towards greater transparency and ensures provision of elements of both the original data set, as well as the interpretative commentary.

3.6.2 Process of analysis

The transformation of observations into data begins in the field, with a focus of interpreting aspects of the situation of relevance to the study (Wilkinson, 2000). Analysis of data from patient mappings and interviews will be both descriptive and interpretive. The focus will be on gaining substantive meaning or understanding from the data, and will follow the structural approach with regards to patient mapping, as outlined by the Department of Health, a legacy remaining from the Modernisation Agency (this was illustrated on www.wise.nhs.uk, at the time of development although this website is now inactive). Initially, analysing processes in the patient journey will consider: how many steps are involved and at what time, how many staff have dealt with the patient, and what the patient's views were.

Where participants present strikingly different scenarios from others from the same episode of data collection, these will be regarded as equally significant in aiding theory development and not discarded as simple outliers (i.e. deviant case analysis, (i.e. deviant case analysis, Clayman & Maynard,

1994). In other words, attention is given to elements of the data which do not support the emerging themes (Mays & Pope, 2000).

3.6.3 Thematic content analysis

Analysis of data from staff interviews and patient mapping will be via thematic content analysis (Ritchie, Spencer & O'Connor, 2003, Mason, 2002, Spencer, Ritchie & O'Connor, 2003). This is a methodology which has been applied in a range of health-related fields including psychologists' reports of children in custody (Brandt et al., 2004) and analysis of eating disorders (Freedman et al., 2006).

Other approaches to analysis of the data such as discourse analysis (Gill, 1996, Perakyla, 2005) or conversation analysis (Potter, 1996, Heritage, 2004) have been considered and ruled out as unsuitable. Discourse analysis with its focus on the construction of a verbal account, and conversation analysis which involves detailed investigation of interactions of speech would not provide data which would most appropriately answer the research questions being posed. Additionally, having to tape record data collection would pose some logistical problems in terms of noise levels and clinical interruption.

Thematic content analysis is the appropriate method to use for two main reasons. Firstly, the approach allows a systematic overview of the scope of the data in order to make comparisons and connections (Ritchie, Spencer & O'Connor, 2003). Secondly, this method maintains relevance by providing a means of incorporating close examination of the expected benefits of the redevelopment as promoted by the hospital redevelopment team. There are a number of further specific advantages to the use of content analysis. The permanence of the data enables re-analysis and therefore, checks for

reliability are possible. For documents already in existence, the nature of the analysis itself is unobtrusive (Robson, 2002).

This method of qualitative analysis adheres to the analytical hierarchy presented by Ritchie, Spencer and O'Connor (2003) for the analysis of qualitative data. This will, through an iterative process, lead from analysis of raw data through to a result which has some application to wider policy. This process is more structured than other common approaches to dealing with qualitative research, with a greater degree of application of pre-determined reasoning (including the development of a topic guide). The iterations described by Ritchie, Spencer and O'Connor (2003) include generating themes and concepts, assigning meaning, assigning data to themes to portray meaning, refining concepts and finally assigning data to the refined concepts to portray meaning. This process justifies the developed topic guide being applied to trigger raw data collection.

3.6.4 Data presentation and triangulation

The research findings will be presented in the raw form as collected where possible, and elsewhere will be portrayed as true to the raw data as possible. This should make clear the analytic constructs as they have developed (refer to Table 3.3.1 and Table 3.3.2 for development of topic guides and Appendices II and III for questions asked around the topic guides). The analysis of the data such as the patient journey as recorded through the mapping tool (see Appendix I) will be intrinsically linked to the collection of the data and the means in which it is presented. Ensuring that the data are available in a manner which is accurate, transparent and enables clear linkage with the researcher's interpretation is critical.

Due to the structured nature of the patient mapping tool, the data collected from patient mapping will in general be presented whole, within grids and the

text boxes detailing further information. Data from the interviews (either attached to the patient mapping tool or in their own right) will be presented in full in text boxes (see Appendices VIII, IX and X for full data), with key points identified through thematic content analysis summarised in evidence tables.

Triangulation (Denzin, 1978), has been the subject of some debate (Seale, 1999) as to whether it validates evidence or extends understanding (Ritchie, 2003), and has been advocated for use in social research (Denscombe, 2007). Denzin outlines different forms of triangulation ranging from triangulation of methods, sources, analysis and theory (Denzin, 1978) which are all useful means of external validation (Lewis & Ritchie, 2003). Triangulation has been applied in a range of ways specifically in a healthcare research setting. These include the use of triangulation of methods (Foss, 2002), triangulation of theory and sources of evidence (Spinewine et al., 2005) and of all forms of triangulation in one study (Murray, 1999).

The processes of triangulation used will be triangulation of sources of evidence and of analysis. Firstly, this will involve drawing the evidence for the key emergent themes from the three broad data collection methodologies. Secondly, it will involve discussion with independent colleagues to check the interpretations made. Therefore, triangulation will not only provide support for a theme from the data gathered through forms of observations, interviews and documentary analysis, but also for the related interpretations.

Triangulation will be used in this context therefore, as a key part of the analytic strategy in order to benefit from the increased breadth of understanding (Ritchie, 2003, Polit & Beck, 2004) which may be drawn as a result of its application. In addition triangulation data tables will help to facilitate the transparency of approach.

4 Methods

4.1 Introduction

Building upon the rationale outlined in the Development of Methods, this chapter will lay out the specific methods applied in the study for the purpose of answering the research questions outlined below. The design and materials used for collection and analysis of the data from the three stages of data collection will be described in detail. The three general methods of data collection (observation including patient mapping, interview and some documentary review) and the process of analysis will be outlined. Where there are service specific research questions (for the acute service, PACU or the respiratory outpatient clinic), any additional activities utilised to answer these research questions will be defined.

4.2 Ethical approval

Full ethical approval has been sought and gained for all elements of this research from the Local Research Ethics Committee (number BEC 1001) and Brunel University Research Ethics Committee.

4.3 Research questions

This study was designed to holistically address the following core research questions:

Question 1

How do patient pathways and patient and staff control issues differ within areas of an NHS organisation at various stages of redevelopment?

Question 2

What are the gaps between evolving and existing patient-centred NHS policy and practice in the evidence collected from a range of services within the NHS organisation from staff and patients?

There were some additional questions which were specific to individual services.

Table 4.3.1 Specific service questions

Acute Service	Paediatric Ambulatory Care Unit	Respiratory Clinic
1. What developments or changes were occurring within the hospital A&E service	1. What was the nature of the service's structure and how did its boundaries operate?	1. What developments or changes were occurring within the hospital respiratory outpatient service?
2. What was the impact of the changes on staff and patients from their respective perspectives?	2. What were the issues specific to paediatric services, in terms of staff and patient control?	2. What was the impact of the changes on staff and patients from their respective perspectives?

4.3.1 Background of clinical services studied

4.3.1.1 Acute Service

The acute service data were collected from the main hospital within the Trust facing comprehensive redevelopment, incorporating a new purpose-built hospital and redeveloped model of service delivery. The focus for the redevelopment was upon improved hospital provision and greater integration with community services. The accident and emergency department was, according to the managers of the redevelopment programme, intended to represent a microcosm of the overall redevelopment facing the hospital, and was therefore chosen as the location for the first round of data collection for this study. It was chosen to begin an in depth exploration of the impact and perceptions of changes facing staff, in conjunction with shifting patient expectations and increased governmental demands, and in the light of the patient and staff experiences and any relevant cultural expressions or service model approaches within the department.

In order to capture the range of activities within the A&E department and more fully reflect the work that took place within this acute service, three subsets of majors A&E patients were focused upon. These were:

- Phase One - the generic day time A&E patient,
- Phase Two - patients who were treated by the gynaecological direct referral team (GDR), and
- Phase Three - night time patients

4.3.1.2 Paediatric Ambulatory Care Unit

The second location for data collection was a purpose-built paediatric centre referred to generically as the Paediatric Ambulatory Care Unit (PACU). PACU had recently been developed and established within the sister hospital to that of the main site facing comprehensive redevelopment (which provided the location for acute service data collection in the previous

section). Broadly speaking, ambulatory paediatrics focuses on elements of treatment or care that do not require the child to be admitted to hospital, including, A&E, outpatients and day care (Heller, 1994). This unit presented an opportunity to collect data at the Trust from within such a distinctive service area; with its specialised staffing, patient group and the advantage of incorporating into the data set, a service where redevelopment was complete.

4.3.1.3 Respiratory Clinic

This final study took place within the respiratory outpatient clinic environment with its differing clinical team roles and service structures. The aim was to examine, through the patient and staff experiences, issues of control and patient-centred service provision in the context of service change within an outpatient clinic environment. This variation in context from the previous research studies allowed for a comparison between the various organisational cultures and any other relevant considerations between different hospital services of emergency (acute day time, GDR and night) and paediatric facilities.

4.4 Study design and materials

The study design consisted of three qualitative approaches applied within acute service, PACU and the respiratory outpatient clinic of an acute hospital NHS Trust in London during 2005 to 2006. The research design was based upon a clearly defined framework structured upon the approach advocated by Ritchie and Lewis (2003). The three modes of data collection were: observations, interviews and documentary analysis. The justification for the utilisation of these techniques has been outlined in the Development of Methods.

1) Observations

- Patient observations in a clinical setting were facilitated by the use of a patient mapping tool (see Appendix I) in the acute service and PACU.
- Staff (and additional patient) observations were collected through general exposure to the clinical environment by the researcher through immersion within all clinical service settings. This was framed upon a pre-defined observation topic guide (see Appendix II) and/or recorded as general field notes as appropriate.

2) Interviews

- Semi-structured interviews took place (based on the topic guide) with patients following mapping in the acute service and PACU. Primary data collection from patients in the respiratory outpatient clinic was through semi-structured interview (the topic guide was adapted for this purpose).

- Staff interviews (both formal and informal) were carried out using a semi-structured approach which contained general themes for the acute service, PACU and the respiratory clinic within the hospital (consistent with the topic guide, see Appendix III).

3) Documentary review

- Documentary analysis was carried out to a limited extent within the three services where written evidence relating to the specific service, patient or staff group was available. This ranged from reviewing patient medical records to general clinical information posted around the hospital and Trust policy documentation.

4.4.1 Inclusion and exclusion criteria

The use of pre-defined selection criteria for patient and staff participants has been integral to this study. A small number of specific selection criteria have been an important element in sample selection, ensuring symbolic representation to reflect character rather than statistics, and diversity of sample (Ritchie, Lewis & Elam, 2003). There have been some general inclusion and exclusion criteria to the sampling frame which are consistent across the research, whilst others are unique to the specific context of the clinical service. In general, inclusion for participating patients included all genders, broad age ranges and ethnicity, and symptoms reflecting those typical to the service. Generic exclusions were applied to extremely sick service users, those under the age of 16 (except in PACU) and patients unable to understand written and spoken English to the extent that informed written consent would be compromised.

Individual medical or nursing staff were briefed regarding which patient groups would be relevant to the study and which were not appropriate. They were responsible for initially identifying a suitable service user for participation, based on the variables outlined above. After a potential participant was identified the inclusion and exclusion criteria (listed below) were formally applied.

General inclusion and exclusion criteria were applied to staff who were potential participants in the research. All staff from relevant service areas were eligible to participate. It was hoped that a range of professional groups at varying grades would be involved in the research.

General inclusion criteria

For patients/families:

- Male and female
- Aged 16 and above (except in PACU)
- All ethnic groups
- Presentation of typical clinical symptoms

For staff:

- Working in relevant service area
- All ages, genders and professional groups

General exclusion criteria

For patients/families:

- Patients experiencing medical crisis
- Patients under 16 years of age (except in PACU)
- Patients unable to understand written and spoken English to the extent that informed written consent was compromised
- All patients who wished not to participate

For staff:

- Staff working outside the clinical service area were excluded when the interview was focused in a specific service
- All staff who wished not to participate

It is important to recognise the limitations presented as a result of working within the defined criteria. The most seriously ill patients within all areas of the hospital service have not been included in this study. It is recognised that consequently, the patient sample is biased towards those patients who were alert, willing to consent and perhaps had a stronger voice at the time of data collection. The perspectives of patients (and staff) who chose not to consent despite meeting the criteria cannot be represented in the findings. Efforts have been taken to ensure as far as was feasible samples were representative within the criteria.

4.5 Population and sample

All participants who took part in this study were either patients at the Trust where the research was carried out, or were staff working within the hospital. Sampling was generally opportunistic (Neal, 2005) on an individual patient and staff participant level. This involved following leads from clinical staff during the field work process and taking advantage of any unexpected moments for data collection. In terms of the services selected for data collection, an approach was taken in order to capture data from a range of services at different stages of redevelopment. Efforts were made to ensure participants were representative of the typical patient within the service, based on criteria from clinicians and allowing for a range of demographics to be reflected. Selection of participants was to an extent influenced by clinicians or clinic staff who assisted the researcher in approaching suitable

participants. For each individual service investigated within the hospital, the samples were as follows:

1. Acute patient Phases One, Two and Three (general adult day time acute, gynaecological direct referrals (GDR) and general adult night time acute) population and sample:

- a. **Total patients mapped N=13: (Day time N=6; GDR N=4; Night time N=3; 1 patient declined to consent).** Children were excluded. Otherwise, generic inclusion and exclusions applied.
- b. **Staff observation N=15, of which 6 were also interviewed; 2 staff declined to consent.** Only staff working with or in the A&E department were included. All ranges of staff were included.

Access to the A&E department was taken over a period of eight days in total and during specific shifts. Times for data collection were prearranged with the service manager by the researcher. A member of staff was always made available to escort the researcher into the unit and introduce them to the appropriate staff members. This always involved a brief meeting with a clinical lead (Matron or senior doctor) to outline the purpose of the research (although posters and verbal information had already been provided to staff to forewarn them about the research).

2. PACU population and sample:

- a. **Patient/parents N=10; none declined to consent.** All participants were parents accompanying their sick child. Participant selection was initially based on direction from medical staff but otherwise attempts were made to gain a

representative sample of demographics and symptoms presented. Prior to initiating data collection, information was gathered from the lead consultant to ascertain what constituted a typical patient, to ensure usual symptoms were reflected in the sample. A certain element of uncertainty in the sample was unavoidable due to the unpredictable nature of hospital admissions. Exclusion criteria were any parent/patient in a critical condition, or unable to speak a good level of English.

- b. Staff interviews were in the form of informal discussions N=5; none declined to consent. Additional informal observations were also made of staff.** Only staff working within PACU were included. All ranges of staff were included.

Access to PACU was made available to the researcher over a period of three days. This period of data collection was prearranged by the researcher with the lead consultant. A member of staff was expecting the researcher each day (on arrival, the researcher reported to the reception and was met by a nurse). Due to the nature of the unit being relatively small, most staff were aware upon arrival that the researcher was present. The access to the unit was determined by the opening hours of PACU which closed overnight.

3. Respiratory outpatient population and sample:

- a. Patient interviews N=16; none declined to consent.** This sample was opportunistic, with the aim of representing a typical patient in attendance at the clinic. Children were excluded
- b. Staff N interviews N=5; none declined to consent. Additional informal observations were also made of staff.** Only staff working with or in the respiratory department were included. All ranges of staff were included.

Access to the respiratory outpatient department was on two separate days which spanned a period of two weeks. Times for data collection were prearranged with the lead consultant by the researcher. As a result, the clinic care coordinator was expecting the researcher on both occasions. The clinic had specific opening hours and the researcher was permitted to attend for the duration of both clinics. Access was also provided to the researcher for time with staff members for the purposes of interviewing outside of clinic time.

4.6 Setting and procedure

4.6.1 Acute patient Phases One, Two and Three setting and procedure (General adult day time acute, gynaecological direct referrals (GDR) and general adult night time acute)

4.6.1.1 Patients

Total Patients mapped N=13. Patients admitted to the 'majors' accident and emergency department were approached in a consistent manner for each of the three phases of data collection during the day time, within the GDR service and at night time. Participants were approached once in an A&E majors treatment cubical by the researcher and provided with information regarding the study and an information sheet to read (see Appendix VI for sample). Having been given time and space to consider the information provided those who wished to take part were asked to read and sign the consent form (see Appendix VII for sample). Following consent, the researcher collected one of the patient's unique hospital stickers which was attached to their corresponding consent form, for use within the hospital only, to link the patient to their hospital number and to enable accurate

access to patient notes when follow-up was required. From this stage, participants were asked basic questions regarding their visit to the hospital. Following this, the patient mapping tool was used as a framework by the researcher for recording the observations made of the patient journey until point of discharge where possible. Where appropriate, patients were also asked questions regarding the positive and negative aspects of their care and were provided with the opportunity to raise any other issues. General researcher observations in and around A&E also took place throughout the period of data collection. The observation topic guide for this was based upon the research questions being asked (refer to Appendix II).

Data collection for Phase One of the research work took place over a period of four days in May and again in November 2005, within the 9am to 9pm time frame, and focused on seven patients who were admitted to the A&E majors department of the hospital (Phase One = 'day time acute'). The Phase Two work took place over a period of three days in November 2005, from 9am to 9pm, and focused on four gynaecological patients who were admitted to the A&E majors department of the hospital, and were treated by the Gynaecological Direct Referral Service (GDR), (Phase Two = 'GDR'). Phase Three of the research work took place during a night time shift in (Nov 2005). This work focused upon three patients who were treated in the generic majors function of the A&E department, along with a collection of staff observations, brief interviews and general researcher observations (Phase Three = 'night time acute').

The times of data collection were dependent on agreement with the service manager and were therefore, restricted as outlined above. The selection of patients was guided by direction from clinical staff who were aware of the research taking place and had been asked by the researcher to assist in ensuring as wide a range as possible of patient type was captured.

4.6.1.2 Stages of the patient journey

Patients were observed for a period of up to eight hours to follow the stages of care they received. The term 'stage' refers to the significant events for the patients with respect to which element of their care pathway or functional area of the hospital they were in (for example reception, triage, A&E - incorporating speciality, or discharge). This approach also allowed for recognition of which professionals were involved in the patient's treatment and why. This tool was based upon the patient mapping tool originating from the Modernisation Agency (as captured from the now discontinued Modernisation Agency website and documented in their Process Mapping, Analysis and Redesign Guide 2005). The process of gathering data with respect to stages of the patient journey was a useful means of making comparisons between patient journeys and experiences in relation to both clinicians' role and processes for the patient. This approach acted as a framework upon which to carry out the observations incorporating both the activities of the staff and the experiences of the patient.

4.6.1.3 Staff

Interviews took place with staff when they were less busy with patients or clinical duties, at a time convenient to themselves or through pre-arranged interview slots. Staff observation took place with two lead nurses, one staff nurse, six nurse practitioners, three junior doctors, two consultants and one service manager (total N=15) of which six were also interviewed. Those interviewed included sister, matron, two nurse practitioners, a doctor and a consultant. Staff were provided with an information sheet which they were asked to read before agreeing to take part. Those wishing to participate were then asked to read and sign a consent form. The semi-structured interview topic guide was consistent for all staff in A&E (see Appendix III), but with some additional questions which evolved for the GDR staff regarding specifics of the service. These additional questions were focused

upon the facilities and processes involved in the direct referral system. It was generally not practical to gain written consent for purposes of observation, but verbal consent was sought with staff in accordance with the research ethics approval.

4.6.1.4 Phase One – generic day time

A significant aspect of this research included the observations of the various health professionals involved in the care and treatment of patients within the A&E department (N=8). Of those observed, two members of staff (Matron and Sister) were also interviewed. A number of informal contributions from other staff were also made including the consultant and a junior doctor.

4.6.1.5 Phase Two – gynaecological direct referral (GDR)

The second phase of the acute service research involved observations of five members of staff who worked in the gynaecological direct referral service, (GDR), two of whom were also interviewed. The approach used in observing and interviewing staff was consistent with that utilised in Phase One.

4.6.1.6 Phase Three – night time

The third phase of the acute service research involved brief interviews with a consultant and a staff nurse working on the unit in addition to further staff observations. The method was consistent with that employed in Phases One and Two.

Data collection from staff took place when they were less busy with patients or clinical duties, at a time convenient to themselves or through pre-arranged interview slots. Where feasible, staff were provided with an information sheet which they were asked to read before agreeing to take part. Those wishing to participate were then asked to read and sign a consent form. The

interview topic guide was consistent for all staff in A&E (see Appendix III), but with some additional questions which evolved for the GDR staff regarding specifics of the service. These additional questions were focused upon the facilities and processes involved in the direct referral system. It was generally not practical to gain written consent for purposes of observation, but verbal consent was sought with staff in accordance with the research ethics approval.

4.6.2 PACU setting and procedure

4.6.2.1 Patients / parents

Patient N=1 / parents N=9; total N=10. It is important to note that in most cases, informed consent and participation was provided by the parent accompanying the child patient. On one occasion the child was deemed mature enough by the accompanying parent and the researcher (in accordance with 'Gillick' competence; *Gillick v West Norfolk and Wisbech AHA*, 1985) to make this decision themselves, and so consent was sought directly in an appropriate manner from the patient, who agreed to participate and responded to the research questions. All other collection of data took place with parents at the bed-side of the respective patient and adhered to the patient mapping tool structure utilised previously. Parents of patients referred and admitted to PACU were approached by the researcher and provided with information regarding the study and an information sheet to read. Having been given time and space to consider the information provided, those who wished to take part were asked to read and sign the consent form. The researcher collected one of the patient's unique hospital stickers, which was attached to their corresponding consent form for use within the hospital only, to link the patient to their hospital number and to enable accurate access to patient notes when follow-up was required. From this stage, participants were asked basic questions regarding their child's visit to the hospital. Following this the patient mapping tool was used as a

framework by the researcher for recording the observations made of the patient journey until point of discharge or referral elsewhere where possible. Where appropriate, parents were also asked questions regarding the positive and negative aspects of their child's care and were provided with the opportunity to raise any other issues.

The tool used for mapping patients was identical to that used in the acute service (see Appendix I). The tool consisted of a patient details section which recorded basic demographic information, details of symptoms and pre-existing chronic conditions. The main element of the tool was a table which enabled the researcher to record each step of care sequentially and make notes of observations. Details of actions taken by healthcare professionals were recorded, along with start and end times of each step and any relevant comments.

Data collection took place on PACU over a period of three days during which time 10 participants were recruited and observed. As part of the approach, observation of patient journeys, following the patient and parent journey from point of arrival at the unit as they proceeded through the service to discharge or admission to the ward (through patient mapping), in conjunction with questioning participants was carried out. This study employed the techniques of patient mapping consistent with those utilised elsewhere in the research,

4.6.2.2 Gaining consent

Given the vulnerable nature of the patient population in this service, choosing an appropriate parent to involve in the study and ensuring parental consent was a carefully considered stage of the research, and was guided to some extent by the clinicians. Parents who were highly distressed or had very sick children were not approached. Parents who did not speak fluent

English were not approached, and this has been recognised as an unavoidable limitation. Otherwise all conditions including the most common of: respiratory problems, gastroenteritis, rashes, fever and fits (as indicated to the researcher by the lead consultant) were included in the acceptance criteria. It is important to reiterate, given the nature of the patient population that in most cases informed consent and participation was provided by the parent accompanying the child patient. On one occasion the child was deemed mature enough by the accompanying parent and the researcher, in accordance with 'Gillick' competence (Gillick v West Norfolk and Wisbech AHA, 1985) to make this decision themselves.

4.6.2.3 Stages of the patient journey

Patients were observed for a period up to eight hours to follow the stages of care they received. The term 'stage' refers to the significant events for the patients with respect to which element of their care pathway or functional area of the hospital or PACU they were in (for example reception, treatment cubicle receiving a form of treatment or going through the discharge process). This approach also allowed for recognition of which professionals were involved in the patient's treatment and why. The process of gathering data with respect to stages of the patient journey was a useful means of making comparisons between patient journeys and experiences in relation to both clinicians' role and processes for the patient. This approach acted as a framework upon which to carry out the observations incorporating both the activities of the staff and the experiences of the patient.

4.6.2.4 Staff

Staff informal discussions and observations N=5. Observations and discussions with staff took place when they were less busy with patients or clinical duties, at a time convenient to themselves. Staff were always approached and asked for their permission to be observed. Due to the

informal nature of these observations or discussions, written consent was not gained, but verbal assent was given in accordance with the research ethics approval. General observations in and around PACU took place throughout the period of data collection. The observation guide was applied for general observations, as discussed in Development of Methods and detailed in Appendix II.

4.6.2.5 Key stakeholders

Discussions were held prior to the patient mapping exercise with a number of key stakeholders including a paediatric consultant. A meeting was held with the nursing manager of PACU to establish the most appropriate stages at which to approach patients and their parents. This discussion also facilitated higher level identification of key clinical stages of the patient journey. The head secretary and secretary responsible for PACU were both consulted to gain further information regarding the processes involved in the journey for the patient.

4.6.3 Respiratory outpatient clinic setting and procedure

4.6.3.1 Patients

Patient interviews N=16. Patients awaiting an outpatient clinic appointment were approached by the researcher whilst in the waiting area. Following a verbal introduction of the research, potential participants were provided with an information sheet and asked to read it and consider whether they would like to take part. Those who wished to be interviewed were provided with a consent form which they were asked to read and sign. The researcher collected one of the patient's unique hospital stickers, which was attached to their corresponding consent form for use within the hospital only, to link the patient to their hospital number and to enable accurate access to patient notes when follow-up was required. 16 participants were then interviewed in

accordance with the topic guide, which also provided scope to ask individual probes or capture patient initiated comments. Patients who were called to their appointment during the interview process were then offered the chance to complete the interview after their appointment. On completion patients were thanked for their participation and reminded that the information sheet given to them by the researcher contained contact details and further information for their future reference should it be required.

Data collection took place over a two week period in February-March 2006 covering two respiratory outpatient clinic slots on the Tuesday of each week. The data collection tools utilised were consistent with those from previous service areas but adapted for relevance to the respiratory clinic as necessary (see Appendices for data collection tools).

The times of data collection were dependent on agreement with the service manager and were therefore, restricted around the clinic times outlined above. The selection of patients was guided by direction from clinical staff, particularly the clinic care coordinator, who was aware of the purpose of research and had been asked by the researcher to assist in ensuring as wide a range as possible of patient type was captured.

4.6.3.2 Stages of the patient journey

In order to achieve some consistency with data collected in other areas of the hospital, the interview guide was developed to best reflect elements of the stages in care from the patient perspective from referral to the clinic appointment onwards, in addition to other areas of focus such as process of referral. The consideration of stages in the clinic context was not entirely comparable with previous data sets due to the nature of the respiratory service, but certain aspects of the patient journey and experience were consistent, justifying the approach.

4.6.3.3 Staff

Staff interviews N=5. Staff interviews were carried out prior to the patient interviews in order to gain a fuller understanding of the operational functioning of the respiratory outpatient clinic. Semi-structured interviews were carried out with five staff within the respiratory clinic; the clinic care coordinator, the clinic registrar, chronic disease nurse practitioner, lung function technician and the senior consultant. Staff working within the respiratory outpatient clinic were approached by the researcher and asked if they would consider participating in an interview. Information sheets were provided for potential participants to read prior to agreeing to take part. Those who wished to be involved were asked to read and sign a consent form. For those who were able to, the interview took place immediately. Others requested a later time slot be used, in which case the researcher returned to carry out the interview later. Notes were taken by hand. It was generally not practical to gain written consent for purposes of observation, but staff were always approached and asked for their permission to be observed. General observations in and around the clinic also took place throughout the period of data collection. This observation took place in accordance with the observation guide (see Appendix II) which was based upon the study research questions and the emergent themes relating to staff roles and the hospital redevelopment programme, patient control and environment emerging from previous sections.

Declined consent: One patient from the night time A&E data collection phase and two staff members (doctors) declined consent, all other potential participants consented.

4.7 Methods of analysis

4.7.1 Preparation for analysis

The description of research methods, analysis and consequential interpretation of the data in this thesis is intended to provide a level of transparency which presents a clear pathway to how the conclusions have been reached.

Immersion by the researcher into the raw data was achieved in a number of ways. Data were entered into Microsoft Word 97-2003 in the case of interview transcripts and patient maps, using the responses provided by participants as written down by the researcher (the raw data). For patient and staff interviews within the respiratory clinic, data were entered into a Microsoft Office Excel 2003 spreadsheet for the purposes of reviewing consistency, analysis and reporting.

4.7.2 Data analysis strategy

The process of thematic content analysis as recommended by Ritchie and Lewis (2003) and detailed by Ritchie, Spencer and O'Connor (2003) was followed and applied in order to reduce the volume of raw data to a meaningful level, on the basis of the predetermined research questions.

The conceptual framework of two levels of data as outlined in the Development of Methods has been considered when dealing with the data. Level one includes basic factual and descriptive information and level two reflects additional researcher observations. This conceptual framework has been applied in order to facilitate analysis as recognition of the difference between data which are more interpretative in nature than others.

As outlined in the Development of Methods, this approach to qualitative analysis adheres to the analytical hierarchy presented by Spencer, Ritchie and O'Connor (2003) and Ritchie, Spencer and O'Connor (2003) which, through an iterative process, intends to lead analysis of raw data through to application to wider policy.

This approach is founded on the ideal of upholding transparency at all times, and maintaining a link back to the relevant data, context and literature. Data have been comprehensively reported in the results chapter of this thesis where the presentation has been designed for transparency between the raw data and the emergent themes.

The role of the researcher within the research process has been considered and it is recognised that the researcher is to an extent inextricably linked to the collection, presentation and interpretation of the data (reflexivity is fully addressed in the 'Development of Methods'). Through the process of in depth discussions with others involved in the research, the use of triangulation and a high level of transparency, attempts have been made to negate any untoward impact of the researcher upon the validity of the findings.

4.7.3 Thematic content analysis

Interview transcripts and patient mappings were examined using the approach to thematic content analysis advocated by Ritchie and Lewis (2003), as identified above. The initial stages of analysis based on the iterations suggested within the thematic content analysis approach described by Spencer, Ritchie and O'Connor (2003) and Ritchie, Spencer and O'Connor (2003) were followed. Themes and concepts were roughly generated prior to data collection, as represented in the topic guides. These topic guides were based on both the literature and information gathered from

key stakeholders and the redevelopment programme team. The purpose of this stage was to establish political context and meaning of the issues and helped ensure relevance.

Subsequently, data were assigned to themes to portray meaning and a refinement of concepts took place. This stage of the thematic content analysis consisted of repetitive reviewing of the data to help the researcher to build a sharper picture of the direction of the evidence and ensure for example, that parts of the raw data which did not relate to a topic were given equal consideration to avoid bias and keep interpretation clear. Hard copies of all data were sorted and themed by hand based on those areas pre-determined by the topic guide and with a view to identify any additional themes. A colour coding system was used to distinguish between themes. Coding was applied both in order to identify the existence of a theme and also to highlight its frequency in occurrence. In order to increase the reliability of the coding after it was developed, a small sample of text was tested from each stage of the data to ensure categories were unambiguous, through a process of discussions with colleagues independent of the research process. Where relevant the themes were amended.

The final phase of analysis was to assign data to the refined concepts to portray meaning. An important aspect of such analysis is sorting of categories (Robson, 2002) and so a systematic process was applied to refine the concepts before final meaning was reported. In order to ensure the continued appropriateness of themes, in depth discussions took place before, during and after the research process between the researcher and independent colleagues who were neither participants nor were they involved with the gathering of data.

4.7.4 Data presentation

Data presented in the following results chapter are as follows: Schematic representations in the form of diagrams of the individual patient pathways have been developed to represent each of the three services where data collection took place (for example the respiratory clinic patient pathway, Figure 5.3.1). These diagrams provide a clear view of the patient journey and the service context from which the interview, observational and documentary evidence emerged. Demographic information for patients (for example Table 5.1.1) and staff (for example Table 5.1.2), and service structures (for example Figure 5.1.1, Figure 5.1.2, and Figure 5.1.3), plus an illustrative extract from the raw patient data of one patient journey mapping (Table 5.1.3) are presented along with an illustration of the process of thematic content analysis charting (Table 5.1.4). The results from patient mappings along with the field notes have been presented in text boxes along with descriptive grids of the stages of individual patient journeys (located in full in the appendices).

Interview data have been reported in text boxes (see for example a patient interview from the respiratory clinic, Figure 5.3.2). Summary tables of emergent themes have been used for clarity (for example respiratory clinic patient data in Table 5.3.4 and respiratory staff data in Table 5.3.5) to draw out the key concepts. Based on the conclusions drawn from the process of thematic content analysis, each of the themes supported by the patient and staff data sources have been summarised in a written account and are supported by illustrations in the form of evidence tables (refer to Table 5.1.5 and Table 5.1.6). The main heading of each emergent theme is accompanied where appropriate with subheadings for other themes which fit into the same overall category.

The evidence from the different sources (patients, staff or researcher) and different methods, (observation, interview or documentary review) have been

combined to form the triangulation tables also presented in the results chapter (for example, triangulation of themes from the respiratory clinic are shown in Table 5.3.6 to Table 5.3.9).

4.7.5 An example of the analysis process

The aim of this section is to illustrate the analytical process as it was applied to the raw data. The following table, Table 4.7.1 demonstrates the process of thematic charting and is based on excerpts of the data as they were collected during the acute phases of research (as displayed in raw form in the Appendices). This illustration represents on a small scale the activities applied across the data set on a wider scale.

Having assigned themes and colour coded the data, thematic charts were used to appropriately synthesise and assign data within the 'thematic matrix' (Ritchie, Spencer & O'Connor, 2003). It is important to note that some aspects of the raw data may have been coded within close proximity to one another, or with a fit into more than one theme. The close interweaving of some themes may be significant to subsequent analysis and any associations are found in this illustration in the notes section of the thematic chart.

For each of the three services where the research was carried out, comparable examples in the forms of extracts of the process of analysis will also be incorporated for the purpose of clarity within the results chapter.

Table 4.7.1 A thematic chart for teamworking/roles from the Acute Service

Theme: Teamworking/roles					
Patient ID, Gender, Age Ethnicity, Symptoms	Contextual information	Team (profession or member of multidisciplinary group) involved in patient care	Impact on patient of patient journey / Exposure of patient to aspects of team interaction	Awareness of professional group	Notes
Acute Patient 1 Female 32 years old Asian Feeling dizzy and sick	The patient had attended A&E the previous week as she had felt unwell and tests had been carried out then. She felt that this current episode was related to her illness of the previous visit, where things were not resolved properly.	1) The patient had most contact with and was responded to more by the nurses. 2) The patient was discharged by the doctor.	Patient called out to several doctors who evaded responding to her and caused her some frustration, finally managing to get the attention of a nurse who reassured her.	The patient was unable to decipher whether it had been a doctor or a nurse who had administered the tests, but was not concerned by this, purely that she was being treated.	Suggestion is that expectations of role responsibility on the part of the clinicians differ between the two professional groups.
Acute Gynae Patient 4 Female, 42 years old Caucasian Heavy bleeding	The patient had previous interaction with a different hospital for her fibroids condition – her GP referred her to the hospital.	The nurse practitioner took on much of the work with the patient, and worked in collaboration with the doctor.	The patient was seen by the gynaecological nurse practitioner (who arrived at A&E together with the registrar, each seeing a different patient). At this point full clerking took place. The nurse practitioner was able to seek advice from the registrar, who then saw the patient and made the decision that it would be necessary to transfer her to another hospital where the consultant could be involved.	The patient did not report any issues around professional impacting her care.	Fairly flat hierarchy in GDR service between nurse practitioners and doctors.

4.7.6 Triangulation

An important element of the analysis related to the process of triangulation (based on the work of Denzin, 1978). Triangulation of data has contributed to the external validity of the research findings, through comparison of data from various qualitative approaches (interviews, observations/patient mapping and review of documentation). Triangulation has not only been of use in drawing together information from differing methodologies, it has also enabled different types of evidence to be used to assess efficacy of the services. For example, in the respiratory clinic evidence from senior clinicians, patients and various other clinical staff has strengthened the justification for certain inferences to be made, whilst also keeping the findings fluid until the degree of evidence is strong enough to make a firm statement.

Triangulation has been applied to the analysis process to extend and support understanding (and is in part facilitated by the consideration of 'levels' of data). The findings from patient and staff data and researcher observations have been drawn together and summarised at the end of the results section (see Table 5.1.10 to Table 5.1.13). This is useful as a means of comparing data from different sources, in order to produce a more comprehensive picture of what is occurring and also to increase transparency of approach.

4.8 Limitations of the data

It is important to recognise that there are boundaries with regards to the inferences which can be drawn from qualitative data (Snape & Spencer, 2003). Whilst effort has been taken to ensure reliability and validity through detailed description of design, methods, analysis and data presentation, it must be acknowledged that all qualitative data rely on a certain degree of interpretation and are vulnerable to bias. However, the

rich layers of detailed information gathered through a triangulation of methods in this study have been dealt with as stringently as possible to ensure conclusions met are accurate, relevant and transparent.

5 Results

5.1 Acute service results

In total thirteen patients (six day time, four GDR and three night time) and 15 members of healthcare staff completed all requirements for the research interviews, informal discussion or observation (refer to Table 5.1.1). The patient sample consisted of thirteen participants (four male, nine female) who agreed to participate. Their mean age was 41 (SD 22.71, range 18 – 83) years; men 53 (SD 24.69, range 27 – 81) and women 36 (SD 21.12, range 18 – 83) years. A summary of the data are presented followed by the emergent themes from patient, staff and researcher.

Table 5.1.1 Patient demographics

<i>Patient</i>	<i>Service</i>	<i>Age</i>	<i>Sex</i>	<i>Ethnicity</i>	<i>Diagnosis (if known) or presenting symptoms</i>
1	Day	32	Female	Asian	Gastro-enteritis
2	Day	52	Female	Caucasian	Gall stone
3	Day	27	Male	Asian	Diabetic relapse
4	Day	65	Male	Asian	Right-sided numbness
5	Day	38	Male	Asian	Chest pain
6	Day	33	Female	Afro-Caribbean	Back pain and breathing difficulties
1	GDR	20	Female	Caucasian	Dehydration
2	GDR	19	Female	Asian	Loss of appetite
3	GDR	23	Female	Asian	Dehydration
4	GDR	42	Female	Caucasian	Heavy bleeding
1	Night	81	Male	Asian	GP referral
2	Night	83	Female	Caucasian	Sickness/swallowing difficulties
3	Night	18	Female	Afro-Caribbean	Stomach pains

Table 5.1.2 Staff observed, interviewed or informally spoken to

<i>Staff Number</i>	<i>Service</i>	<i>Sex</i>	<i>Profession</i>
1	Day	Female	Sister
2	Day	Female	Matron
3	Day	Male	Nurse Practitioner/Bed manager
4	Day	Female	Nurse Practitioner/Bed manager
5	Day	Female	Consultant
6	Day	Male	Doctor (SHO)
7	Day	Female	Doctor (SHO)
8	Day	Male	Staff Nurse
9	GDR	Female	Nurse Practitioner
10	GDR	Female	Nurse Practitioner
11	GDR	Female	Nurse Practitioner
12	GDR	Female	Doctor (SpR)
13	GDR	Female	Service Manager
14	Night	Female	Nurse Practitioner
15	Night	Female	Consultant

5.1.1 Basic service structure

Basic factual data relating to the structure of the service, conceptualised as level one data are presented in the following figures. This information is in the form of three flow diagrams which have been developed to represent evidence collected relating to the generic pathways and stages for the patients in A&E. Figure 5.1.1 depicts the day and night time, Figure 5.1.2 the GDR service and Figure 5.1.3 the 'ideal' redeveloped night time service.

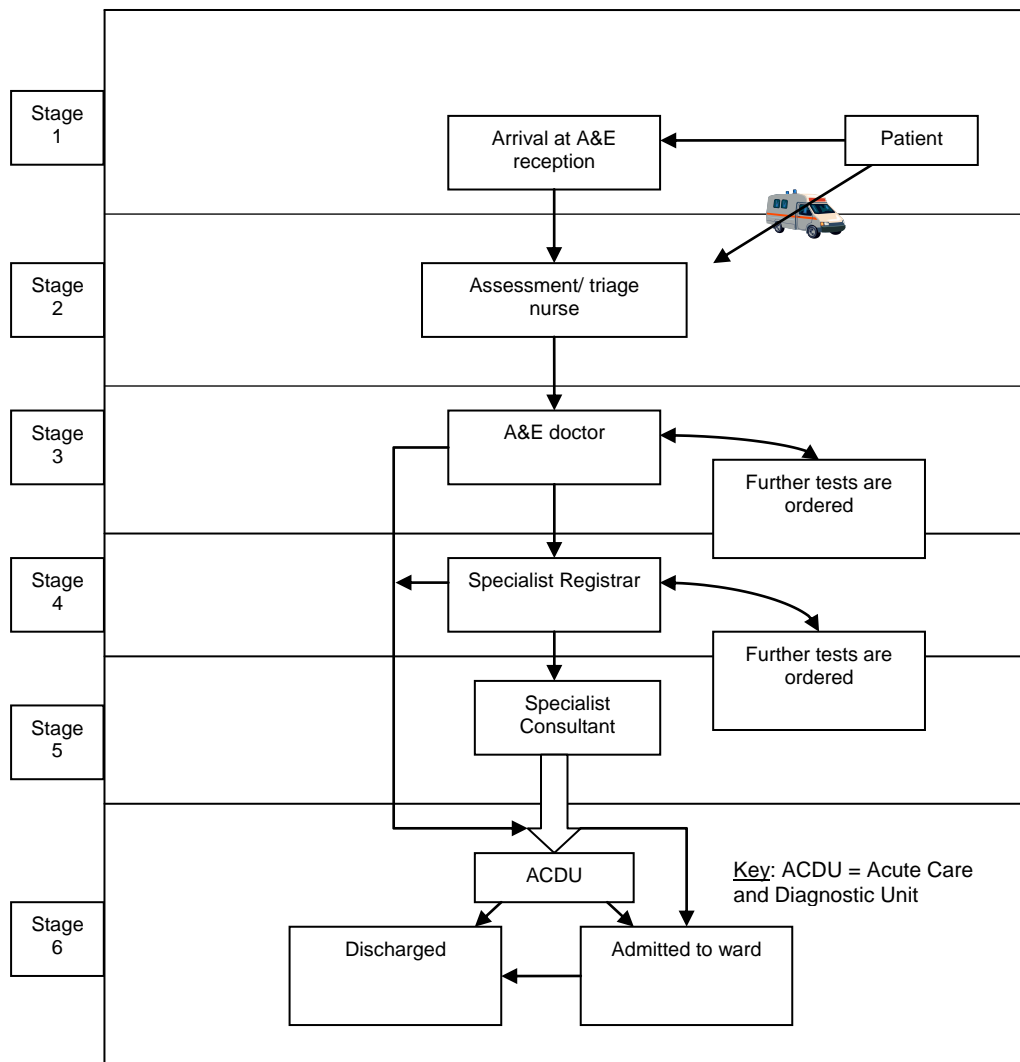


Figure 5.1.1 The day time and night time acute patient pathway

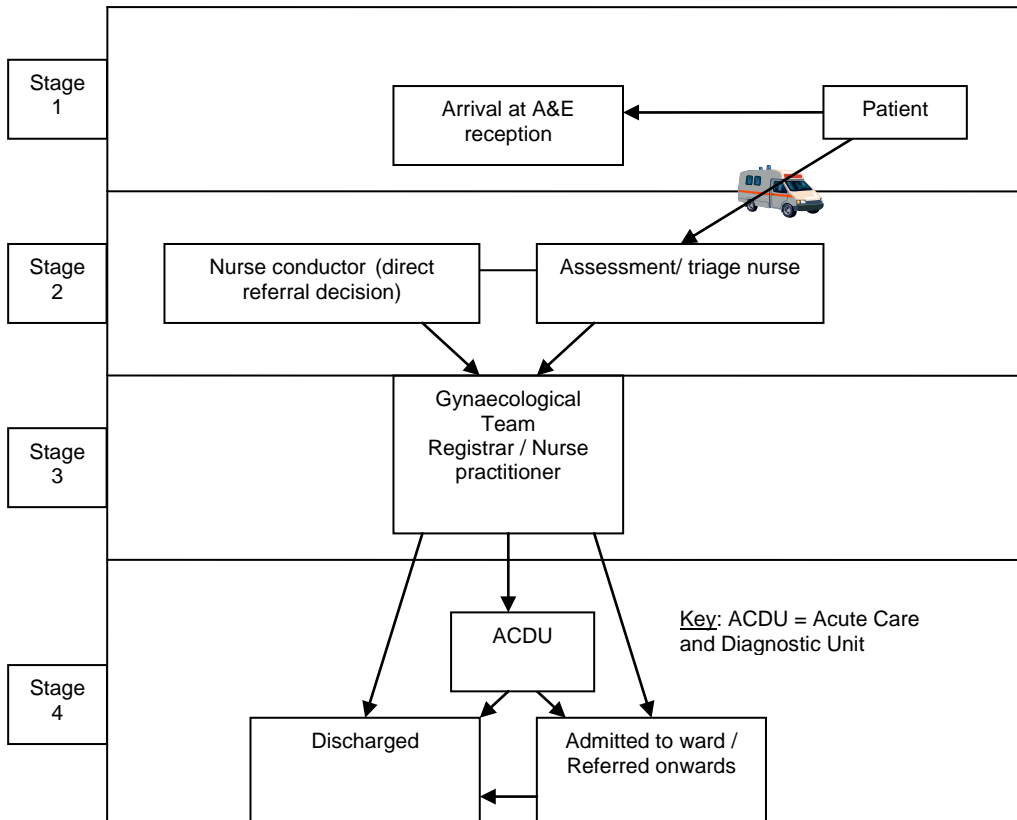


Figure 5.1.2 The gynaecological patient pathway

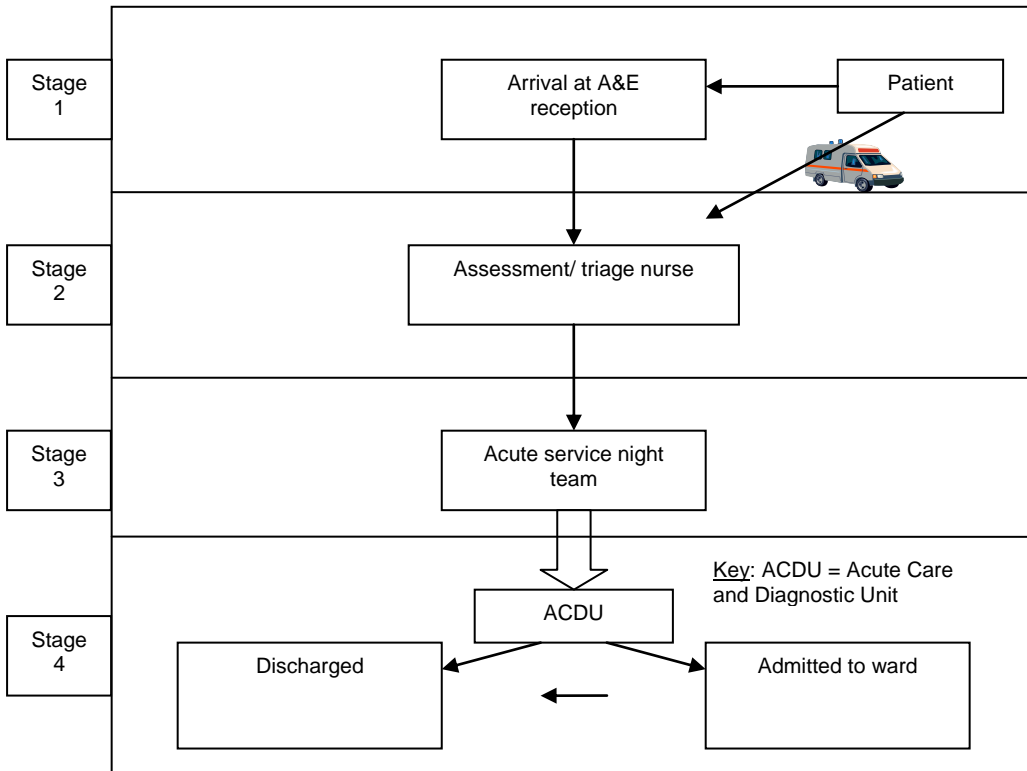


Figure 5.1.3 The proposed ideal acute night team patient pathway

5.1.2 Extract from the raw patient data

For illustrative purposes an example of the data collected from the patient mappings and the format in which such data are reported is presented below. This includes a written description taken during the patient mapping which incorporated patient comments (Figure 5.1.4). This data is followed by a grid summarising the stages of the patient journey and any supporting information (Table 5.1.3). (Please refer to Appendix VIII for the complete data set).

Gall stone patient. This patient was in an A&E bed accompanied by her daughter. She had felt sick during the evening prior to admission, which developed into severe pain in her stomach and side. The patient was brought to hospital by car and arrived at A&E at 7.30 am.

Number of stages in patient journey: Six. Length of stay: four hours in A&E then moved to the Acute Care and Diagnostic Unit (ACDU)

The patient felt she had only to wait for a short time in reception, approximately five minutes. She was then met by a nurse who took her to be triaged. She was asked questions and basic tests were administered. The patient recalled being seen by two nurses at this stage which spanned around 15 minutes. The patient stated that at this time she “felt rough” but was confident with the service she was receiving. At around 8.45am the patient was brought to a bed in majors where more tests were carried out by a different nurse (including blood and urine). At around 9am the patient was seen for the first time by a doctor who sent her for a chest x-ray, which did not incur any delay. The hospital porter assisted the patient to the x-ray room situated adjacent to the far end of the A&E department. The results of this investigation were returned quickly according to the patient and were normal. At 9.35am the patient was given one litre of oxygen by a nurse.

The patient felt that both the doctor and nurses had been “very good”. At 9.40am the House Officer spoke to the patient, gave her an injection and topped up her drip. The doctor made several attempts to take blood from the patient (the patient commented that this was “even though she had good veins” indicating her surprise at the doctor being unable to perform the task). The

nurse came to successfully take the blood from the patient and told her to rest. During this time, junior and senior doctors in the department were observed discussing the patients' symptoms amongst themselves.

The patient had a good deal of interaction with both doctors and nurses. By 10am the patient was suspected as having a gall stone and was told by a nurse she would need an ultra sound as they needed to confirm her condition and need to establish the size of the stone to assess whether surgery will be necessary. As the 4 hour target approached, the decision was made to move the patient to the Acute Care and Diagnostic Unit (ACDU) (effectively another room which functions as an offshoot of A&E where patients are moved to avoid breaches of targets). At 10.25am the patient was moved to ACDU where her treatment continued.

At 10.40am the surgeon arrived on ACDU to discuss the situation with the patient. The patient felt very involved and reassured by the visit from the surgeon who she said "was really very nice and answered her questions". The patient waited to go for her scan and from 11.30am was asleep up until she was admitted to the ward at 2.25pm. Overall this patient was very happy with the care she received. At times she was waiting for test results and to go for a scan but did not feel this was a problem as she was in the process of receiving the care she needed.

The patient was extremely willing to cooperate with the staff. This patient was relatively passive to her care, a situation which appeared to result from an understanding of what was happening. On occasion where the patient felt unsure, she was also expressive of her opinion. She readily accepted the decisions of the medical staff who were treating her.

Figure 5.1.4 Acute Patient 2: description of the patient journey

Table 5.1.3 Acute Patient 2: stages of patient care

Stage	Action	Who?	Time
1	Patient arrived at hospital via car and registered at reception	Patient accompanied by daughter – registered by receptionist	7.30am
2	Patient was assessed by 2 nurses and admitted to the majors department of A&E at end of this stage - Blood test and urine sample taken	Nurse	7.35am – 8.45am
3	Doctor initial assessment and patient sent for chest x-ray. Results returned (normal)	Doctor/hospital porter	9am- 9.35am
	Patient was given 1 litre of oxygen. Doctor returned to speak to patient – attempts to take more blood were made but nurse was required. BP also taken.	Doctor/nurse	9.35am- 9.40am
4	Patient informed that she had suspected gall stone and required ultra sound scan to confirm – due to time pressure patient moved to ACDU	Nurse and 2 nd Doctor	10am - 10.25am
5	Surgeon arrived to discuss situation with patient	Surgeon	10.40am
	Patient slept whilst waited for scan		
6	Patient was admitted to the ward where her care continued		2.25pm

5.1.3 An illustration of the thematic content analysis process

This section, for illustrative purposes only, shows the principles of the analytical process as they were applied to the raw data. Having assigned themes and colour coded the raw data, thematic charts were used to appropriately synthesise and assign data within the 'thematic matrix' (Ritchie, Spencer & O'Connor, 2003).

The following table (Table 5.1.4) demonstrates the process of thematic charting for the teamwork theme and for practical reasons is based on selected excerpts of the data as they were collected during the acute phases of research from two of the patients (as displayed in full raw form in the Appendices). This illustration represents on a small scale, the principles applied across the whole data set for this service.

Table 5.1.4 An example of a thematic chart for teamworking/roles from the Acute service

Theme: Teamworking/roles					
Patient ID, Gender, Age Ethnicity, Symptoms	Contextual information	Team (profession or member of multidisciplinary group) involved in patient care	Impact on patient of patient journey/ Exposure of patient to aspects of team interaction	Awareness of professional group	Notes
Acute Patient 1 Female 32 years old Asian Feeling dizzy and sick.	The patient had attended A&E the previous week as she had felt unwell and tests had been carried out then. She felt that this current episode was related to her illness of the previous visit, where things were not resolved properly.	1) The patient had most contact with and was responded to more by the nurses 2) The patient was discharged by the doctor.	Patient called out to several doctors who evaded responding to her and caused her some frustration, finally managing to get the attention of a nurse who reassured her.	The patient was unable to decipher whether it had been a doctor or a nurse who had administered the tests, but was not concerned by this, purely that she was being treated.	Suggestion is that expectations of role responsibility on the part of the clinicians differ between the two professional groups.
Acute Gynae Patient 4 Female, 42 years old Caucasian Heavy bleeding	The patient had previous interaction with a different hospital for her fibroids condition – her GP referred her to the hospital	The nurse practitioner took on much of the work with the patient, and worked in collaboration with the doctor.	The patient was seen by the gynaecological nurse practitioner (who arrived at A&E together with the registrar, each seeing a different patient). At this point full clerking took place. The nurse practitioner was able to seek advice from the registrar, who then saw the patient and made the decision that it would be necessary to transfer her to another hospital where the consultant could be involved.	The patient did not report any issues around type of professional impacting her care.	Fairly flat hierarchy in GDR service between nurse practitioners and doctors.

5.1.4 Emergent themes – from patients

The following results and those in the subsequent sections incorporate the conceptualisation of level two data. These are the emergent themes from the experiences of six day time, four GDR and three night time acute patients who were observed and interviewed during their admission to the 'majors' function of the A&E department at the Hospital. The main emergent patient themes are presented here, and further illustrated using evidence in Table 5.1.5. Triangulation of all main findings (from each of phases of A&E data collection; day, GDR and night time) from patients, staff and the researcher are found at the end of this section (refer to Table 5.1.10, Table 5.1.11, Table 5.1.12 and Table 5.1.13). Full data are located in Appendix VIII. Taking a collective patient view, four broad themes have emerged from the analysis of the patient data across the three phases of A&E data. These were Patient/staff control, Teamworking/roles, Service boundaries and Clinical information flow.

Patient/staff control

The first of the themes drawn from the results related to patient control and medical dominance during interactions with staff. Patients throughout A&E were generally observed to comply with staff requests during their time as patients in A&E. On the whole patients reported being more concerned with receiving treatment and care than being involved to any great degree, beyond asking questions. A few exceptions to this were observed. This was illustrated by the case of the day time acute Patient 1 who became somewhat frustrated at a lack of communication with staff and night time Patient 2 who willingly did what the doctor asked her until she became frustrated at having to answer repetitive questions.

Teamworking/roles

Staff teamworking and roles had an important influence upon the patient. Particularly in the GDR service, the virtually flat hierarchy between clinicians and nurse practitioners enabled a more rapid and efficient

service to be provided to the patient. From a patient perspective in the day and night A&E services, although nurse practitioners were members of the clinical teams, they did not have such a visible impact on the service to the patient. In the day A&E service, the overlap with ACDU (Acute Care and Diagnostic Unit) led to involvement with ward-based staff including a consultant who operated in a more traditional style than elsewhere in A&E. It was also noted by a number of patients that they were not always aware which professional it was who was treating them, but whilst they felt they were receiving good care this did not cause patients to report any concern.

Service boundaries

In terms of service boundaries, these were fairly consistent and apparent from the patient perspective across the A&E services. All patients required admission to the department either from arrival via ambulance, self referral or referral from a GP. A number of patients from across each of the three phases of data collection with the A&E department were observed to be admitted into ACDU towards the end of their care. This indicates a consistent issue with meeting targets which may have impacted the patient by having to be moved elsewhere within the hospital, without any new advancement in their care at the time of the move.

Clinical information flow

Clinical information flow and communication surrounding this was a recurrent theme for many patients throughout A&E. However, instead of reporting feelings of frustration with waiting for information such as blood test results, patients accepted the necessity to wait, so long as they felt they were receiving good care. GDR patients benefited from a service with good clinical information flow due to the speciality of the service. Stages of the patient journey have been captured to reflect the progression of care through the service. Patients were not troubled by moving to an additional stage, for example moving onto ACDU, despite the managerial assertion that reduction in stages would be beneficial.

Table 5.1.5 Patient themes from the three acute services phases

Theme	Evidence from the Patient
Patient / staff control	<p><i>The patient called out to several doctors until she was able to get a response (Day Acute Patient 1)</i> <i>The patient was very willing to follow instructions from clinicians (Day Acute Patient 2)</i> <i>The patient was fully cooperative with the staff (Night Patient 3)</i> <i>The patient was treated with dignity by the doctor, and willingly did what she asked of her, however she felt some frustration with the surgeon when she was required to provide information she had already given to the initial doctor (Night Patient 2)</i></p>
Teamworking roles/(incl. clarity of professional group	<p><i>The patient was not able to identify which professional had been treating her (Day Acute Patient 1)</i> <i>The patient was seen by the gynaecological nurse practitioner (who arrived at A&E together with the registrar, each seeing a different patient (GDR Patient 4)</i> <i>The doctor was...concerned about the patient's low weight and together with the nurse they weighed her. This was a delicate procedure which was observed to have been carried out with great dignity towards the patient, who was very frail (Night Patient 2)</i></p>
Service boundaries	<p><i>At the approach of the 4 hour target the patient was moved to the Acute Care and Diagnostic Unit (ACDU) (Day Acute Patient 2, 3, 4; GDR Patients 1 & 2)</i> <i>GDR Patients were grateful for dedicated, protected nature of the service, both in terms of facilities and staff</i></p>
Information flow (Clinical; incl. waiting)	<p><i>Patient waited for a scan but did not perceive this as a problem as was happy to be receiving treatment (Day Acute Patient 2)</i> <i>"...satisfied with the communication with staff and don't mind waiting whilst they're trying to fix me" (Day Acute Patient 4)</i> <i>"I'm very happy that I didn't have to go far, they did a scan very quickly to rule out ectopic pregnancy which was reassuring and I'm really happy it has happened so quickly" (GDR Patient 3)</i> <i>The patient waited for test results (he was informed by the doctor there would be an hour to wait) according to the computer system these had already been returned, when they had not (Night Patient 1)</i></p>

5.1.5 Emergent themes – from staff

The following section presents a summary of the data gathered through observations, interviews and some informal discussions with staff from within the A&E department. This is a collective of the findings drawn from staff during the day, from the GDR service and at night time. Sources included the A&E sister, matron, nurses and nurse practitioners and their manager, junior doctors and the consultant in ACDU. Context and identification are given below where relevant, and a summary of the key evidence is presented in Table 5.1.6. These findings act not only to support the emergent themes from the patient data but also raise some further considerations which may not have fitted with original expectations.

In addition to the themes consistent with the patient data (i.e. Patient/staff control, Teamworking/roles, Service boundaries and Clinical information flow) the staff data also identified two further themes, firstly, organisational information flow which particularly related to the imminent changes to the hospital as part of the redevelopment programme, and secondly, raised the issue of the hospital environment.

Patient/staff control

As a result of a lack of exertion of power from patients across A&E, control was in the hands of the staff who were generally not presented with behaviour which challenged them. The sister in charge during the period of observation in the Day Acute service indicated that patient experience was highly influenced by a patient's expectations of what care they would receive and the potential involvement or choice they might have.

Teamworking/roles

Effective teamworking was perceived by staff to be an important part of the functioning of the A&E department, which was influenced to some extent in the view of a nurse practitioner from A&E, by how well the staff

knew each other. The hierarchy within the teams was in evidence in so far as consultants or junior doctors were responsible for activities such as discharging patients, whilst nurses tended to more basic functions. Having said this, episodes where the doctors and nurses worked together for the benefit of the patient were observed. The exception to the traditional roles within professional was illustrated by the nurse practitioners. This professional group enjoyed increased responsibility and, to some extent, autonomy in comparison to the more traditional perspective of nursing. The teamwork in the GDR service was particularly effective, where there was observed to be a very flat hierarchy between the doctor and nurse practitioner.

Service boundaries

The service boundaries and the parameters of the service from a staff perspective were fairly consistent throughout the entire staffing group in A&E and were not something which staff generally had much influence upon. The GDR service was really the only service with increased control over who was admitted, as this was dependent on clinical condition and meeting the criteria for the service (i.e. female and probably pregnant). The GDR service also benefited from having a smaller patient base, access to allocated clinicians and scanning equipment and private rooms for patients.

Clinical information flow

Information flow on a clinical level emerged as a theme from A&E staff. From the staff perspective, there was some frustration with clinical information flow, for example between the A&E department and pathology. There were also frustrations raised by an A&E clinician between A&E and the medical team who had been viewed as becoming resistant to taking on referrals from A&E and therefore more obstructive. Clinical information flow in the GDR, partly due to the nature of the teamwork in evidence, operated very smoothly. Patients in the GDR benefited from this by experiencing less delay in care as clinical information flowed well between members of the team.

Staff, particularly in A&E in the day and night, rejected the idea that the number of stages of a patient journey was a decisive indicator of quality of care, however, it was noted by some staff that repetition was sometimes clinically pertinent.

Organisational information flow

Issues around organisational information flow and communication between managers and staff working in A&E were a recurring theme. The A&E consultant briefly conveyed her view that the current focus (by the Trust senior managers) on targets and patient throughput was not always appropriate. There was an implication that she felt that her senior managers did not always listen to her thoughts relating to workload, patient numbers and targets, or at least there were some issues in terms of organisational level information flow.

Poor organisational information flow was also held accountable for some of the staff concerns expressed regarding the redevelopment of the new hospital, particularly in relation to A&E at night time and the suggestion of the introduction of a new night team. The impression had been given by senior managers that a new night team has been successfully operationalised with teams generally working well together. However, the opinion of a doctor spoken to as part of the research opposed this view, suggesting it was purely a new name for the same thing and the clinicians had not changed their way of working. A reduction in stages in the patient journey was reported by redevelopment managers as key within the redeveloped A&E. However, this led to some frustration from clinicians who reported that repetition may be clinically appropriate where more information was being gathered from the patient.

Environment

The final theme drawn from the staff was that of the environment. Most staff felt that the move to a new hospital building in terms of the facilities offered would be positive and eagerly awaited the move in this respect.

Table 5.1.6 Staff themes from the three acute services phases

<i>Theme</i>	<i>Evidence from Staff</i>
Patient/staff control	<p><i>The issue of expectation and control was raised, with the example of patient transport where patients are told they will be provided with transport but then do not appreciate that the transport must wait for a group of patients to be ready for collection and cannot be put into action for just one patient (A&E Sister, Day time)</i></p>
Teamworking/roles (incl. clarity of)	<p><i>“They know we know our stuff as we know them individually. We have a good rapport with the doctors” (Nurse practitioner, Night time)</i></p>
Clinical information flow	<p><i>“We were sitting here talking about them [blood results] and waiting for them at the time they [the system] say[s] they came out!” (Doctor, Night time)</i></p> <p><i>The GDR nurse practitioner highlighted the benefits of a flatter hierarchy with the doctors in her service, which enabled the service to have greater efficiency by removing the blockages which might otherwise have caused some delay to patient care. (GDR Nurse practitioner – also relevant to teamworking)</i></p>
Organisational information flow (incl redevelopment issues)	<p><i>“I only wish we could get the powers that be to understand that we could be more busy with just 4 patients who are very sick and need great care and time given to them, than when there are 10 patients who are less sick. The number of patients being treated is not a fair reflection of how busy we are.” (A&E consultant)</i></p> <p><i>“The night team is not different to the day apart from in name; I don’t see it as a fixed set of people who make up the night team.” (A&E doctor)</i></p> <p><i>“Repetition is necessary in some cases where more information is being gathered, especially where patients don’t speak English.” (Doctor)</i></p>
Environment	<p><i>Generally, staff were positive about moving to the new building and having a redesigned layout based on staff feedback to the redevelopment programme.</i></p>

5.1.6 Emergent themes – researcher observations

This section presents the researcher observations in support of or in addition to the information collected from patients and staff. These observations supported the themes emerging from the patient and staff data as highlighted above and/or identified issues which would not have otherwise been captured. The following section describes the key researcher observations which have been made.

Phase One: Day time acute Access to the A&E service was open to all who walked through the door. Patients arrived independently at the main reception area where they waited to be assessed, or via ambulance which operated with direct access to A&E. The Acute Care and Diagnostic Unit adjoined to A&E had an official objective to operate as an observational unit. Issues arose during data collection regarding placing patients in this unit to act as an overflow for A&E in order to overcome the four-hour A&E target, however, the patients did not seem to oppose this, despite a lack of clinical reason for it.

Phase Two: Gynaecological direct referral (GDR) A patient arriving at the hospital could bypass the traditional, more extensive A&E route by being directly referred to the GDR on arrival/triage. Access to the GDR service was through referral by the medical staff operating within the general A&E department. The majority of patients were pregnant or had been pregnant recently, although not exclusively. Patients would arrive independently to the general waiting area where they waited to be assessed, or via ambulance which operated with direct access to A&E.

The GDR was a distinct service whose operational activity was located in A&E, but with specialised dedicated nurse practitioners and doctors. The service was available during day time only and ended at 8pm. A specialised sonographer provided a scanning service in the morning (10am-12pm) for patients who could have an appointment booked from a previous A&E visit or through their GP, or for emergency cases that

arrived on the day. For patients who arrived after 12pm, the gynaecological nurse practitioner was able to rule out ectopic pregnancies in most cases using a scan, but for complicated conditions would recommend the patient returns during the following morning for a qualified scan.

GDR patients were generally provided with private treatment rooms located within the main A&E department. This offered easy access but increased privacy. The GDR service had its own specialised equipment for the care of the patients using the service.

The staff who worked within the GDR were specifically allocated to the service. Nurse practitioners had an integral role in the service and treated patients independently with consultation or collaboration from the GDR doctor where necessary. There was a flatter hierarchical approach to the care of GDR patients than in general A&E.

Phase Three: Night time acute The concept of the 'night team' was something which had been presented by hospital redevelopment management to the researcher as a relatively new feature which had recently been introduced after a period of development to the service. The basis of the new night team was one in which a specialised team of clinicians would be able to provide treatment more efficiently by referring patients in a more direct manner to the appropriate care. Figure 5.1.3 illustrates the expected operation and patient pathway of the night team from a managerial perspective, in comparison to the actual service observed during this research. The environment within A&E at night was fairly consistent with the day time, apart from a more noticeable security presence at night.

Stages of patient care Due to the nature of the patient mapping tool and the direction provided by the redevelopment managers, data collection has focused in part upon the stages of patient care. It was noted that all

discharging of patients was the responsibility of a doctor. Data from the patient mapping tools have been used to provide summaries of the factual aspects of the patient journey, as represented in Table 5.1.7, Table 5.1.8 and Table 5.1.9.

5.1.7 Summary of all acute patient activity in stages

Table 5.1.7 Phase One – day time acute patients: stages summary

Acute Patient Number	Time in A&E	Number of Stages
1	3 hrs 10mins	5
2	4 hrs	6 + ACDU
3	4 hrs	6 + ACDU
4	4 hrs	6 + ACDU
5	3 hrs	4
6	2 hrs	5

Table 5.1.8 Phase Two – gynaecological direct referrals: stages summary

Acute Patient Number	Time in GDR	Number of Stages
1	4 hrs	4 + ACDU
2	4 hrs	4 + ACDU
3	4 hrs	3 + ACDU
4	4 hrs	4

Table 5.1.9 Phase Three – the acute patient at night: stages summary

Acute Patient Number	Time in A&E	Number of Stages
1	3 hrs 50mins	4
2	4 hrs 10mins	6
3	3 hrs 10mins	5

5.1.8 Triangulation of emergent themes

Table 5.1.10 Triangulation of emergent themes –Patient/staff control

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Patient control (incl. the role of expectation)	Patients were not observed exerting control over care, where they attempted this, some resistance from staff was observed.	The issue of control is linked to patient expectation.	The impact of perceived versus actual patient control upon patient perceptions was highlighted by staff and corroborated by researcher observations.
Staff control	Patients generally accepted the direction from staff of their care.	Staff maintained control over patients, particularly where patients behaved within the expectations of staff.	The consultant held seniority in A&E, where a traditional hierarchy was generally observed. The exception was the nurse practitioners in the GDR service and general A&E.

Table 5.1.11 Triangulation of emergent themes – Teamworking/roles and service boundaries

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Teamworking/ roles	Patients dealt with in flatter hierarchy in GDR than other areas of A&E.	Very positive staff views expressed from GDR, also from some parts of A&E at night time and day.	Traditional hierarchy of roles observed in much of A&E. Some issues with interactions between A&E and medical team which resulted in delay for the patient.
Service boundaries	Access to A&E day and night was very open, more restrictive for GDR service. Whilst the '4 hour target' impacted patient care through movement to ACDU, this was not a concern for them.	Clear awareness of service boundaries from staff, for GDR staff particularly. Targets were influential in terms of creating links with other areas such as ACDU and referral beyond A&E.	A number of visible targets throughout A&E services were evident and clearly influenced much of the structure of the department for day night and GDR patients and staff. Movement to ACDU was often not for clinical purposes.

Table 5.1.12 Triangulation of emergent themes – Information flow

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Clinical information flow (incl. waiting)	Patients were generally accepting of the need to wait, on the condition that they received the care they needed.	Some tension between A&E and onward referral services, which were somewhat resistant to receiving patients and so could be obstructive through clinical information flow. Concerns from staff about delays in results - the system recorded them as returned when they were not.	Researcher observations supported those of patients who were generally satisfied and staff who were frustrated by some difficulty in referral to medical teams. Issue of ACDU. Number of stages in the patient journey <i>may</i> not represent efficiency or quality or care.
Information flow (Organisational)	Patients generally not obviously affected by organisational information flow.	Staff reported concern regarding future direction of the service and hospital as a whole. Some anger was expressed due to lack of communication from redevelopment managers relating to change, particularly relating to targets and a perceived lack of understanding from managers of clinical workload.	Some anxiety was expressed from staff regarding the new hospital and an apparent lack of information regarding the future. Disparity between managerial and clinicians' views of changes such as the night team.

Table 5.1.13 Triangulation of emergent themes – Environment

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Environment	Patients did not raise significant concern regarding the environment.	Staff generally felt very positive about moving to a new hospital which they expected to have better stocked, newer facilities.	Researcher observations supported those of staff who anticipated the benefits to come as a result of the new hospital building.

5.2 PACU results

Ten participants completed all requirements for patient mapping. The sample consisted of ten patients (6 male, 4 female) whose parents agreed to be interviewed. The patients' mean age was 2.7 years (S.D. 43.5, range 0.20–144 months); male 3.3 years (S.D. 54.1, range 1–144 months) and female 22.1 months (S.D. 23.6, range .20 – 48 months).

Table 5.2.1 Patient demographics

<i>Patient</i>	<i>Age</i>	<i>Sex</i>	<i>Ethnicity</i>	<i>Diagnosis (if known) or presenting symptoms</i>
1	18 months	Male	Asian	Right-sided numbness
2	22 months	Male	Caucasian	Breathing problems
3	2 months	Male	Caucasian	Colic and sickness
4	12 years	Male	Caucasian	Nephrotic Syndrome
5	4 years	Male	Caucasian	Temperature and rash
6	5 days	Female	Asian	Jaundice
7	1 month	Male	Afro-Caribbean	Rash
8	3 years	Female	Persian	Rash and sickness
9	4 years	Female	Asian	Wheezing/cough
10	4 months	Female	Caucasian	Lack of appetite

Table 5.2.2 Staff observed or informally spoken to

<i>Staff Number</i>	<i>Service</i>	<i>Sex</i>	<i>Profession</i>
1	PACU	Female	Receptionist
2	PACU	Female	Doctor
3	PACU	Female	Nurse
4	PACU	Female	Nurse
5	PACU	Male	Consultant

5.2.1 Basic service structure

PACU was purposefully designed to be a child-friendly environment. Once a patient arrived at PACU, they were greeted by a receptionist stationed directly beyond the main doors. There was a seated waiting area with toys available, where parents and their children were invited by the receptionist to sit and wait until a nurse was ready to collect them from PACU. The unit itself consisted of a number of treatment and assessment areas which spanned either side of a short corridor. On the right hand side of the corridor there were two assessment areas; assessment area one had four bed spaces; assessment area two had four cot spaces. In between the two assessment areas were the sluice and the cleaning room, which also housed the patient white board. Directly outside these two rooms and on the main corridor was the nurses' station with a folder containing patient records. The notes trolley was kept just opposite this. On the left hand side of the corridor were two treatment areas followed by the major treatment room. At the end of the corridor was the observation area which had five bed spaces. The unit was situated in a newly built area of the hospital which was adjacent to the main children's ward.

The unit was part of a growing generation of acute assessment outpatient units where patients were observed, diagnosed and treated for periods of up to nine hours. After this period of time, a decision was made as to whether to admit a child to hospital for longer periods or to discharge them home. Some distinctive features of the PACU service were that it was a gated referral only unit which took no admissions after 6pm, and which closed its doors by 9pm.

The stated objectives of PACU as provided by the senior clinical lead were:

- To support the referrer with accurate, rapid and timely diagnosis
- To manage paediatric emergencies appropriately through adherence to multidisciplinary, evidence-based protocols

- To give parents and carers sufficient information about diagnosis
- To increase parents'/carers' knowledge and confidence in managing their sick child
- To provide and support users' access to health education information
- To reduce the proportion of overnight hospital admissions (defined as equal to or greater than 24 hours)
- To increase the proportion of children with medical emergencies receiving prompt specialised children's nursing observation and medical care who attend the hospital – thus reducing the risk of adverse incident

Basic factual data relating to the structure of the service, conceptualised as level one data are presented in the following Figure 5.2.1. This information is in the form of a diagram which has been developed to represent evidence collected relating to the generic pathways and stages for the patients within the PACU service.

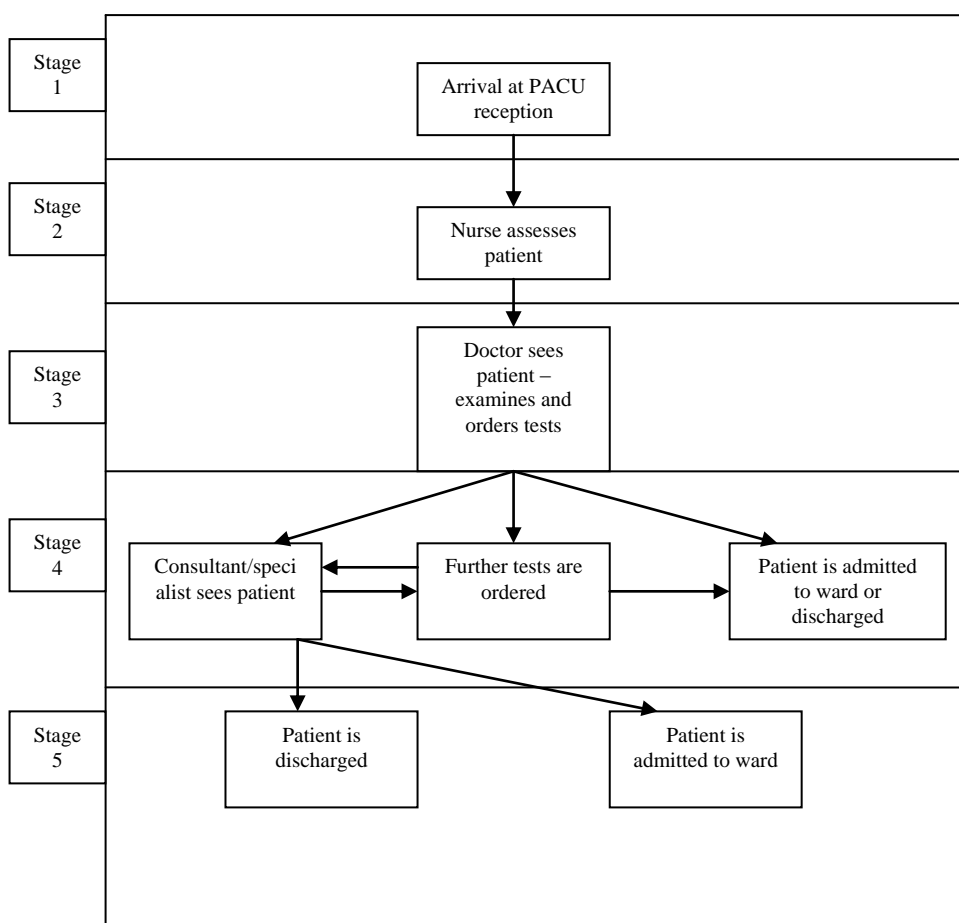


Figure 5.2.1 The PACU patient pathway

5.2.2 Extract from the raw patient data

For illustrative purposes one example of the data collected from the patient mappings and the format in which such data are reported is presented below. This includes a written description taken during the patient mapping which incorporated parent comments (Figure 5.2.2). This data is followed by a grid summarising the stages of the patient journey and any supporting information (Table 5.2.3). Please refer to Appendix IX for the complete data set.

This patient, a baby girl 5 days old, attended PACU with her parents as she had jaundice.

Number of stages in patient journey: 5. Length of stay in PACU: 5 hours 10 minutes (admitted to the children’s ward). The patient was

brought to PACU by her parents following referral from their midwife. The baby's parents expressed that they had been worried since the recent birth of their daughter who had lost 12oz from her birth weight and was jaundiced. The family arrived at PACU at 4.20pm and were given a bed immediately as they were expected (no cots were available at the time). The nurse carried out an initial assessment of the patient and reassured the parents that it is normal for some babies to lose weight after birth. At 5.05pm following an update from the nurse and review of notes, the doctor informed the nurse that blood samples would be required (although at this stage the doctor had not seen the patient). At 5.25pm a student nurse took further details from the parents to update the records. At 5.50pm the nurse collected the baby from the cubicle to take her for a blood test. The blood test was carried out by a doctor. The mother was asked whether she wanted to accompany her daughter through this process which she was warned may be distressing for her to watch. The mother chose to go with her daughter into the room where the blood was taken. Following on from this procedure, at 6.10pm the doctor took further information from the parents regarding their own medical history and that of their daughter. At 6.30pm the doctor carried out a full examination of the baby. Shortly after this examination a cot became available and the baby and her family were moved. At this stage the parents were informed by the nurse that their baby would be admitted to the children's ward over night for further observations. At 9.30pm a bed became available on the ward and they were moved.

The parents reported their high satisfaction with the facilities provided by PACU. As users of the maternity unit, they made the comparison between the two services with PACU rated as far better, in that it appeared to them to be cleaner and warmer. The parents were grateful that they had been given a bed straight away and appreciated the fact that their arrival had been expected. The colourful surroundings, toys and friendly staff eased their minds regarding the concerns for the welfare of their daughter.

Figure 5.2.2 PACU Patient 6: description of the patient journey

Table 5.2.3 PACU Patient 6: stages of patient care

Stage	Action	Who?	Time
1	Patient was brought to PACU by her parents (referred by maternity) and registered	PACU receptionist	4.20pm
2	Immediately provided with bed and patient given initial assessment	PACU nurse	4.25pm
3	Communication between staff regarding patient	Doctor and student nurse	5.05pm-5.25pm
	Blood samples and further patient information taken	Doctor and nurse	5.50pm-6.10pm
4	Full examination of patient – family informed patient required admission to ward, patient moved to cot	Doctor and nurse	6.30pm
5	Patient admitted to the ward	Nurse	9.30pm

5.2.3 An illustration of the thematic content analysis process

This section, for illustrative purposes only, shows the principles of the analytical process as they were applied to the raw data. Having assigned themes and colour coded the raw data, thematic charts were used to appropriately synthesise and assign data within the ‘thematic matrix’ (Ritchie, Spencer & O'Connor, 2003).

The following table (Table 5.2.4) demonstrates the process of thematic charting for the ‘service boundaries’ theme and for practical reasons is based on selected excerpts of the data as they were collected during the acute phases of research from two of the patients. This illustration represents on a small scale, the principles applied across the whole data set.

Table 5.2.4 A thematic chart for service boundaries from PACU

Theme: Service boundaries					
Patient ID, Gender, Age Ethnicity, Symptoms	Contextual information	Process of referral	Adhering to the service boundary 'rules'	Resistance against the service boundary 'rules'	Notes
Patient 1 Male 18 months Asian Right-sided numbness	The patient was brought to A&E by his parents. He had an accident and fell over, banging his head. His mother took him to the generic A&E department where he was given an x-ray to assess any injury.	The decision was made by A&E staff for the patient to be referred to PACU.	A nurse from A&E accompanied the patient and his mother to PACU at 2.15pm where his arrival was expected, and he was immediately given a bed.	N/A	The family reported feeling "very happy" with the care their son was receiving.
Patient 7 Male 1 month Afro-Caribbean Rash	The patient was brought to A&E by his mother as she was concerned about a rash which was covering the baby's body.	The patient was brought to A&E by his mother without an appropriate referral.	Once within the service, the mother adhered to the directions from medical staff.	The patient's mother was informed by her health visitor that PACU was a walk-in centre and she did not require a referral to attend. The nurse who received the patient was displeased that this information had been given to the mother, as it was inaccurate.	The nurse felt strongly about non-acute babies who had inappropriately self-referred. However, the nurse admitted the patient and highlighted to the researcher that the fault did not lie with the patient.

5.2.4 Emergent themes – from patients

The following results and those in the subsequent sections incorporate the conceptualisation of level two data. These are the emergent themes from the experiences of ten paediatric patients and their families who were observed and interviewed during their admission to the recently developed paediatric ambulatory care unit. The main emergent patient themes are presented here and further illustrated using evidence in Table 5.2.5. Triangulation of all main findings from patients, staff and the researcher are found at the end of this section (Refer to Table 5.2.8, Table 5.2.9, Table 5.2.10 and Table 5.2.11). Full data are located in Appendix IX. Taking a collective patient view, five broad themes have emerged from the analysis of the patient data across the unit. These were patient/staff control, teamworking/roles, service boundaries, clinical information flow and the environment. It is important to recognise that the majority of the participant responses from this section of the data were from parents and not the patients. Potential implications for this are discussed.

Patient/staff control

The issue of patient control and medical dominance during interactions with staff was a dominant feature within the data. Patients being cared for in PACU along with their parents were generally observed to comply with staff requests. In conjunction with this, the parents and their children being treated were overwhelmingly positive about their experiences within the unit. One exception to the controlled behaviour was observed by the parent of Patient 7, whose parent directly self-referred to PACU (a finding which linked to, and is discussed in more detail in the 'service boundary' theme). Whilst the patient group served by PACU were 'special' in that they had their own facility specifically to ensure that children had a separate facility away from the main A&E department, the control was generally very much in the hands of the doctors in terms of what happened to the patients and any treatment

they received. All patients were accompanied by their parent, resulting in each patient having a personal advocate to support them and ensure they were treated in an acceptable manner.

Teamworking/roles

The teamworking and roles between staff within PACU specifically were observed to be fairly traditional in their interaction with the patient. The nurses welcomed patients and their families into the unit and carried out the initial examinations whilst doctors made decisions around medication and further admission or discharge.

Service boundaries

All of the patients, with the exception of one, gained access to the service via referral from their GP, midwife, health visitor or from the hospital A&E department. The patient who arrived at PACU without a referral was still treated despite it being made clear to the parent by the staff that this was not the formal procedure.

The facilities and staff within the service were specialised and service centric. On one occasion medical staff were called away from PACU to attend A&E but this was the exception rather than the rule and the consultant arrived to rebalance the lack of medical staff present within the unit.

Clinical information flow

Generally the clinical information flowed without major consequence for the patient. On the couple of occasions where there were some problems around clinical information flow this was due to the misplacing of notes which caused some frustration to patients' families, but did not otherwise impact their overall perceptions of the service.

The environment

Without exception, the feedback from patients and their families being cared for within PACU regarding the physical environment within the unit was positive. Reports were given from families of the benefit of having child friendly facilities including brightly coloured curtains and toys, in addition to the cleanliness and warmth appreciated by many parents.

Table 5.2.5 Patient themes from PACU

Theme	Evidence from the Patient
Patient/staff control (advocates and satisfaction)	<p><i>The parent and patient willingly travelled beyond their local hospital to get to PACU (Patient 3)</i> <i>The patient was encouraged to drink by the doctors which he did (Patient 2)</i> <i>A number of patients actively sought out advice beyond the remit of their GPs hence attendance to PACU (Patients 2, 3, 5)</i> <i>As a patient with a long-term condition he was able to self-refer when necessary for review, to test for protein in his urine & be observed (Patient 4)</i> <i>All patients reported satisfaction with the care received</i></p>
Teamworking/roles	<p><i>Traditional roles were observed in all patient cases with nurses collecting patients and carrying out initial assessments and doctors providing diagnoses and/or discharging patients</i></p> <p>~</p> <p><i>The decision was made by A&E staff for the patient to be referred to PACU (Patient 1)</i> <i>The patient was referred to PACU by his GP whom he had attended an appointment with earlier that day (Patient 2)</i></p>
Service boundaries	<p><i>The patient was brought to A&E by his mother. The patient's mother stated that she was informed [incorrectly] by her health visitor that PACU was a walk-in centre and she did not require a referral to attend (Patient 7)</i> <i>The patient was brought to PACU by her mother directly from their GP who made the referral (Patient 8)</i></p> <p>~</p>
Clinical information flow	<p><i>The mother...was waiting for the results of the blood tests to be returned. Approximately one hour later the mother approached the doctor to ask if the blood results were back and was told they were (Patient 5) [smooth flow]</i></p> <p>~</p>
The environment	<p><i>The parents reported their high satisfaction with the facilities provided by PACU. As users of the maternity unit, PACU rated as far better, in that it appeared to them to be cleaner and warmer. The colourful surroundings, toys and friendly staff eased their minds regarding the concerns for the welfare of their daughter (Patient 6)</i> <i>She [the patient's mother] recognised that the adult world of a generic A&E department is not a pleasant environment for a child, unlike PACU (Patient 9)</i></p>

5.2.5 Summary of patient activity in stages

Table 5.2.6 PACU patients: stages summary

Patient Number	Time in PACU	Number of Stages
1	7 hrs	5
2	3 hrs 30 mins	4
3	5 hrs 15 mins	4
4	3 hrs 20 mins	3
5	6 hrs	4
6	5 hrs 10 mins	5
7	3 hrs	4
8	5 hrs 50 mins	4
9	3 hrs 15 mins	4
10	1 hr	4

5.2.6 Emergent themes – from staff

The following section presents a summary of the data gathered through observations and some informal discussions with staff from within PACU. This data is a collective of the findings drawn from staff during the research period. Sources included the PACU receptionist, consultant, a doctor and two nurses. A summary of the key evidence is presented in Table 5.2.7. These findings acted to support the emergent themes from the patient data and contributed to further considerations for comparison with other services.

Patient/staff control

The findings in terms of patient and staff control related to two issues. Firstly, the issue of access to the service and patients attempting to override the formal procedure for gaining entry to PACU (this is also addressed in the service boundaries theme). The second issue in terms of control related to the way in which staff and patients interacted. From a staff perspective, the patients were perceived generally to be compliant to the direction they provided.

Teamworking/roles

Staff within the unit reported very positive views towards the teamworking and clearly took pride in the team they were a part of. Whilst the evidence suggested that the working roles of staff were fairly traditional in nature, this was not expressed as a negative aspect of the service from the perspective of those working in PACU.

Service boundaries

The healthcare professionals working at PACU made it clear that there was a certain degree of territorial feeling regarding the service. Staff were specialists in the paediatric field and maintained this position through close collaboration with their team and boundaries in approach to the service from the outside. The emphasis of PACU being a referral-only unit, not only meant patients in theory should not have been able to turn up without being expected, but also that any other healthcare professionals, either internal to the hospital, or in a community setting, needed to comply with the rules by which PACU operated for its admission of patients.

Clinical information flow

The ability of clinical information to reach the appropriate member of staff as and when required was reported by staff to be a benefit of the service having specialised facilities and clinical support.

The environment

A number of staff commented on the poor toilet facilities during the period of data collection. However, aside from this staff reported positively in relation to the clinical facilities, security and child-friendly nature of the unit. The staff recognised the benefit of the environment to the patient and appreciated it from a personal perspective, in terms of offering a more pleasant working environment.

Table 5.2.7 Staff themes from PACU

<i>Theme</i>	<i>Evidence from staff</i>
Patient/staff control	<i>Whilst staff expressed frustration when a patient inappropriately self-referred to the unit, they did agree to treat that patient. Aside from this, staff were not required to explicitly exert control over patients as patients tended to adhere to staff requests (Nurses)</i>
Teamworking/roles	<i>Staff were very proud of the good teamworking within the service (receptionist, lead consultant and nurses)</i>
Service boundaries	<i>All staff were very clear about the boundaries in terms of referral, access and operation of the unit</i>
Clinical information flow	<i>The staff were satisfied with the clinical information flow and access to clinical services in support of their care to the patient (doctor)</i>
The environment	<i>A number of nurses commented on the poor toilet facilities within the unit, but otherwise the environment was regarded as positive, with good clinical and child friendly equipment</i>

5.2.7 Emergent Themes – researcher observations

This section presents the researcher observations in support of or in addition to the information collected from patients and staff. These observations support the themes emerging from the patient and staff data as highlighted above and/or have identified issues not otherwise captured. The general observations made from within and around PACU are in part summarised in Figure 5.2.1 reflecting the overall operating processes of the unit, with related researcher observations presented below. The following section describes the key researcher observations which have been made.

Observations indicated that patients in general experienced perceived control over their care (as opposed to actual care in most cases), that they felt the service was set up to cater for them with specialist facilities and equipment. It was noted that parents acted as advocates for their children.

The dynamics of teamworking within PACU were immediately evident to the observer. The staff were cohesive in their teamwork, with the receptionist dealing with patients in the waiting area, the nurses calling patients from the waiting room to the unit where they were assessed and then seen by a doctor. The staff on PACU consisted of receptionists who dealt with PACU patients, a team of nurses (which ideally consisted of four nurses, though at times it was observed to only consist of two) and a team of doctors which included a number of Senior House Officers, at least one Registrar allocated to PACU (with one on the ward) and the Consultant. PACU was staffed by clinicians who operated under the traditional hierarchy of a consultant overseeing junior doctors who dealt with diagnosis, treatment and discharge, supported by nurses.

The PACU team appeared confident in terms of service structure and positioning of the unit within the hospital generally. The lead consultant maintained open lines of communication with the PACU team and made

himself available for staff. The nature of the unit, in treating children held a certain level of 'special' status, both in terms of the patients themselves as children and the clinicians who were treating them. The majority of staff within PACU were dedicated specifically to the service and were specialists in paediatric care.

PACU maintained strict service boundaries, in relation to its operation and service policy. However, there was occasion where this was breached by patients. There appeared generally to be a collective understanding of the service operational policy from both the patients, staff within the unit and other health professionals who interacted with the unit. There was a strong sense of the protected nature of access into the service and the boundaries protecting it.

As a referral only unit, theoretically all patients who arrived at PACU should have been expected, though researcher observations have highlighted where this was not the case. Route of referral was from GP, health visitor or other hospital department such as A&E. Patients could only self-refer if they were given permission to do so by the unit due to a pre-existing condition, often even in these cases they would contact PACU in advance to arrange an appointment time. The service was available from 9am to 9pm. This was a strict service boundary which was observed to apply to all patient cases. No patients would be admitted to PACU outside of these hours, any patients requiring further observation or treatment overnight were admitted to the children's ward.

Whilst there were some minor issues around mislaid patient records, generally observations within the clinic indicated that clinical information flow remained operative and did not present major blockages to patients or staff.

The PACU waiting room and unit facilities in general were observed to be modern, clean and spacious with ample specialist equipment. Nurses were observed to wear colourful child friendly uniforms and none of the

doctors observed during this research were seen to wear a uniform or white coat. Patients and staff both appreciated the specialist nature of the environment and observations suggested that the closeness and protected nature of the environment supported positive social interactions between patients' families and staff which contributed to a relaxed atmosphere for patients and their families.

5.2.8 Triangulation of emergent themes

Table 5.2.8 Triangulation of emergent themes – Patient/staff control

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Patient control (patient advocates)	Observations were made of a patient overriding the referral route into PACU and taking control of their care. Parents are patient advocates in PACU.	Staff maintained control over patients, perhaps partly inadvertently as a result of the service meeting the needs of the users. Self-referred patients were accepted despite not adhering to official admission routes.	Staff were in a position to offer the patient what they required whilst the patients and families were generally highly satisfied.
Staff control	Generally staff directed patients when in the unit.	Staff acknowledged that control over their patients, supported via the structure and systems in place at PACU were important.	Staff were observed to maintain control over patients, apart from the occasion where patients self-referred.

Table 5.2.9 Triangulation of emergent themes – Teamworking/roles and service boundaries

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Teamworking/ roles	Patients dealt with by specific staff for individual elements of care with high feelings of satisfaction.	Staff views were very positive about the PACU working environment, the support from colleagues and general teamwork. Supportive lead consultant.	Traditional hierarchy of roles observed. High degree of 'special status' of staff. No nurse practitioners. Good teamwork ethos.
Service boundaries	Access to the service via referral only, with some cases of patients overriding the service boundaries.	Staff were vocal about the service boundaries, describing to the researcher the policy of referral only and closure at the end of the day.	High visibility regarding boundaries, based on general awareness of the service and some visible notices/ policies.

Table 5.2.10 Triangulation of emergent themes – Information flow

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Information flow (Clinical)	Patients generally very satisfied, with only limited occasions where information had to be repeated by the parent (or unusually, was lost) causing frustration.	Staff generally had access to and presented patients with the clinical information in a timely manner.	Generally this took place without incident and staff operated with the information they required.

Table 5.2.11 Triangulation of emergent themes – Environment

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Environment	Patients were highly satisfied with the environment in PACU, with parents also appreciative of the specially adapted surroundings.	Staff were on the whole very positive about the environment, apart from some minor concerns regarding a lack in provision of toilet facilities.	The environment was observed to be specifically adapted to suit the needs of a modern paediatric facility, both in terms of clinical apparatus and child friendly furnishing. It supported positive social interaction between patients, family and staff.

5.3 Respiratory clinic results

Sixteen patients and five members of the healthcare staff completed all requirements for the research interviews. The patient sample consisted of 16 patients (5 male, 11 female) who agreed to be interviewed. Their mean age was 52.7 (S.D. 12.8, range 29 – 72) years; men 55.8 (S.D. 9.26, range 40 – 62) and women 51.3 (S.D. 14.3, range 29 – 72) years.

Table 5.3.1 Patient demographics

<i>Patient</i>	<i>Age</i>	<i>Sex</i>	<i>Ethnicity</i>	<i>New referral/ follow-up</i>	<i>Diagnosis (if known) or presenting symptoms</i>
1	58	Female	Asian	Follow-up	Asthmatic
2	55	Female	Caucasian	Follow-up	Asthmatic
3	62	Male	Asian	Follow-up	Breathing problems
4	70	Female	Caucasian	Follow-up	Breathing problems
5	61	Male	Caucasian	Follow-up	Coughing up blood
6	44	Female	Caucasian	Follow-up	Irregular heart beat
7	34	Female	Caucasian	Follow-up	Hole in heart
8	53	Female	Afro-Caribbean	Follow-up	Asthmatic
9	35	Female	Caucasian	New referral	Breathing problems
10	54	Female	Caucasian	New referral	Heart murmur
11	60	Female	Caucasian	Follow-up	COPD
12	55	Male	Caucasian	Follow-up	Churg Strauss Syndrome
13	29	Female	Afro-Caribbean	Follow-up	Small lungs
14	40	Male	Afro-Caribbean	Follow-up	Multi System Sarcoidosis
15	61	Male	Caucasian	Follow-up	COPD
16	72	Female	Caucasian	Follow-up	Asthmatic

Table 5.3.2 Staff observed or interviewed

<i>Staff Number</i>	<i>Service</i>	<i>Sex</i>	<i>Profession</i>
1	Respiratory Clinic	Female	Clinic care coordinator
2	Respiratory Clinic	Male	Clinic registrar
3	Respiratory Clinic: (community care)	Male	Chronic disease nurse practitioner
4	Respiratory Clinic	Female	Lung function technician
5	Respiratory Clinic	Male	Consultant

5.3.1 Basic service structure

Basic factual data relating to the structure of the service, conceptualised as level one data are presented in the following diagram (Figure 5.3.1). This information is in the form of a flow diagram which has been developed to represent evidence collected relating to the generic pathways and stages for the patients within the respiratory clinic service.

The original redevelopment programme objectives for the new Expert Consulting Centre (ECC) (incorporating the respiratory clinic):

- Office-based consultation service
- Email support/advice to GPs/community based professionals
- General Practitioners with a specialist interest (GPSIs) to educate GPs
- Efficient administrative processes (including managed 'did not attends' (DNAs))
- Clinic care coordinator will take/manage the patient through the journey
- Timely management of people with chronic disease
- More stringent referral strategies (protocol not in place yet)
- Imaging will be close by as is dedicated x-ray, so less walking
- Telemedicine – links with home. A central server analyses patient responses to specific questions and blood oxygen and looks for trends.
- Positive for the patient – good environment, no mix of patient speciality

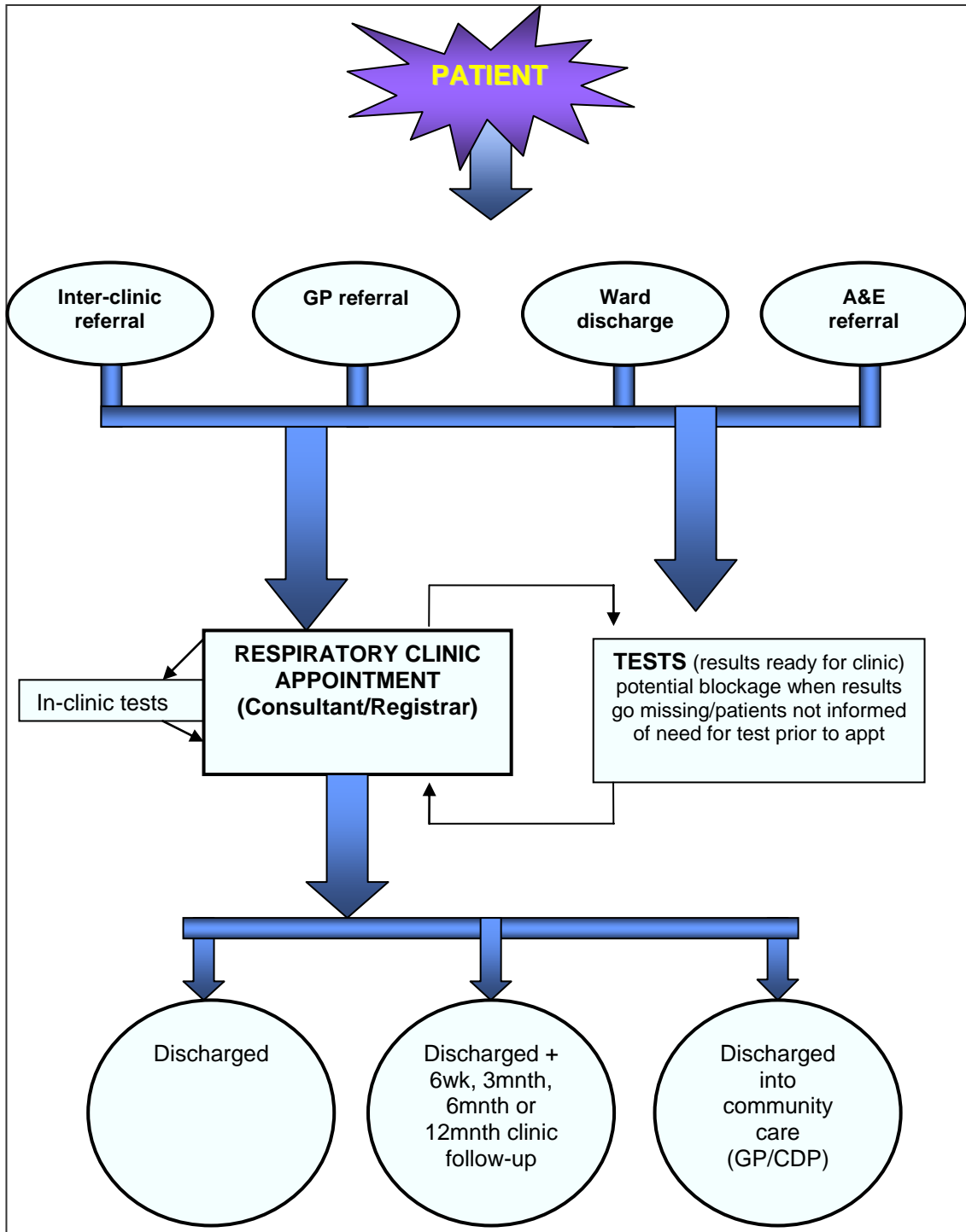


Figure 5.3.1 The respiratory clinic outpatient pathway

5.3.2 Extract from the raw patient data

For illustrative purposes an example of the data collected from the patient interviews and the format in which such data are reported is presented below. Please refer to Appendix X for the complete data set.

This female 58 year old asthmatic patient was attending the respiratory clinic as a follow-up patient; her previous appointment had been mid way through the preceding year. The patient was originally referred to the clinic from another clinic within the hospital (ENT clinic)

This patient was attending hospital for her second appointment with the clinic to discuss her respiratory condition and for what she explained was her expectation of a diagnosis for her current condition. The patient expressed views that GP visits were seen in her eyes to be “an extra unnecessary phase, when the hospital specialist is very good...better.” When asked her views towards the way in which she had been referred to the clinic, she felt the timings for the appointment were good, but her only problem had been tests and waiting to have them done, rather than anything else causing delay. The patient reported that the hospital clinic “tell you straight away when an appointment has to change...but it is difficult to get through on the phone and it takes ages to get to talk to someone.” In terms of the patient’s views of the physical environment, she felt it was not particularly pleasant “it’s dingy and dark doesn’t make you feel good. Toilets are atrocious, meant to be hygienic but I’m worried about what I might catch!” The patient did not feel anxious on her arrival to the hospital, but did report this was due to having her husband accompanying her. The patient regarded the consultant as the main professional involved in her care “My GP is too general, the consultant doesn’t fob me off – he investigates and I feel comforted I’m under a skilled person. I’m BUPA paid member but I choose the NHS and this hospital as I know they don’t give unnecessary treatment, x-rays. They do a marvellous job, the care is what matters above all and they do their very best in the circumstances. It’s a nice atmosphere and I’m lucky to be under them!”

Figure 5.3.2 Respiratory clinic Patient 1: description of the patient experience

5.3.3 An illustration of the thematic content analysis process

This section, for illustrative purposes only, shows the principles of the analytical process as they were applied to the raw data. Having assigned themes and colour coded the raw data, thematic charts were used to appropriately synthesise and assign data within the 'thematic matrix' (Ritchie, Spencer & O'Connor, 2003).

The following table (Table 5.3.3) demonstrates the process of thematic charting for the 'Environment' theme and for practical reasons is based on selected excerpts of the data as they were collected during the respiratory phases of research from two of the patients. This illustration represents on a small scale, the principles applied across the whole data set.

Table 5.3.3 A thematic chart for Environment from the respiratory clinic

Theme: Environment					
Patient ID, Gender, Age Ethnicity, Symptoms	Contextual information	Positive aspects	Negative aspects	Patient's perception of importance	Notes
Patient 1, Female, 58 years old, Asian, Asthmatic.	Patient attending regular follow-up appointment for dealing with long-term chronic condition.	"It's a nice atmosphere and I'm lucky to be under them!"	"It's dingy and dark doesn't make you feel good. Toilets are atrocious, meant to be hygienic but I'm worried about what I might catch."	Despite negative views of the environment the patient chose to attend the hospital rather than use her private healthcare scheme.	Patient was extremely positive about the care received at the clinic.
Patient 9, Female, 35 years old, Caucasian, first appointment.	Patient was attending the respiratory clinic was a new patient hoping to receive a diagnosis. The patient was referred to the clinic by her GP.	"I found it ok and felt relaxed when I got here."	"It's a bit old, puts you off but that's not what matters!"	The environment was not perceived by the patient to be an overly significant aspect of the overall care received.	

5.3.4 Emergent themes – from patients

The following results reflect upon experiences from 16 clinic patients who agreed to be interviewed. The main emergent patient themes are presented here, illustrated using evidence in Table 5.3.1. Six themes emerged from the analysis of the patient data. These were Patient/staff control, Teamworking/roles, Service boundaries, Information flow (clinical), Information flow (organisational) and Environment. Triangulation of all main findings from patients, staff and the researcher are found at the end of this section (refer to Table 5.3.6, Table 5.3.7, Table 5.3.8 and Table 5.3.9) and full data are located in Appendix X.

The first of the themes drawn from the results related to patient control over care. Patients were not generally observed exerting high levels of control over their care in the respiratory clinic, a point which was well illustrated by the case of Patient 10 who felt uncomfortable about complaining about, or to, the doctor for fear of causing him distress despite feeling unsatisfied over certain elements of her experience. In addition there were mixed views from patients when asked who they felt was mainly responsible for their care, with responses ranging from the GP or consultant to the patients themselves. A feeling of some patients being unable to exert control to complain, despite reported dissatisfaction with elements of care related, was observed.

Teamworking and roles, particularly from the patient perspective proved important in the busy clinic environment. The clinic care coordinator was the key administrative role and proved very popular, although patients did not always appear aware of her full responsibilities, beyond that of simply being the receptionist. The access to the clinic was a theme which arose, not as problematic to the patient, but from the information they provided by comparison it was clearly more restricted than in some other services observed. Patients gained access to the clinic via referral from another healthcare professional, which tended to be the patient's GP or another service within the hospital.

Information and communication was not an issue for most patients. Clinical information flowing within the respiratory clinic and between other services, however, was shown by the data to be problematic for some patients, with unnecessary waiting or neglectful approaches causing delays and frustration. Patients were yet to experience the move to the newly built hospital. However, the information flow in the hospital on an organisational basis for patients dealing with aspects of non-clinical services (i.e. delays and car parking) impacting upon the clinic were found to pose problems or cause frustration for some patients.

The final theme from the patient data related to the clinic environment. A number of patients reported a dislike of the physical environment, but this was tempered with a positive regard to being familiar with the clinic location and more importantly, what really mattered to patients was the standard of care they received. The poor standards of cleanliness and hygiene were found to be of concern in the clinic for some patients.

Table 5.3.4 Patient themes from the respiratory clinic

Theme	Evidence from the Patient
Patient/Staff Control	<p><i>"I've had a long wait - sitting waiting and then saw doctor who then told me to go for x-ray - why didn't he tell me to go for x-ray as soon as I got here? I felt I couldn't cause unpleasantness for him so didn't want to complain." (Patient 10)</i></p> <p><i>"My GP is too general; the consultant doesn't fob me off." (Patient 4)</i></p> <p><i>"The [hospital] doctor is in charge of your care, but I feel as a patient just as equally responsible. Ask questions and follow instructions, but when you get home it's up to you." (Patient 7)</i></p> <p><i>"My GP is very good, sensitive and understands my situation. I get more from my GP." (Patient 8)</i></p> <p><i>"The worst bits are that I'm made to feel like I'm making a big deal of something and I have to live with it." (Patient 4)</i></p> <p><i>"I don't like my name being yelled out when it's time for my appointment; I find this quite embarrassing (GP surgery electronic style is better.)" (Patient 12)</i></p>
Teamworking/ roles	<p>~</p> <p><i>Clinic care coordinator a big part of the team: "The receptionist is friendly." (Patient 10)</i></p> <p><i>"A double gold star for her [the clinic care coordinator]." (Patient 12)</i></p>
Service boundaries	<p>~</p> <p><i>"Straight away when I went to visit my GP and I asked to be referred to the hospital which happened and was good, I was actually offered an appointment in 6 weeks which I couldn't make and it was put back, it's been brilliant." (Patient 2)</i></p> <p><i>"Quick referral from my GP [to the clinic] - it was very good." (Patient 9)</i></p>
Information flow (Clinical)	<p>~</p> <p><i>"I wasn't given much information by this hospital...I never see the same consultant twice. My first (incorrect) diagnosis was from a female doctor who didn't answer my questions. I left the room with a diagnosis of a potentially very serious condition with no information." (Patient 7)</i></p> <p><i>"I would have liked someone to talk me through what I have - maybe using TV programs about asthma to help. Leaflets are not always understandable." (Patient 8)</i></p> <p><i>"I've fully understood the information given by the clinic and overall am satisfied with the care." (Patient 9)</i></p>
Information flow (Organisational; incl. waiting)	<p>~</p> <p><i>"Nobody warns you if there is a delay - 2 hours wait is unacceptable...Car parking in the hospital becomes a major problem when appointments run late. During treatment when my consultant changed no one told me this would happen, it wouldn't take much to do, information makes all the difference." (Patient 12)</i></p> <p><i>"...had to wait 3 months to have an echo done." (Patient 7)</i></p>

Theme	Evidence from the Patient
Environment (incl. cleanliness)	<p style="text-align: center;">~</p> <p><i>"It [the physical environment was] ok, we know where we're going in the hospital so it's ok to find things." (Patient 6)</i></p> <p><i>"It's a bit old, puts you off but that's not what matters! I found it ok and felt relaxed when I got here." (Patient 9)</i></p> <p><i>"The care is what's important." (Patient 11)</i></p> <p><i>Toilets are atrocious, meant to be hygienic but I'm worried about what I might catch!" (Patient 1)</i></p> <p><i>"People need to learn to cover their mouths when they cough!" (Patient 8)</i></p>

5.3.5 Emergent themes – from staff

The following section presents the five key emergent themes of Patient/staff control, Teamworking/roles, Information flow (clinical), Information flow (organisational) and Environment. The full data from the semi-structured interviews carried out with five of the staff from the respiratory clinic; the clinic care coordinator, the clinic registrar, chronic disease nurse practitioner, lung function technician and the senior consultant can be found in Appendix X.

Generally, patients were not observed to exert control over their own care and as a result the staff were not required to behave reactively in this regard. There was a traditional medical hierarchy, and thus power structure for staff, in so far as the consultant was most senior and there did not generally appear to be any sharing or overlap of responsibility outside of professional groups.

Following interviews with the various professionals working within the respiratory clinic, the functionality of individual roles became more apparent. Without directly asking the staff members what their responsibilities were, this would not have been immediately obvious as they are not always visible. Certain staff provided the researcher with distinct job roles during interview, some of which were facing changes (for example the clinic care coordinator). The nurse practitioner role was notably absent from the clinic.

Information, both clinically and organisationally speaking, were emergent themes from staff. From the staff perspective, there was some frustration with clinical information flow with the poor functionality of the existing central patient booking service resulting in a lack of information being transmitted to patients. In terms of the future move to the new hospital, concerns were expressed regarding how the patients would find the transition to the new facilities and service. Major concerns were

expressed regarding the overall hospital model and the impact of changes in clinical information flow from the consultant who explained how changes in information flow between GP and hospital would cause financial problems. Issues around organisational information flow, and communication between managers and staff working in the clinic, particularly in relation to the hospital redevelopment and changes taking place, pointed towards uncertainty and a lack of direction within the team, also linked with low staff morale. Staff data indicated a lack of joined up thinking regarding the new hospital and there appeared to be no real cohesion of approach identified across members of the respiratory clinic staff

The final theme reported from the staff data was that of the environment. The anticipation of the imminent change in environment resulting from the new hospital building was something which permeated across all staffing groups. The physical environment was important to staff in varying degrees, from the building itself having little significance, to it being viewed as playing a crucial role in care to be provided and experience for both staff and patients.

Table 5.3.5 Staff themes from the respiratory clinic

Theme	Evidence from Staff
Patient/staff control	<p><i>“The patients should always be seen at least once by the consultant.” (Clinic care coordinator)</i></p>
Teamworking /roles	<p>~</p> <p><i>“Now we will be doing clinical healthcare assistant things, we’ve done NVQs and so can take blood pressure etc...We work all together as one big team.” (Clinic care coordinator)</i></p>
Clinical information flow	<p>~</p> <p><i>“As long as patients get seen, it should be fine, as long as they understand and will be followed at home not just at clinic necessarily, it will be ok but we need to wait and see for sure.” (Clinic care coordinator)</i></p> <p><i>“There has been no information on the patient’s letters they don’t know [regarding the hospital relocation]. It is a good idea but in practice it’s a different matter. There may be a problem with chronic disease patients who will be happy at home, but some will prefer to see a doctor [in hospital] and feel more secure with this as it is how they have been brought up” (Clinic registrar)</i></p>
Organisational information flow (including disjointed thinking and poor staff morale)	<p><i>“We have developed a model with a reduced need for staff, done what the government asks but we don’t get payment if the patients don’t come into the hospital. A phone call by the GP to the consultant, or use of the email clinic avoids admissions or the need for patients to come into outpatients.” (Clinic consultant)</i></p> <p>~</p> <p><i>“We work all together as one big team...morale is a bit low at the moment as we don’t know what’s going on, there has been little explanation (from line management) we are just told. It is important to keep staff up to date on what’s happening.” (Clinic care coordinator).</i></p> <p><i>“[I’ve been given] no information what-so-ever, I will have to hot desk in the [new] outpatient clinic, but I don’t have an office so I’m not sure how it will work! I’m sceptical until I’ve experienced the service change.” (Clinic registrar)</i></p>
Environment	<p>~</p> <p><i>“This new hospital is about putting services in the community and not about patients coming into hospital, even though it is an attractive building it’s not about attracting them!...For the staff working here the new hospital will be a breath of fresh air – a new building and new equipment encourages new ideas and new ways of working.” (Chronic disease nurse practitioner)</i></p> <p><i>“For the patients it [the new hospital] will be better, easier way-finding and a new environment.” (Lung function technician)</i></p>

5.3.6 Emergent Themes – researcher observations

This section presents the researcher observations in support of or in addition to the information collected from patients and staff. These observations supported the themes emerging from the patient and staff data as highlighted above and/or identified issues which would not have otherwise been captured. The following section describes in the key researcher observations which have been made.

Access to the clinic was via referral only (from GP, via A&E or other clinic). Patients arrived at the reception desk in the clinic with the letter they had been sent confirming their appointment time. The clinic care coordinator (CCC) often referred to by patients as the receptionist, was the first point of access to the service for patients. The role of CCC was being developed during this period of observation to include carrying out basic tests such as blood pressure. As part of this development, the service was utilising fewer nursing staff. Patients were either attending the clinic for the first time as new patients, or were follow-ups with regular appointments approximately every three, six or 12 months.

Observations supported a lack of assertion by patients with the clinic staff regarding involvement over their care. The dynamics of teamworking within the respiratory clinic were not immediately evident. The staff were physically separated in their work, the clinic care coordinator dealt with patients in the waiting area, and the clinical staff called patients from the waiting room to the consultation rooms. The roles of the staff were observed to be quite distinct from one another with little overlap.

The clinic care coordinator was seen working mainly as the administrator. The supporting clinical services such as the lung function technician's role were entirely separate (in location and functionally). The registrar and consultant were the clinicians treating patients in the clinic and the managers of the service were located upstairs from the clinic with no

involvement in day to day clinic activities. The role of the nurse practitioner had no visibility in the clinic as they provided home care for patients. The clinic care coordinator was the most visible staff member and appeared to hold together the operational side of the clinic, whilst also proving to be popular with patients.

Service boundaries were apparent in the system of patient arrival at the clinic and staff movement within the clinic and between other hospital services. There was no overt team identity, there did not appear to have been any discussion between the clinic staff regarding any team agreement or service boundaries (unlike other services studied). No targets or systems governing the clinic were visible within the clinic (for example on posters, signs or clinic memos).

There did appear to be some problems relating to the clinical information flow of the respiratory service. General observations of staff in the clinic, specifically the clinic care coordinator, indicated frustration with reference to the central patient booking service which had failed to inform patients when they required certain tests. However, some good examples were also observed of successful information flow for example when a translator was pre-booked for a patient who did not speak English, they arrived as scheduled.

The flow of organisational information relating to the hospital redevelopment had been observed and noted in the duration of the time spent at the hospital by the researcher. The managerial staff had posted notices in public areas of the hospital relating to forums or presentations to inform staff regarding the changes taking place. In contrast to this, through informal conversations or from general observations, some staff were observed to be unhappy with the degree of effort which had been made by the Trust to inform them of what developments were taking place.

The hospital environment was notably tired (and the new hospital building being erected adjacent to the old building a stark visible contrast to this). The respiratory clinic waiting room and facilities in general were observed to be out-dated and in need of some repair. The waiting room was observed to be cramped and dark.

5.3.7 Triangulation of emergent themes

Table 5.3.6 Triangulation of emergent themes – Patient/staff control

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Patient control (perceived vs. actual)	Patients were unable to exert control, even when dissatisfied with treatment, or feeling a lack of respect from clinicians regarding their condition. Varied views on who was responsible for patient.	Staff did not express any issues with regards to patients and control over their own care, in terms of problems or suggestions for change.	A distinction is made between perceived control and actual control. Patients were observed in general not to overtly exert what they perceived as control. The systems within the clinic reflected a medical hierarchy.
Staff control	Patients generally accepted the control over their care by staff.	Staff maintained control over patients, aided by the structure of and expectations within the clinic. The strategic control held by the consultant was undermined by financial difficulties within the Trust.	The staff, especially the consultant, appeared to be the holder of power in the clinic, with the clinic care coordinator being the most visible consistent contact for patients.

Table 5.3.7 Triangulation of emergent themes – Teamworking/roles and service boundaries

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Teamworking/ roles	Patients dealt with by specific staff for specific elements of care throughout their care pathway.	Staff views varied in teamwork, some positive comments made but little interaction observed, staff roles not shared.	Traditional hierarchy of roles observed. Limited degree of 'special status' of staff. Limited visible interaction between different staffing groups.
Service boundaries	Access to the respiratory clinic service was via referral only, with no cases of patients overriding the service boundaries being reported.	A lack of cohesive thinking from staff regarding elements service structure indicated that service boundaries and objectives were not commonly discussed.	There appeared to be no clear jointly defined focus on this. No visible referral to targets within clinic environment was observed. Medical prestige and specialism limited in relation to other services.

Table 5.3.8 Triangulation of emergent themes – Information flow

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Information flow (Clinical)	Patients reported mixed responses; some were dissatisfied whilst others were not. Patients reported wanting more/better information.	Major threat perceived in new information flow between clinic & GP. Concerns for patients adapting to new systems.	Researcher observations supported those of staff where evidence was collected of staff who were frustrated with central booking service etc.
Information flow (Organisational)	Patients generally not obviously affected by organisational information flow. On occasions where they were, this related to poor inter-department communication.	Staff reported concern regarding future direction of the service and hospital as a whole. Morale was perceived to be suffering as a result of this lack of information.	A general anxiety exuded from many staff regarding the new hospital and an apparent lack of information regarding changes in job roles, responsibility and future job security.

Table 5.3.9 Triangulation of emergent themes – Environment

<i>Key Themes</i>	<i>Patient Data</i>	<i>Staff Data</i>	<i>Researcher Observations</i>
Environment	Patients were more concerned with clinical care than environment. Familiarity of the old clinic, despite it being less modern was appreciated.	Lack of cohesive view: ranged from the building not being important, to recognition of the contribution of new facilities.	Researcher observations supported those of staff where evidence indicated staff were frustrated with central booking services etc.

6 Discussion of patient and staff experience in three NHS services

The following chapter builds from the previous results chapter and is a reflection of the findings from the three clinical services within the Trust at the centre of the research. The data have been analysed in line with the topic guides, with regard to the redevelopment programme, with consideration of stages in the patient journey and in the context of the main research questions and those specific to the individual service areas. Patient experiences, the structures of the service and implications from a staff perspective have been considered. The major changes which are facing, or have faced the service, both in terms of service structure and physical facilities are described in detail in the results. The aim of this chapter is to raise and consider questions and issues which might be relevant from one service to another and to the overall discussion of the thesis.

6.1 Acute service

This preliminary discussion will reflect upon the key emergent themes from the three phases of data collection within A&E; day time, gynaecological direct referrals (GDR), and night time patients. The perceptions of patients and staff of the changes, along with the changes facing the service are reflected in the key themes below.

These findings are a culmination of the analysis and triangulation of evidence from patients, staff and researcher observations, as presented in the results chapter. The key themes are: Patient/staff control, Teamworking/roles, Service boundaries, Information flow (clinical),

Information flow (organisational) and Environment. The critical considerations being drawn out relate to how patients exert control or not with staff within any apparent service model, how staff operate within such service models (knowingly or not) and how information flow and environmental structure influence or relate to this.

The patient sample was fairly representative in terms of what might be expected with regards to presenting symptoms at the A&E department, gender mix and age of patients based on consultation with the lead consultant prior to data collection and cooperation from the lead nurse who aided the researcher in selecting 'typical' patients for interview. Whilst the findings might be broadly generalisable to other similar A&E environments, there were aspects of the service which would only have potential generalisability for other A&E services in a comparable context (i.e. similar patient population and facing imminent redevelopment).

6.1.1 Patient control

As the first location of data collection, this discussion of the findings from the acute service reflects an analysis of the early emergent issues at the hospital. The first theme to emerge related to patient control. This discussion considers patient control, at least as it is perceived by the individual. In this sense, the broader definition of perceived control and health as proposed by Wallston et al. (1987), where perceived control is defined as "the belief that one can determine one's own internal states and behaviour, influence one's environment, and/or bring about desired outcomes" (Wallston et al., 1987, p. 5), is useful.

There is existing evidence of a closing of the gap in medical knowledge between clinicians and patients, especially for chronic conditions (Smith, 2002). Apart from day time acute Patient 3, the range of patients observed

in the acute service were not sufferers of chronic conditions and so it can be assumed that they had relatively limited prior knowledge or expertise relating to their attendance to the hospital, than a chronic patient might. This lack of knowledge left patients more reliant on the clinician for gaining knowledge. Evidence from GP consultations in England already suggests that clinicians tend to accommodate a more passive orientation, making decisions for patients who prefer to have decisions made for them (Makoul, 1998). Individual patients' reaction to this position in the GP environment was supported by the findings here in an acute context, where it was reflected in the majority of the patients observed.

The exception to this, however, was seen in Phase One during the day time observations. Here Patient 1 made attempts to call out for staff attention, which was resisted by two doctors, until the patient was finally responded to by a nurse. The actions of this one patient have raised an area for further consideration around the role of the patient and their apparently willing 'compliance'. This is particularly interesting given that there is the view that the extent to which patients are involved in treatment plans may impact subsequent compliance and furthermore, that such compliance is paramount in the effectiveness of treatment (Catherine, 1996).

The remaining majority of patients observed across the three phases of A&E services in general, were passive and willingly adhered to the instructions and direction provided by the clinicians caring for them. This trend is supported by evidence from Arora and McHorney (2000) whose medical outcomes study identified that a majority of patients prefer to leave their medical decisions to their physicians, (although preferences may vary according to characteristics of the patient). As outlined above, the notable case of exception to this was from the day time Patient 1 whose relatively increased resistance may have been along similar lines to chronic patients' increased awareness, whereby she was more familiar with the experience

due to a recent prior admission of the expectations of her role as a patient. Because she was not content with the information she was being given in relation to her stay in the hospital, she perhaps had some awareness of how to resist any expectations she felt were being placed on her. This evidence from Patient 1 supports the classic work of Lorber (1975) which showed that patients in a general hospital who interrupted well established routines or made additional work for clinicians were termed 'problem patients', which in extreme cases (although there is no suggestion this was the case for Patient 1), could lead to outcomes of neglect or premature discharge.

The ability of doctors to maintain some distance from Patient 1 once she had been treated, and the subsequent avoidance of interaction with the patient suggests implications for patient and staff control which will be discussed at a later stage with reference to the findings which have emerged. That it was a nurse and not a doctor who finally responded to the patient is of interest in terms of the culture on the unit and the differing professional roles and obligations. This may be accounted for through the medical dominance which is perceived as one of the most obvious features of the healthcare system (Brown & Seddon, 1996). At the time of observation, the doctors did not appear to be overly busy, and it was unclear why doctors left it to a nurse to respond to the patient who was directly communicating with them.

Those patients who appeared passive were also on the whole satisfied with the care they were receiving. Day time Patients 2 and 3 may be seen to have felt they were in control of their situations; in as far as they were both getting treated. Although at times this meant that they were not required to do anything, the interpretation might be that they felt they were the focus of the staff's attention and so were satisfied.

Day time Patient 3 presented a different scenario from a clinician's perspective. The previous two patients presented fairly simplistic medical

cases which were swiftly dealt with and actions put in place to resolve. Patient 3 presented a more complex clinical case. As a chronic patient, he was used to treating himself and having a greater understanding, involvement and control over medication and decision making, an effect supported by the work of Smith (2002). In this case, however, as he was severely ill despite having knowledge of his condition and awareness of treatment, he was mainly happy to allow the doctors and nurses to care for him without much input.

During the observations of Patient 3, it was clear that the staff's inability to reach an understanding of why the patient was not getting better as quickly as they would have liked was frustrating. There is support for the effect of being unable to resolve the situation of the patient's condition causing frustration for staff (Roberts & Dyer, 2003). The patient himself was fairly resigned to the fact that he was to a certain extent in limbo waiting for an improvement. Despite the fact that the patient required a longer stay in the hospital, he was not admitted to a ward but left for the few days on ACDU. In terms of the medical condition, as this patient presented a more complicated case to staff, it may also have resulted in greater stimulation of interest or challenge to the medics.

Attendance by all the patients to A&E by Phase Two gynaecological patients was related to pregnancy. Consequently, this patient group was observed to receive increased consideration from staff and more individualised facilities as provided by the direct referral service (i.e. private rooms and dedicated scanning). The provision of specialised facilities for the women treated in the GDR was reflected in the objectives highlighted by the nurse practitioner which was to be an 'advocate' for patients. The nurse practitioners were able to fulfil such an aim in a service which, unlike generic A&E, had fast track systems. Average expectations of a patient experience in hospital A&E may have been exceeded for this patient group, in that they reported

satisfaction with waiting times and the focus upon establishing the welfare of any pregnancy was of great reassurance to the expectant mothers. This is in line with findings from Wilson (2000) who acknowledged that to accommodate appropriate, faster care for the mothers, unborn children or patients potentially suffering miscarriage is beneficial to the patient. There was little evidence of the GDR patients needing to place greater demands upon those treating them, potentially due to the dedicated facilities and staff able to focus solely on their care. However, for GDR Patient 4, some aspects of this were lacking in her view, perhaps influenced by her previous experiences of a pre-existing condition.

It might have been expected that given the reported changes from the redevelopment managers around the new night team, something exceptional or at least different to the day time, would occur during the night time phase of the research. Two of the patients observed being treated by the A&E night team were particularly elderly and the female patient especially frail. In the case of Patient 1, the relative who accompanied the patient was more vocal with the clinicians than the patient himself. Patient 2 was particularly frail and hard of hearing, so as a result was less able to clearly exert her will in the same way that other patients might have been able to. In terms of patient control, this may have resulted in the balance of control being different than it might otherwise have been, given that frail older adults often have many complex medical problems, have a lower ability for independent living, may have impaired mental abilities and often require assistance for daily activities (Torpy, 2006).

Elements of 'playing the game' or adhering to the well established routines as Lorber (1975) suggested, in the case of day time and GDR patients observed in A&E, where they were seen to be passive when receiving good care, and more vocal when they felt in need of more time from clinicians, whilst still apparent to an extent were less obvious at night. This may

perhaps be due in part to fragility in the case of Patient 2 and due to the strength of the doctors' view that Patient 1 may not have required referral from his GP. As a result a subtle shift in power may have occurred.

6.1.2 Staff control

The working context in A&E may bear some relation to the consideration of staff and issues of control. Those staff working within the A&E department were governed by the four-hour target, as outlined in the NHS Plan (Department of Health, 2000) implemented in 2004, within which 98 percent of patients were expected to be treated. In addition to heightened targets to provide patients with a more efficient service structured around their needs, (Department of Health, 2006c), this staffing group was also concerned with major changes facing them as a consequence of the redevelopment programme at the Trust. The impact of such change programmes on staff has been illustrated to lead to a danger of the 'psychological contract' between staff and their employer suffering damage (Cortvriend, 2004).

From a staff perspective, the hospital represented a working environment. Any uniqueness of the experience as it would be for patients would not be as heightened for staff (although clearly they were aware of stressfulness of the situation facing patients in A&E). Research has shown that most patients attending A&E experience anxiety both with regards to psychological and physical factors (Byrne & Heyman, 1997). From the patient perspective, the nature of a visit to A&E was associated with an urgent situation which in the majority of cases would have been unexpected.

Research has been shown elsewhere in a healthcare context that providing or failing to provide the care patients hoped for is an important predictor of patient satisfaction with care (McKinley et al., 2002). The data from the current study where the majority of patients reported that they were satisfied,

perhaps suggests that patients' expectations were met. The evidence also indicated that clinicians were sensitive to patient expectations of hospital experiences. This is an important finding considering that staff were generally observed to maintain control and is particularly relevant given the aim of the redevelopment facing the service. The source of these expectations may have been individual to the patient, or possibly linked to the high public awareness of the NHS as a result of its politicised nature. This finding is supported by evidence from GP prescribing behaviour which has shown if the general practitioner thought that the patient expected medication, patients were ten times more likely to be prescribed medication (Cockburn & Pit, 1997).

Managing patient expectation was raised as an issue by the A&E sister, in terms of what a patient should be entitled to, the control they had over the situation and expectations, with the example given of transport. Cockburn and Pit's work also illustrated some of the implications of patient expectation, where those who expected prescription of medications were three times more likely to be prescribed medicines for new conditions. With respect to the current study, this suggests that a patient's prior expectations and view towards the level of control they had over care and how this influenced levels of satisfaction are important to understanding experiences.

6.1.3 Teamworking/roles

There is a vast literature on the NHS, team roles and teamworking in particular which incorporate a focus on the interaction between variations in team factors and both psychological (including stress, for example Evans, 2002, and satisfaction for example Adams & Bond, 2000) and clinical performance and outcomes (for example patient safety, Flin et al., 2003, Leonard, Graham & Bonacum, 2004, Jain et al., 2006).

The service models which defined the teamworking arrangements for the A&E department had been highlighted by the redevelopment programme team as a particularly important aspect of the redeveloping A&E service. The A&E department (as it was observed here) prior to the move to the new hospital was seen by the redevelopment team as a 'microcosm' of the clinical and team systems which would be operationalised after the move on a hospital-wide basis. For example, this included focus on a reduction in the number of unnecessary stages in patient care, greater multidisciplinary working and an increase of more highly skilled clinical staff in the context of an overall reduction in general staffing levels.

The introduction of the new night team was a significant aspect of the changes in A&E. A number of the clinical staff were not aware of the concept or label of a 'new night team'. This was despite the term having been so frequently raised by redevelopment programme managers to the researcher, prior to commencement of data collection. Some staff were in fact adamant they knew nothing about the new night team and that systems of working had not changed. The view that teamwork involves a range of functions and people working together for the benefit of the group and crucially as Wright and Hill (2003) outline requires an alignment in their purpose and direction, might indicate this as an area of concern for the staff of the new night team who were unaware of its future direction.

Observations of staff working in A&E at night time were generally similar to those in the day time. However, there was one notable difference in that staffing levels were lower at night time and many of the other hospital services which A&E might refer to were closed over night. The general teamworking during the night time was highlighted positively by one nurse practitioner who made a point of stating that relations with doctors were good and further more, they were better than during the day. This may have been as a result of more limited multidisciplinary support than during the day,

which is interesting given that multidisciplinary teamwork is said to becoming more important in both the delivery of healthcare and in the organisation and management of that delivery (Boaden & Leaviss, 2000). A&E night time staff were observed to function with more limited facilities and had the least protected of any boundary to a service, so it may be that the increased challenge drew the staff closely together despite the limitations inherent in a night time context.

The benefit of good teamworking and awareness of others' roles and good communication in a team has been identified as being an important foundation from which patients receive comprehensive and consistent information (Jenkins, Fallowfield & Poole, 2001). Based on the observations and feedback of individuals studied, the teamworking in the GDR service was clearly functioning in a way which suited the staff and the patients. All GDR staff members had positive regard for the structure of their service, the view of what they offered to patients and the process of interaction with other clinical services.

The objective of the Trust, as outlined in the hospital strategy (reference removed for purposes of anonymity) was to provide integrated care from multidisciplinary teams working closely together. However, there is evidence from this study that not all teams were so integrative. A separation between the roles of doctors and nurses referred to by Robinson (1995) as the "subjugated position of nurses within health care" (p. 65) was observed to some extent in this study, particularly in the day and night time services. Nurses were observed to be responsible for the majority of day to day care of patients. Patients also appeared to be aware of this and noted when their experience did not match the expected stereotype. For example, Acute daytime Patient 2 highlighted an episode of the doctor attempting to take blood, perhaps one of the more menial tasks traditionally associated with nurses (Bradshaw, 1999). The doctor failed and the nurse completed the

task successfully. This reflects, albeit on a small scale, an attempt to be fully integrative as a team, but also illustrates that unexpected blockages can occur. It is also supported by research elsewhere also based in an A&E setting which revealed areas in which nurses' work appeared to move closer to the focal tasks of diagnosis and treatment and also observed patterns of doctor-nurse interaction at odds with this common supposition of roles (Hughes, 1988).

The GDR team, on the other hand was an example of where the nurse practitioners and registrar had more apparent equal status. Their system appeared to work well, with patients being seen very quickly (although delays experienced waiting for a bed on a ward after being treated in A&E were consistent across the phases).

The consultant in the A&E observational unit 'ACDU', was observed as senior to nursing staff and the anticipation of some nurses to the consultants arrival was indicative of this; whether this was to the extent where they were "being treated like 'gods'" (Meehan, 2000, p. 3) was not clearly determinable. There was also evidence of the power of doctors generally, for example as doctors were the only ones who were able to discharge a patient. Kennedy's (2001) Bristol Inquiry Report made it clear that medical culture has an imbalance of power where "consultants enjoyed (and still enjoy) what is virtually a job for life. Their relationship with the trust that employs them makes it difficult to bring about change" (p. 3). Clearly some traditional medical hierarchies, as Baggott (2004) describes, remain stubbornly fixed.

Whilst some aspects of the evidence supported a more stereotypical hierarchy between doctors and nurses, there was also evidence where this was not reflected, and where shifts in professional roles were observed. The role of Sister and Matron were both in operation in A&E, and held significant weight in managerial terms. Nurse practitioners were being offered, and

were taking up developed and extended roles which were observed in operation, particularly in Phase Two where GNP had high levels of autonomy in comparison to the standard nurse. This finding supports the view that senior nurses are well placed to promote and support substantive change in NHS culture (Pollard, Ross & Means, 2005). Furthermore, the finding provides additional support for evidence offered by Rafferty, Ball and Aiken (2001) that the common notion of teamwork being emphasised over professional autonomy particularly in nurses, is misplaced. The nurse practitioners involved in this research viewed favourably their increased autonomy. Whilst this is positive, on a logistical note, however, there is also a concern relating to the validity of the policy assumption itself; that a sufficiency of nurses is available for doctor substitution, whilst still allowing the nursing element to function at appropriate capacity (Calpin-Davies & Akehurst, 2001).

This shifting of some of the basic stereotypes surrounding the power of medical and nursing professionals is supported by the assertion that, as the largest occupational group within the NHS, nurses have attracted considerable management attention (Bolton, 2004). The role of nurses in managerial positions and with greater clinical responsibility requires further investigation perhaps with a focus on roles such as the nurse practitioners at the Trust.

Service context or structure plays an important role in the formation of teamworking and collaboration between all health professionals results in high quality clinical care (Begley, In press; Available online 4 January 2009). Evidence of the impact of service context has been illustrated by Reynolds and Timmons (2005) who suggested that in theatres as opposed to multidisciplinary teams on hospital wards, doctors and nurses were able to get on in a “friendly, informal and efficient atmosphere” (p. 110). The influence of service context upon teamworking found in this research was

somewhat mixed. The observations of the hospital A&E department reflected the relationship of teams working in a somewhat segregated manner, despite the strategic objective of fully integrated teamworking. Doctors' physical location on the unit reflected this. However, there were also clear indicators that the doctor-nurse relationship was at times more positive and nurses with good working relations with doctors often regarded that problems were due to specific and limited personality clashes. The GDR service presented a more closely knit team structure and may provide a potential explanation for the impact of different service context upon teamworking. The GDR service had focused vision and specialised equipment. On the other hand however, good teamworking was reported by the night team staff who did not appear to have the same service structure, indicating there are more factors involved.

6.1.4 Service boundaries

Service boundaries were fairly consistent for each of the acute phases, but during the research discussions with staff, the issue of targets was raised as relevant to the acute service. The government's 'four-hour target' for patients in A&E as outlined in the NHS Plan (Department of Health, 2000) and implemented in 2004, was intended as a means to reducing waiting times for patients (Warner, 2005). The target has proved a popular topic of debate across the NHS in general and has attracted some negative attention from clinicians (Eaton, 2004, Cronin & Wright, 2006). This was illustrated in a survey by the British Medical Association (BMA) which claimed that sustainability of the target was of concern and the focus upon A&E departments was limiting (www.bma.org.uk, 2005).

The concerns raised nationally from the BMA (2005) survey were reflected, to some extent, by staff at the hospital. The four-hour target was viewed as an issue in A&E with concerns raised by staff spoken to relating to the focus

on time, rather than purely on treating the patient. As a result, as in many other hospitals according to the staff at the hospital, additional units have been created to work around this. The Acute Care and Diagnostic Unit was created at the hospital, which acted effectively as an extension of A&E, but was officially used as an observation unit to prevent breaches of time targets without having to discharge the patient or admit them to a standard ward. Staff felt that the creation of ACDU “plays the game” to avoid bad statistics and meet with government targets. This is something which has taken power away from, as opposed to increasing it, for both clinicians and patients alike.

The notion that the existence of units such as ACDU being used to ‘cheat’ the target system, without necessarily having a clinical justification for doing so is one which has some support (Gulland, 2003) and is not unique to this hospital. A response by hospital doctors to an article published in the British Medical Journal (Shah & Shah, 2004) reflecting upon the four-hour target in A&E also highlighted the seemingly common practice of labelling wards or other areas traditionally distinct from A&E, in a manner which bypasses the four-hour target in a similar manner.

The values of the GDR service, in aiming to provide more efficient specialised care, were echoed both by the staff and the patients. One nurse practitioner working in the GDR specifically regarded her role as one of patient advocate. The four patients observed had positive views about the speed in which they were seen by the GNP and were reassured by the dedicated facilities. The findings indicated that the GDR service had protected boundaries and artefacts which were specific to the service, such as the specialised scanning room and private patient rooms. These factors contributed towards being able to define the service as culturally distinct from the generic A&E department which housed the day and night services,

as such artefacts are commonly reflected in the various definitions given of culture (Scott et al., 2003a).

In A&E at night time, there was no immediate alternative for staff to refer patients on to another service. This may have resulted in greater obligation or feeling of responsibility on the part of the staff to treat patients within the department, irrespective of any possible boundaries or targets. On the other hand, the very nature of the fact that the service was open over night may have meant that it attracted inappropriate admissions. This might have included people with no-where else to go, putting further pressure on the service. It might be considered that patients who attended during the night and were admitted at such an unsocial time perhaps felt they were more genuinely in need of urgent treatment, thus making the service busier due to the potentially heightened clinical demands of patients. Lower staffing levels could further confound the situation through other services closing overnight or be purely due to the reduced staffing structure in A&E at night.

The GDR service had relatively greater protection of boundaries and specific artefacts than the other the acute service, for example, the specialised scanning room and private patient rooms which contributed towards being able to define it as having a cultural identity of its own. With services shut down over night, due to reduced staffing levels, this forced patients to wait to have certain scans done the following morning. Despite this, the government strategy outlined by the NHS plan of the A&E four-hour target (Department of Health, 2000), was observed generally to have been adhered to in the patients studied.

6.1.5 Information flow (clinical)

Patients had some awareness of clinical information flow, particularly with respect to delays and waiting for results. However, they were happy to wait

on such occasions so long as they felt they were receiving good care, which all did. This is clear indication of the patient focus being upon perceptions of how they received care (functional issues) compared to the staff focus which tended to be around more technical concerns (for example the GDR staff appreciation of a dedicated qualified sonographer, versus the patient focus on the speed of being scanned). The issue of technical and functional aspects of service is an important aspect of the findings which will be followed up in subsequent chapters.

The government strategies outlined by the NHS plan (Department of Health, 2000) for patient-centred care and improvements in waiting times were reflected in part by literature referring to service procedures visible and observable on the hospital walls or the Trust intranet. However, the conclusion drawn by Michie, Miles and Weinman (2006) in their review of the field was of an inconsistency of evidence as to whether patient-centeredness is associated with beneficial physical and psychological outcomes.

Furthermore, as the evidence from the current study showed, these patient-centred procedures were not always reflected in the flow of care given to the patient in the way they were originally intended and certainly patients were not informed for example, that they were being moved to ACDU in order to avoid breaching targets. The movement of many of acute day and GDR patients to ACDU to overcome the threat of breaching the A&E four-hour government target was evidence of how some areas of the service's espoused values were more idealistic than realistic.

The existence of ACDU, with its declared objective of functioning purely as an observational unit, in comparison to the actual usage as both a treatment and longer-term option (as for acute Patient 3 who was on the unit for almost three days) is one significant example of where clinical action and information flow to the patient did not match policy. Critical reactions to

similar activities in order to adhere to targets have been illustrated in hospitals elsewhere in the UK.

6.1.6 Information flow (organisational)

The redevelopment programme appeared to be on the minds of many of the staff involved in the acute phases of data collection. Staff were aware that significant changes to their working lives were imminent but many voiced concerns over lack of information or consultation from senior levels. This finding has been reflected in the literature where it has been suggested that that leadership and management styles have a significant impact on staff experiencing such changes (Cortvriend, 2004). When considering what Schein (1985) referred to as the basic underlying philosophies, whether an organisation truly does what it says it does, this finding is particularly interesting.

Aspects of the redevelopment programme team objectives around the hospital reorganisation and new service policy were at times observed as misaligned with staff views. In fact Schein (1985) suggested that it may be the case that espoused values are not employed in practice. An example from the evidence might include the consultant who was adamant about the lack of night team as a concept in reality and the direct contrast of this view to that coming from the managerial perspective. This is emerging evidence which questions how feasible it is for any hospital to operate in a way which genuinely reflects its basic underlying philosophies and specifically in this case, of some form of mismatch between the clinical reality and policy. This is also reflective of how cautionary an approach must be when attempting to interpret aspects of culture when reflected through experiences of individuals. The mixed response from staff relating to the redevelopment is consistent with the call for increased evidence of the impact of redevelopment upon staffing (Aiken, Clarke & Sloane, 2000).

6.1.7 Environment

The physical environment within the A&E department during the day and at night time was generally consistent. The main difference related to the fact that there tended to be fewer other patients wandering around at night, and the staffing levels were slightly lower for certain services. The artefacts Schein (1985) described or the visible structures within the organisation were not specifically distinct from those in the day or night time acute care. However, for GDR patients there were some differences. Whilst patients were located within the broad context of A&E, they were also provided with private side rooms, specialist staff and dedicated equipment. Overall, therefore, the environment the GDR patients found themselves in was protected from the discordant atmosphere sometimes associated with A&E departments (Saines, 1999) contributing to the general perception of the GDR as more comfortable than for generic A&E patients.

6.1.8 Stages of the patient journey

In addition to the themes drawn from the data, reflections upon the stages of the patient journey have been a supplementary means through which to consider the overall situation within each of the hospital services studied.

Each individual patient has been represented through stages on their journeys whilst in hospital. Analysis of the stages in a patient journey has the potential to be a useful means of comparing patients and categorising certain elements of their experience. 'Stages' refers to occasions when there is a hand over to a different group or specialist healthcare professional. Hospital managers initially reported that one of the objectives of redeveloping the hospital was to streamline patient care and reduce the number of stages in the patient pathway throughout A&E. This was reported to be part of the reasoning for the introduction of a new night team which

would operate a system of faster referral to the appropriate speciality for patients attending A&E.

The staff expressed a view that the numbers of stages themselves were not important, but the appropriate care given to patients was. This has been reflected by the views of the patients who were satisfied when they were referred to different teams of specialities providing that they felt they were receiving good care.

The variations in terms of stages for the staff working within Phase One (Acute general) compared to Phase Two (GDR) presents useful points of comparison. The Phase One staff appeared at times, to come up against a greater level of delay when requesting blood tests or other investigations, than the GDR with their own scanner, for example. Clearly there was some link to facilities available to the respective services. It may also be possible that the protected boundaries of the GDR service had an influential role, preventing the less appropriate patients from reaching the service in the first place.

The general environment was, on the whole, the same for day, GDR and night time services. Certainly both day and GDR services relied heavily upon ACDU to avoid missing their four-hour target. The Phase Two GDR patient group benefited from having a specialist team who were devoted to their care, in addition to specific medical equipment to increase the efficiency of examinations and treatment. However, despite this specialist provision proportionally, the GDR service was actually observed to rely on ACDU more than the generic A&E service.

The evidence from both patients and staff suggested that fewer stages in the patient journey did not always reflect more efficiency or better care for the patient. All of the patients observed officially met the criteria for the official

four-hour target in A&E. However, ACDU was utilised heavily specifically to ensure this was the case. The two exceptions to this in the data (acute Patients 3 and 4) where patients were left for relatively unusually long periods of time in ACDU were curious. It is unclear from the evidence, why if they were unwell enough to stay in hospital for two or three days, these patients were not admitted to a ward. There are a numbers of reasons which may be speculated at, including a lack of beds on the wards.

6.1.9 Policy match to clinical reality

Reform and development in the NHS has increasingly placed the patient at the centre of services. The role of patients has evolved from a focus on customer or consumer culture in the NHS which had begun emerging by 1990 (Warden, 1990) through to explicit NHS policy striving for more choice and control for the patient. (Creating a Patient-led NHS, Delivering the NHS Plan: Department of Health, 2007a)

Interestingly, in the case of this study, putting patients in control of and at the centre of care was not something which emerged from the evidence as something the patients expressly desired. On the other hand, the patients may have felt that receiving attention from staff and being the subject of clinical professionalism resulted in them feeling in control despite not having to make explicit demands. This may go some way to explaining the actions of Phase One Patient 1 who began to impose her wishes on the staff as she was not feeling comfortably in control at the time. Patient 2 appeared relatively passive, but again, this may have been due to receiving the care she expected and not feeling a need to redress the balance. There appeared to be some unspoken mutual agreement in the A&E scenario between the patient and staff. The degree to which patients themselves were happy with the responsibility of their care (had they felt obliged to take

more control) requires further consideration and will be reflected upon throughout this study.

The framework within which all patients are treated once admitted to any A&E department hinges upon the four-hour government target (NHS Plan, 2000). The A&E service observed in this study was no different, and in fact had systems (i.e. ACDU) set up to facilitate adherence to the target. In reviewing the data presented here, it has become apparent that patients were being shoe-horned into a process which complied with this target, purely because the policy existed, rather than for any specific benefit to the patient. The target did not appear to make any difference to the patient experience; a finding both supported by staff who commented on this issue and as indicated by observations of patient journeys.

The system at the hospital allowed for adaptation to accommodate patients who need to stay beyond the target time of four hours, by simply moving them to ACDU. This raises the obvious question of why the target exists at all. It has been suggested that such targets are applied for their ease of measurement rather than their clinical effectiveness (D'Sa et al., 2003). Patients appeared content when being cared for in ACDU, despite this involving a bed move. This acceptance of moving may have been in part due to the indirect benefit for the patient in that it operates as a forced information giving point. When a healthcare professional moved the patient, explanation was required and the patient was for that short time the main focus. However, staff were far less positive about the need for ACDU, the fact that one nurse specifically referred to it as "playing the system" was clear evidence that for the staff it was a constant reminder either of the bureaucratic or unrealistic nature of the four-hour target. A more negative interpretation might be ACDU functioning as a reminder to healthcare professionals that they were continually failing to serve their patients in a manner which met with government expectations.

There are also questions around the hospital model having a focus upon stages within the patient journey. The clinical relevance of the various stages from a managerial perspective may be less apparent and have therefore (perhaps inappropriately) presented an obvious way in which to approach reducing the time a patient spends in hospital. This attitude was found to be present with the project team who developed the hospital model and broke down elements of patient care into stages in order to eliminate unnecessary stages. However, the clinical need for stages to be followed does not appear to have been fully considered in this.

6.1.10 Conclusion

The evidence suggests that given the current political backdrop and seemingly unanswered questions about the appropriate degree of patient involvement in healthcare, a number of complex issues are at play. In the context of a major hospital redevelopment programme with the patient at its core, any indication that patients demanded extensive control or choice was not observed within the acute service. However, the reasons for this may be many and varied, not apart from the mid-point stage of the redevelopment at which data was collected.

Deal and Kennedy (1988) believed that the most significant influence on a company's culture was the broader social and business environment in which it operates. Therefore, culture will tend to reflect how a particular organisation responds to the market place. Given the history of NHS development through internal markets and continual NHS reform, this may be directly applicable to the NHS as an organisation. However, it seems that there is a lack of acknowledgement of the number of facets to the role of the patient within such a 'market place'. An apparent lack of evidence outlining the position or wishes of the patient is emerging. Or rather, there seems to

be a poor distinction of what the terms 'involvement', 'choice' and 'power' specifically relate to, given that within the A&E department context examined in this case, patients did not seek such attributes. Whether this was because of personal characteristics of the patients, or was due to their illness could not be accounted for beforehand on the basis of any governmental or policy guidelines.

Schein's (1985) approach to culture considered the organisation as a group. The observations in this study indicated that there is a desire from the hospital for healthcare professionals to operate as a group to do their job most effectively, and much of the redevelopment programme for the hospital was structured around the notion of new team structures. Schein's model of culture emphasised common language and group boundaries. Certain tasks within the hospital A&E were very individualised and continued to be despite so called changes, for example the consultant very much held the power and the nurse did much of the communication, particularly reassuring the patient.

Drawing together the themes of patient/staff control, teamwork, service boundaries and aspects of information flow, treatment of Phase Two patients in the GDR service provided evidence of where operation as a group was strongly observed and appeared to be successful from both a staff and patient perspective. The GDR team was observed to move patients through the hospital A&E system more efficiently than elsewhere as the dedicated staff were focused on one patient group and patients do not travel through unnecessary stages of seeing various A&E doctors before being referred to a gynaecological specialist.

The patient studies, staff data and research observations discussed illustrate the detail of the individual experiences which has been shown to be affected by arguably minor issues, such as doctors being able to dismiss a patient's attention and leave it to a nurse to deal with. It is these smaller episodes

which are of such importance for patients. There is limited sensitivity apparent within the policy in directional terms, to accommodate for this or to take into consideration the feelings towards issues of control for the patient. Nor is there opportunity to consider experiences for patients who do not understand, or actively choose to break the rules.

The perspective of the researcher may be limited with regards to considering aspects of organisational culture and change. Despite this, the patient experience may vary as a result of, or potentially may be affected by this culture or change in its variant forms throughout the hospital service and therefore it is an important deliberation. This study allows a degree of examination through the eyes of the patient as to what these effects are, but also it allows for a step back to be taken, to give consideration of how things may be different. Through mapping, observing and interviewing the patient, seeking their views of experiences during a visit to the hospital and gaining a more objective view, a gradual picture can be built of the patient and their journey in relation to the environment within which they are treated.

The evidence discussed suggests that for the patients generally across the three phases of data collection, the consequences of changes being introduced were not explicitly obvious to them nor did they indicate any views towards being more involved or in control. Staff were not altogether confident about the change programme or what it represented in terms of improved patient experience. There were also some concerns about job morale and security. Despite this, undoubtedly, many of the staff were looking forward to working in a clean and new environment with modern technology and equipment to support them.

The approach of utilising more generic or more specialist teams will be contrasted with the subsequent service areas studied, which will focus upon areas of the hospital which are more specialised. The varying

consequences for the patient depending on the level of speciality can be assessed, for example the question arises as to the effects of a quicker and efficient service from specialised clinicians in comparison to a more generic staffing group. The issue of speciality also links in with the number of stages in a patient journey. Specialised staff may follow fewer stages and be more focused, whilst generic staff go methodically through each stage, leading to the question of how this influences the patient. Patient interaction with different types of service is also relevant here, and it is of interest to see how patients interface with a service with fixed boundaries, such as the paediatric service which is the focus of the next section, as opposed to A&E where access may appear to be relatively open.

Further analysis of different areas of the hospital will allow more sensitive comparison between variations in patient experience outcomes and NHS or hospital policy, in the context of the redevelopment programme. This will also help to address questions which have arisen relating to focus upon stages of the patient journey and upon time as outlined above, such as the four-hour target (NHS Plan, 2000). What has become apparent is the multifaceted and complex nature of an individual patient experience. More evidence from different patient groups will benefit understanding around patients' views of choice and control, in the context of redevelopment programmes which are hinged on this 'choice' ethos.

6.2 PACU

This discussion will reflect upon the key emergent themes from the PACU data. These deliberations are a culmination of the analysis and triangulation of evidence from patients, staff and researcher observations, as presented in the results section. The key themes are: Patient/staff control, Teamworking/roles, Service boundaries, Information flow (clinical) and

Environment. The critical considerations being drawn out relate to how patients exerted control or not with staff within any apparent service model, how staff operated within such service models (knowingly or not) and how information flow and environmental structure influenced clinical activities or the service in relation to this.

As with the acute service, the data have been analysed in line with the service specific research questions, with consideration of stages in patient pathways and control, and in the context of the main research questions. The results are discussed in a manner which addresses both the nature of the service's structure and operation of its boundaries, and issues specific to paediatric services, in terms of staff and patient control as reflected below. Initial comparisons are drawn between the acute patient data and the PACU data.

The patient sample was fairly representative in terms of what was expected with regards to presenting symptoms at PACU, gender mix and age of patient based on a conversation with the lead consultant prior to data collection. Whilst the findings might be broadly generalisable to other similar paediatric environments, there were aspects of the service which would only have potential generalisability for other paediatric services in a comparable context (i.e. similar patient population and having recently been redeveloped).

6.2.1 Patient control

The generally positive analysis of the patient and parent experience in PACU presented a number of areas of interest for consideration with relation to control.

Patient advocates

An issue which has arisen particularly from within the PACU patient control theme related to the role of the parent as a patient advocate. PACU was unlike any other service focused upon, in that the patients' input to the relationship with clinicians and service providers was generally voiced by their parent. In PACU, the parent acted as a natural advocate for their child. As the parents were not the ones who were sick, the relationship between the staff and parent was likely to be different to that of the general patient to a doctor or nurse as it would normally be observed. This is supported in the literature where it is the parent's view of satisfaction regarding service quality which is considered (Ygge & Arnetz, 2001, Ammentorp et al., 2007).

O'Connor and Drennan (2003) report that when dealing with paediatric patients, the role of the parent is important and that the healthcare professional should be aware of the importance of including parents in all aspects of the child's diagnosis while in hospital. However, healthcare professionals must also be aware of the extent to which the parents wish to participate in the child's care and respect this decision. This appears to be a balance well achieved by the PACU staff in the majority of cases observed. Crucially, however, as patients (and by proxy in the case of PACU, their parents) are unable to judge quality of clinical service (Lee et al., 2000) their focus tended to be on how the service was delivered, and the child-centric environment which was clearly observable.

The majority of patients and their families in particular within PACU were satisfied with the care they received and were not observed to exert particular control or demand greater choice from the service. This might be related to an effect found by Kai (1996) where the pressure on parents to protect their child from harm was grounded in parents' sense of personal control when faced with illness in their child and the perceived threat posed by an illness. The perception of control is important to the parental reaction in the clinical setting. As PACU provided patients and their parents with care

in a dedicated and timely manner, the pressure may have been reduced upon the parent, in allowing them to feel more in control.

The exception to the majority of parents whose children were admitted via the formal route to PACU was the case of a patient whose parent self-referred to the service in order to gain access. Once being treated, however, (and perhaps achieving a feeling of increased control) in a manner which matched her apparent expectation (an effect reflected by the work in GP surgeries by Cockburn and Pit (1997) where patients' expectations were associated with outcome), the patient and parent acted appropriately according to the confines of the service. Patient control was seen in the previous section to play an important role in the patient experience within the A&E department. Where patients were not receiving the care they felt they required, they approached staff for attention. For those patients who were 'playing the game' and cooperating, thus maintaining what could be regarded as a certain level of control, they were ultimately satisfied. Questions are raised for future consideration around the issue of expectation and the relationship this has with satisfaction of care received.

Patient-centred care

On the surface, it appeared that PACU, whilst aiming to provide a patient focused service in line with the politically endorsed approach (Department of Health, 2007a, 2004) was very much in control of which patients it treated and when. By maintaining gated access to PACU through referrals only, there was a greater control over who used the service. However, there was evidence from the sample of patients whose journeys were traced in this research, that self referral did occur and patients were gaining access to PACU despite the apparent barriers to doing so. Individual parents/patients attempted to exert their control in so far as it gained them access.

PACU's structure was, from a patient perspective, in some regards contradictory of an approach positioning patients at the very heart of the service. The service was set up to focus on specialist treatment of paediatric patients to allow them to avoid unnecessary time in A&E and to provide GPs with an avenue for patients to be treated who were more seriously ill than they were able to deal with. For those patients who aligned with this system it clearly worked well, and it appeared they felt the balance of power was positive. However, the patient who inappropriately self-referred challenged the formal system.

6.2.2 Staff control

The clinicians in PACU had clearly defined responsibilities, with clear lines of reporting between the staff. The PACU patient group generally accepted staff control and staff were clearly responsible for the patients' care. The added element of patient advocate in the form of the parent did provide an extra dimension to the control issue, but in general the 'rules of the game' in terms of expectations upon patients were adhered to. There was little evidence of what has been referred to by Bury and Taylor (2008) as a shift from medical dominance in favour of 'managed consumerism'.

Observations of teamworking indicated that PACU staff had the opportunity to be more focused on their specific patient group, and were physically located more conveniently in comparison to the generic A&E staff in the previous section, who were more spaced out and occupied less modern facilities. The teamworking in the Gynaecological Direct Referral service was comparable in certain ways to that observed in PACU, although perhaps to a lesser degree due to the GDR physically sharing space with the rest of the A&E department and intermingling with other staff, as opposed to being concentrated purely on their own.

The PACU evidence tended to suggest that patients (or rather in this case, the parent) perceived they had control over their care. However, the specialist nature of the service and fixed systems and processes governing the access and treatment within the unit indicated that the actual control was not as high as parents might have felt, and in fact the systems and structures forming PACU, kept control very much in the domain of the staff.

6.2.3 Teamworking/roles

Two key aspects of this theme have been identified from the data; teamworking and medical hierarchy.

Teamworking

The staff data from PACU, supported by the researcher observations provided examples of good teamworking. There appeared to be clear cut lines of responsibility, a highly visible service model and an awareness of the operational expectations amongst staff. The findings from PACU of good teamworking given the clear role clarity and expectations of staff are consistent with the literature which indicates that having a common purpose, role clarity and clear goals benefits teamwork (Ulloa & Adams, 2004, Herrman, Trauer & Warnock, 2002, Herrman, Trauer & Warnock, 2002) and prevent conflict (West, 2004). There are serious practical implications for failures in teamwork, with suggestions from some fields within healthcare that breakdown in teamwork and communication are among the leading causes of adverse events (Guise & Segel, 2008). As it is recognised that effective healthcare teams are associated with quality patient care (Mickan, 2005) it can be extrapolated from this that the patient experience benefited from the teamwork with PACU.

Medical hierarchy

PACU as a service, more so than A&E, was seen to maintain the traditional medical hierarchy whereby the doctors and nurses were subordinate to the consultant. This is a contrast to the suggestion that medical dominance in the UK has experienced a slight decline in the past few decades (Harrison & Ahmad, 2000). In PACU the consultant was the overall lead of the service and doctors took decisions around treatment, diagnosis and discharge for patients. There were no nurse practitioners observed working in PACU, and the dominance of doctors as also indicated elsewhere by Baggott, (2004) was clear. This was in stark contrast to both general A&E and the GDR where nurse practitioners played a fundamental role in the efficient functioning of services and shared some of the tasks of the junior doctors. How and why this hierarchy was preserved in PACU and not the other service is open to interpretation. Perhaps it was due to the protected nature of PACU as a service, along with the special status of the patients. It should be noted, however, that the perception of the impact of the medical hierarchy gathered by the researcher was not a negative one and that staff working in PACU appeared highly satisfied and felt supported.

6.2.4 Service boundaries

The service boundaries theme can be split into two key subcategories based on the PACU data. These are access to the clinic and the impact of medical specialism and prestige.

Access to the clinic

Access to PACU was governed by strict policy of admittance via referrals only, which all staff were aware of and formed an important element of the service identity. The nature of the referral process is felt to have contributed towards the identity of the service as it distinguished it from other paediatric services available and maintained the clinical control. It is for this reason that any cases observed where patients arrived unexpectedly with their parents hoping to be treated by PACU were of particular interest.

The government strategies outlined by the NHS plan (Department of Health, 2000), including for example, the A&E four-hour government target, did not transpire in the same way to PACU. Due to the nature of the gated service PACU offered, it avoided having to strive for this particular target and in this respect was somewhat unique as a hospital service which, unlike A&E, was very much protected in both access to the service and expected outcomes. In fact, from an observer's perspective there was noticeably no mention of targets or government directives by any of the PACU staff during the period of data collection.

The espoused values of a culture (Schein, 1985) are related to the values which govern artefacts, such as strategies, goals and documents describing a company's values. In terms of the observations at the hospital, this covers the issues such as hospital organisation and policy objectives which might not necessarily match clinical reality. Schein (1985) suggested that it may be the case that espoused values are not actually employed in practice. To some extent this was observed, for example for the patient who self-referred to PACU, who was treated despite not adhering to the rules of access for the service. This indicated that PACU attempted to maintain espoused values with respect to the policy for users but that in actual fact in some cases, the patient would be treated outside of this boundary. This flexibility may be enough to deal with the apparently small number of parents who challenged the structure of the service access, whilst the majority of patients adhered.

Medical specialism and prestige

The influence of medical specialty and the associated prestige of paediatric medicine have been most potently observed in PACU. Paediatrics has experienced significant growth in sub-specialisation (Pearn, 1997). The specialised nature of PACU and the values of the service aiming to provide ring-fenced specialised care for children echoed in many ways the ethos of

the GDR service captured in the previous section. The positive experience of the GDR patients was comparable in its high regard from patients, to those of the patients and parents utilising the PACU service. Some reflections of PACU's structure which contributed towards its distinctiveness were observed in the GDR service with its protected boundaries and service specific artefacts. For example, the specialised scanning room and private patient rooms may have contributed towards being able to define it as having a cultural identity distinct from the generic A&E department. The results of such protection, or simply the improved access to facilities and other specialist colleagues for staff working in PACU therefore, were likely to be positive ones in terms of their working experiences.

Reflection of the notion from Deal and Kennedy (1988) of the importance upon organisational culture of the broader social and corporate context within which a company operates was again relevant in this consideration of issues relating to the apparent culture in PACU. This was due in the main to the seemingly special status already highlighted of children and paediatrics as an element of the health service. It is known that active, specialised, biomedical, and high-technological types of medicine practised in the upper part of the bodies of young or middle-aged people have been accorded higher levels of prestige (Norredam & Album, 2007, Morrison et al., 2003). Public perceptions regarding children's healthcare tend to be highly charged and politically speaking hold weight in terms of potential fallout from scandals or bad press which may surround them for example the media coverage of the Bristol Heart Inquiry (Kennedy, 2001). Given that the mass media have the power to shape the public's perceptions of healthcare issues (Suresh, 2006) there are clear implications for the service paediatric patients in particular might receive, given the increased attention and awareness as a result of such events.

6.2.5 Information flow (clinical)

Any problematical issues around information flow were perceived by patients to be fairly minimal. Patient notes were misplaced causing frustration and some delay for the respective patients. However, on the whole patients and parents were pleased about the general care provided and happy with the time spent in the unit. Staff were appreciative of the clinical facilities within the unit which on the whole benefited and supported the process of clinical information flow and of providing patients and their families with good care. There were no apparent barriers to verbal information flows which supported care and were routed clearly between patients, their parents and staff.

6.2.6 Environment

As ambulatory paediatrics is about having a flexible approach and making the service as child and family oriented as possible (Meates, 1997), the environment is an important element of this. The issue of the environment appeared to be particularly important to those working within and being treated by PACU. Artefacts, or visible structures given their importance to aspects of culture (Schein, 1985) have been particularly relevant in this study. This easiest level of culture to observe when going into an organisation includes everything that “you see, hear and feel as you hang around” (Schein, 1999, p. 15). In PACU, the visible artefacts were most striking in their distinctiveness. Examples included nurses’ uniforms which were brightly coloured and the curtains around cubicles which were child-centric and adorned with pictures and patterns. Doctors were not seen to be wearing uniform, unlike in A&E where this was observed.

The waiting area for PACU was filled with toys and there was distinct lack of any features which may have posed as intimidating to a child and which would be more obvious in an A&E department. Treatment rooms in PACU were filled with specialist equipment dedicated for the PACU service. There

was also a notable calmness at the time of observations perhaps due to the well designed unit facilities. This benefited the staff, as it has been shown that high noise levels are associated with stress in paediatric nurses (Morrison et al., 2003), and it enabled patients to receive treatment in a more peaceful environment.

Schein's (1985) common artefacts, shared between the groups in an organisation such as uniform was observed in A&E to follow more traditional expectations. Nurses tended to wear traditional uniforms (although there was no apparent differentiation between grade) with a mixture of some doctors in plain clothes, with others wearing scrubs. Previous comments from some of the acute patients that they were not always aware which healthcare professional they were being treated by, were not reflected in this study of PACU, indicating a comparatively stronger identity or presentation with regards to common artefacts around the PACU staff.

Social Interaction

A further factor which impacted both patients and staff in terms of the environment was how this supported a degree of social interaction. Interactive space which allows friendly contact between staff and patients has been shown to be important in a therapeutic setting (Curtis et al., 2007). The physical layout and quality of the PACU service was seen to encourage patients and their families to feel reassured and relaxed, but it also brought them into contact with one another at certain stages of the patient pathway. The positive attitudes of staff towards the PACU 'team' may also have been encouraged due to the modern and specialist nature of the physical environment.

6.2.7 Stages of the patient journey

The stages of the patient journey observed at PACU were a useful means of comparison between the PACU service and the A&E acute pathway. The data seems to suggest that using this as a measure in itself to rate aspects of the service does not reflect the whole picture for the patient. For example, there may have been occasions when a patient needed to be seen by a number of different groups of healthcare professionals and was deemed to have gone through more 'stages' than a patient who was treated and discharged within fewer stages. It may be that there were a number of factors of significance such as time spent in hospital and patient views of their care. Again, a patient may well have experienced the same number of stages as another patient, but this did not necessarily reflect an equivalent period of time spent in hospital. The issues are more complex than a simplistic consideration of stages might allow and will require some further consideration throughout subsequent sections.

The specialist nature of the staff in both the GDR and PACU may have implications for the stages which the patient goes through. Patients in PACU often went through perhaps four or at the most five stages of care during the observation, whilst acute patients in the generic A&E majors department commonly followed six stages. The GDR patients were comparable to PACU in with respect to having marginally lower numbers of average stages of care. The focus on stages in the patient journey for a generic A&E patient was a useful means to trace what happened to a patient who attended A&E, as they travelled through a system which dealt with their condition or directed them to the appropriate speciality. However, for the patient in PACU, this direction by virtue of their referral, had already taken place to some extent and the specialist staff in the service were able to focus their care with less distraction from non-eligible admissions.

The majority of PACU patients were treated and discharged from the unit in four stages, with an approximate mean average time of four and a half hours in PACU. The key factor in this service was that this time value reflected the whole time spent in PACU until admission to the ward or discharge. There was no equivalent to A&E for the patients to be placed whilst beds became available or for any other purpose. PACU, in contrast to A&E, had a dedicated structure for patients exiting the service, (as with its access) in so far as all patients' clinical care needed to be resolved before the service closed for the night. Therefore, unlike in A&E where staff had to deal with handovers and a 24 hour culture, the PACU staff would focus on dealing with patients and discharging them home or having them admitted overnight to the children's ward.

6.2.8 Conclusion

The data collected suggested that patients and families felt that they were receiving a high standard of healthcare in a pleasant, child-friendly environment and that generally they felt in control. A parent with a sick child was observed to take control themselves, if necessary, to gain access to the PACU service. However, on the whole patients and parents did not exert control and nor did they express a desire for more involvement in their treatment.

It is suggested that the specialist nature of the staff and teamworking evident in PACU contributed to the satisfaction which staff appeared to have. The ability to be able to shut the doors having either treated patients and discharged them home, or admitted them to the children's ward for a longer term stay, presented a form of closure for the doctors and nurses working at PACU. This was far removed from the experience of staff particularly in A&E whose service was available to patients and functioning continually throughout the day.

The PACU staff's good collective knowledge of the policies and procedures which governed all elements of PACU from referral through to discharge provided a benchmark from which to make subsequent comparisons. This leads directly to the question of how such collective awareness of the structure and resultant behaviour of a service might differ in other hospital services. Along with any associated impact for patients using the outpatient respiratory clinic, this will be the focus of the next section.

6.3 Respiratory clinic

This discussion will reflect upon the key emergent themes which have been formed as a result of the analysis of the data and triangulation of evidence, as presented in the results section for the respiratory clinic. These themes are: Patient/staff control, Teamworking/roles, Service boundaries, Information flow (clinical), Information flow (organisational) and Environment. The critical considerations being drawn out relate to the explicitness of service models, how patients are required to exert control against or in line with a service model, how staff operate within such service models (knowingly or not) and how information flow and environmental structure influence or relate to this. The results are discussed in a manner which addresses both the developments and changes occurring within the hospital respiratory outpatient service, and the impact of the changes on staff and patients from their respective perspectives. Comparisons are drawn between aspects of the Acute and the PACU data.

The patient sample was fairly representative in terms of gender mix, age, and presenting symptoms or diagnosis of patients at the clinic. This representativeness was ensured through consultation with the lead consultant prior to interviews and cooperation from the clinic care

coordinator who aided the researcher in selecting 'typical' clinic patients for interview. Whilst the findings might be broadly generalisable to other similar clinic environments, there were aspects of the clinic which would only have potential generalisability for other chronic condition clinics in a comparable context (i.e. similar patient population and facing imminent redevelopment).

6.3.1 Patient control

Patients attending the respiratory clinic differed from patients reported in previous sections in one key aspect; that attendance to the clinic was a pre-arranged referral, not reflecting an emergency situation but due to a chronic condition. The respiratory clinic environment was also unique with respect to the potential level of knowledge the patients may have had. Many patients attending the clinic reported an awareness of an existing chronic medical condition, such as asthma. The development of the Expert Patients Programme (www.dh.gov.uk, 2001) is national recognition of the degree of awareness and involvement a chronic patient might have with their condition. This knowledge might lead to the assumption that such patients would be confident in taking control of their care or want to be involved in treatment. However, this was not always reflected in the research. This apparent lack of inclination in patients to exert their position with the doctor was particularly illustrated by Patients 4 and 10.

This disparity between evidence and policy reflects and builds upon questions which have arisen elsewhere in the literature relating to the expert patient, which has queried whether such 'expert' patients challenge dominant traditions in biomedicine or simply adopt these as conventional ways of thinking about illness and health, therefore perpetuating medical dominance (Fox, Ward & O'Rourke, 2005).

The issue of patients playing by unspoken rules is something which has arisen in previous sections (for example, the majority of patients in the acute service and PACU). The following quote from Kay (2006) describes the behaviour exhibited by a patient 'playing the game', apparently the preference of doctors:

"We all recognise 'perfect patients', those who take their medicines as prescribed and attend clinics when they should. Paradoxically, the word most often used by professionals for this 'good' behaviour is 'compliant', which shares with 'obsequious' the Latin root 'obsequiosus'. This in turn suggests that professionals prefer patients who accept passive and unchallenging relationships, and who do as they are told." (p. 8)

There was little evidence observed of patients in the respiratory clinic exerting control over the staff to the extent that it changed staff behaviour towards them. In fact, at times the opposite was observed, very much in line with Kay's (2006) 'perfect patient' which suggested that patients were outside of any control over happened to them at the clinic, that they were excluded from the 'culture' of the clinic and were passive to this exclusivity.

The case of Patient 10 within the respiratory clinic illustrated how the patients did not seem to be able to influence their care when disgruntled or taking more control in quite the same way as those in other services previously discussed. For example, Patient 10 complained to the researcher about being told at a late stage that she needed to have an x-ray thus incurring a greater delay than anticipated. When questioned further about her reaction to this, the patient insisted she did not want to complain for fear of making things unpleasant for the doctor who was responsible for her. Given that there is evidence (albeit from GPs) that patient complaints impact a doctor and lead them to feeling out of control (Jain & Ogden, 1999),

indicates the power of the control relationship between patient and doctor. Patient 4 also indicated that she did not feel she was fully in control of her situation, having experienced symptoms for five years and being in the position to comment that the staff did not appear to show understanding of what she had been experiencing, that it was “a silly cough.” Only as a result of a change of doctor had the patient seen an improvement in this situation, however, this change in doctor came as a result of a doctor leaving the hospital, not due to the patient requesting such a change.

Evidence on an international level suggests that it is common for patient complaints in a hospital setting not to reach the formal stage, with a majority of aggrieved patients not complaining at all (Gal & Doron, 2007). The implications of these findings if they were to apply in the UK in term of an agenda for increased patient control are striking. As analysing complaints can assist in improving the quality of healthcare provision (Saravanan, Ranganathan & Jenkinson, 2007) it would seem clear that any desire to truly capture the wishes of patients and involve them in care must incorporate a system within which patients feel they are able to complain. This was not apparent during observation as a central focus of the service development.

Patient 7 reported a misdiagnosis from a consultant at the clinic which remained for many subsequent months during which time the patient was unaware. The patient reported feeling anxious following her appointment with the respiratory clinic doctor and felt she was not given enough information regarding her condition. Despite these misgivings, either due perhaps to the lack of power on the part of the patient, or the implicit trust of the patient towards the doctor, she did not question what she was told. Only once the misdiagnosis was uncovered due to referral to another hospital was the patient able to express her misgivings. The patient was referred back to the original clinic, but saw yet another consultant and this again was something which she felt reflected poor care. This feedback of concerns

regarding seeing a different consultant at each visit was not echoed by all patients, however, and others reported the opposite, that they were impressed that they had been able to consistently see the same consultant.

Perhaps rather than the patients feeling empowered with the knowledge of their condition as the expert patient movement would indicate, the patients observed in the respiratory clinic perceived themselves in a slightly different way. It may be that they felt obliged to comply with the doctors who they regularly relied upon via the clinic to manage their condition, or that a sense of loyalty or obligation had developed due to the long-term nature of the relationship with particular clinic staff which prevented them from being outspoken for fear of upsetting the clinicians. Certainly there is existing evidence to support the fact that patients identify with a particular physician rather than a clinic (Roberge et al., 2001). The relationships patients had with the doctors in the clinic and the nature of their experience were the patients' main concerns (it tended to be the staff who focused upon the technical quality of care). Whilst some patients had greater knowledge about their chronic condition than the average acute patient might have, perceptions of the functional rather technical aspects of care were most prominent in their reported experiences.

Whilst there has been a development politically in the status of the patient, from a dependent receiver of care with instruction from medical professionals, to a consumer or customer at the centre of service provision (Newman & Vidler, 2006), the evidence from the respiratory clinic was not necessarily a reflection of this shift. Evidence elsewhere suggests that patients have a desire to be supported in their care and to have a sense of control (Douglas & Douglas, 2005). Whilst the findings from the respiratory clinic offered weight to the notion that patients wish to feel supported, there was less indication that a sense of control held much priority. The findings here suggest that the control and choice which they are politically afforded is

not often exercised in the clinical reality. From the patient evidence a distinction may also be drawn from the data relating to what patients perceive as control or is aligned with expectation, and what is actual control.

6.3.2 Staff control

Control or power may be expressed in various forms by clinicians, through the use of specialist language, medical terminology and the employment of unclarified jargon which asserts professionalism (Castro et al., 2007), or in the restriction of information offered to the patient. This is an example of where chronic patients differed from the other patient groups observed. Unlike those generally attending A&E, chronic patients by nature of their conditions tended to be familiar with language specific to their conditions (and in fact often gave explanation of such terms to the researcher). This awareness might have been expected to alter the balance of power towards the patients in the clinic. However, the research indicated that staff maintained control over the patients in the respiratory clinic.

Statements provided by patients at interview ranged from them feeling they themselves were mainly responsible for their care, to their GPs or the hospital consultant being so. Responses to the question of which individual the patient felt was mainly responsible for their care provided further indications of the confused nature of the status of the patient and the clinic as a whole. This potentially contradicts the government's Expert Patient Programme (www.dh.gov.uk, 2001), which aimed at encouraging patients with chronic illnesses to simultaneously self-care and manage their condition. The paradoxical nature for chronic patients of "a power asymmetry in the patient and health care professional" (Wilson, 2001, p. 137) is perhaps in part, the explanation for the diversity in response from the patients in the respiratory clinic. However, there was no evidence from the research of any proactive attempts to facilitate patient expertise. Whilst

there was some evidence from the findings of patients seeking more and better information on their condition or treatment, on the whole this was not the case, and control was generally held by the clinicians.

These findings pose potential difficulties for the hospital. The hospital was in the position where there was a demand to provide appropriate services for patients whose expectations varied to extremes. How this is possible when some patients presumed the hospital consultant was in charge of their care, whilst others felt their GPs would maintain control even when they were being treated in the hospital clinic, or that they themselves would be mainly responsible, poses a serious challenge. What is of interest is how much this broad spectrum of expectations from patients is as a result of the unclear focus of the clinic.

Throughout this research, control has been shown to play an important role both fundamentally in terms of gaining access to care, but also to patient experience. For example, within the A&E department for acute patients when patients were not receiving the care they felt they required, staff were approached, and for patients who were 'playing the game' and cooperating, so maintaining what could be regarded as a certain level of control, they were also ultimately satisfied. The relationship observed in PACU was unique in terms of patient control, where the parents acted as both a voice for the patient and the patient's advocate, thus having a knock on effect in the relationship between the staff and parent.

Observations of the staff working within the respiratory outpatient clinic team draws further parallels with different elements of working practices observed in previous sections. The indications for PACU staff showing they had the opportunity to be more focused on their specific patient group was similar for respiratory patients, as both services were structured in relation to staff control and patient access. The benefits of the physical locality and the

modern facilities were unique to the PACU service at the time of observation, although the respiratory clinic was due to move location in the near future. In terms of the control and power the staff held in relation to the patient, staff had been observed on occasion to cause the patient frustration (for example the interaction between the consultant and Patient 10 as outlined previously) where the patient did not feel they would be justified in causing any difficulty for the doctor by raising a complaint of any nature. This illustrates that the control staff had, certainly in the case of senior doctors, applied both in terms of access to the service itself and to the processes and patient interactions which occurred within the clinic.

6.3.3 Teamworking/roles

All clinical teams work under a formal service 'model'. Important questions relating to the model included whether or not staff were aware of it, had a tacit understanding of what it was or how the model was reflected in clinical reality. It is helpful to examine this issue in more depth by focusing upon elements of the teamwork and roles within the respiratory clinic staff. This process of examination is useful in making comparisons between hospital care and considering the impact on patients, as they were treated in services which may or may not have had clear and visible service models (which may or may not explicitly include the patient).

Teamworking

It is important to consider the variations in teamworking between different services as multidisciplinary teamwork is recognised as central in healthcare, to good working relationships and the ability to deliver a good service for patients (Boaden & Leaviss, 2000, Herrman, Trauer & Warnock, 2002). When comparing the hospital services studied which operate within a traditional medical hierarchy (i.e. PACU) and those which do not, such as the GDR team in A&E, aspects of teamwork and the various roles adopted are

key considerations. Evidence has shown that factors which are critical to cooperation in other healthcare teams are: close communication, philosophy, good interpersonal relationships, high commitment and autonomy. Inefficient teamwork has found to be associated with the absence of clear goals, tasks and role delegation, as well as a lack of commitment (Jünger et al., 2007). In addition, the stereotypical dominance of the role of the consultant is also significant in terms of teamworking as it is suggested that the dominance of medical power influences interaction in teams and forms a barrier that may hinder teamwork (Atwal & Caldwell, 2006).

The data suggests a hindrance in the ability of the consultant to fully exert his leadership in a service where changes in frameworks have been undermined by higher management. The frustration expressed by the consultant involved in developing the respiratory service model, of having services quashed due to financial restrictions being imposed by the Trust's chief executive, illustrates this. This is particularly relevant in the context of the literature which suggests, at least in a mental healthcare environment, that practice development frameworks can influence teamwork and culture (Eve, 2004). The common threads emerging from the key themes, of a lack of unified focus of the respiratory clinic service and low staff morale, may all be linked to the frustrations of this lead consultant and the blockages facing him in achieving his ambitions for the service in the context of his dominance over the team.

Medical hierarchy

In the respiratory clinic a hierarchy emerged with the consultant at the top, supported by the lung function technician, with no nurses in the clinic but a shift of their traditional responsibilities with the clinic care coordinator (basic testing of the patient in addition to more administrative tasks). Whilst the one of the key features of the medical profession, autonomy (Ham, 2004), was not impacted at a senior doctor level, changes were taking place in

terms of staff responsibility at less senior (and notably at only non-medical) levels. However, in terms of the rationale for changes such as developing the responsibilities of the clinic care coordinator, it is not clear where the clinical justification for such a change was, other than to save money by removing what may have been under-utilised or simply more expensive nursing staff.

Staff working in PACU were observed to maintain a more organised, stable and traditional medical hierarchy than the respiratory clinic whereby the consultant was in charge of other doctors and nurses in the unit. This is in stark contrast to the flatter hierarchies evident in both A&E and the GDR where nurse practitioners played a fundamental role in the efficient functioning of services and shared some of the tasks of the junior doctors.

The question is raised as to whether the very fact that nurse practitioners were not present within the clinic was linked to the nature of the clinic having a more traditional medical hierarchy, at least at the level of the doctor's responsibilities. Maintaining this hierarchical structure would be difficult alongside the introduction of nurse practitioners whose work commonly has an emphasis upon clinical practice and management (Williams, McGee & Bates, 2001). There would be the potential for conflict of roles between the consultant and nurse practitioners.

The variation in posts and subsequent confusion nationally of the functions of a nurse practitioner (Williams, McGee & Bates, 2001), are supported by the findings here where the utilisation of nurse practitioners has been inconsistent within different areas of the hospital Trust. The importance of nurse practitioners who have been shown in previous sections to hold a fundamental role in other services observed in this study, were not an immediately obvious presence within the respiratory clinic. However, chronic disease nurse practitioners were found to be employed within the service,

operating purely in a home-visit service in a combined role between the hospital Trust and PCT. The nurse practitioners treated patients who were too ill to make a visit to the hospital, or worked in order to support this patient group and prevent unnecessary admissions.

Although not present in the clinic, the role of the nurse practitioner was of importance to the service overall. Nurse practitioners helped to ensure that from within a relatively stable population of known chronic patients, the correct type of patient attended hospital when necessary or was maintained through treatment at home.

6.3.4 Service boundaries

The service boundaries theme can be split into two key subcategories based on the respiratory data. These are access to the clinic and the impact of medical specialism and prestige.

Access to the clinic

Access to the respiratory outpatient clinic for those patients being treated in the service may only have come into contact with the service as a consequence of receiving a referral from another healthcare professional (generally from a GP, other hospital clinic or A&E). Patients did not report any issues in terms of being referred or accepted into the clinic and the boundaries of the referral system appeared to function without causing problem to patients or staff.

The levels of boundaries around the various healthcare services investigated, and the link between this and Schein's (1985) espoused 'values' level of culture (the values which govern artefacts, such as strategies, goals and documents describing a company's values) has varied throughout the services investigated. Assessing any match between clinical

reality and such values has pointed towards some interesting results. The patients who self-referred to PACU illustrated that PACU attempts to maintain espoused values, with respect to the policy for users, but that in actual fact in some cases, data shows the patient will be treated outside of this boundary. The respiratory service is more structured in terms of patient access to the service than PACU was found to be.

One important difference relates to the status of the respiratory clinic in comparison to both PACU and acute emergency services (specifically GDR) where expectant mothers and children appear to have been afforded a certain level of special status (for GDR patients this is reflected in a published call for such specialist services for this patient group; see Wilson, 2000). For those patients being treated in the respiratory clinic, a parallel of this 'special' status effect was not particularly found to be the case, perhaps due to less associated speciality in the nature of the patient group or the medical field.

Medical specialism

With regards to the notion from Deal and Kennedy (1988) that “the biggest single influence on a company’s culture is the broader social and business environment in which the company operates” (Deal and Kennedy, 1988 p. 107) and the relevance of this for previous sections, particularly PACU with its highly specialist status, may not be applied in comparative terms to the respiratory clinic. The clinic holds a certain level of specialist status from the perspective of the doctors (particularly the respiratory consultant). The respiratory clinicians were involved in developing the service in conjunction with a range of other integrated services which aimed to reduce unnecessary admissions to hospital. However, any status of the respiratory clinic was outweighed by the populist view of paediatric services and healthcare for children generally which are politically highly charged and popular in the

media (for example the inquiry into children's heart surgery at the Bristol; Kennedy, 2001)

According to Handy (1993) 'role' organisations are said to be found where technical expertise and depth of specialisation is more important than cost. There is clear evidence where this has been observed in theory rather than in practice in terms of the development of the hospital service model. In the respiratory clinic senior clinicians were heavily involved with the design of the clinical model, and objectives of the service included introducing elements such as email clinics run by the respiratory consultant for the purpose of providing specialist advice to GPs, thus enabling a quicker more accurate response for the patient. However, the 'role' element of this in practical terms was observed to have been compromised due to the limited budget available and a request by the chief executive to withdraw the service. This is evidence which indicates that financial concerns take priority during processes of redevelopment, at times even at the expense of the specialist expertise, or the best interest of the patient. This finding supports the fears over costs expressed by the medical profession regarding the introduction and use of the private finance initiative to build NHS hospitals (Pollock, Shaoul & Vickers, 2002).

Medical prestige

Any identity for the teams working within the outpatient clinic service appeared to be more aligned with the generic hospital service, rather than the case of PACU which had such a distinct identity. Empirical evidence regarding medical specialities and disease groups indicates that active, specialised, biomedical, and high-technological types of medicine practised in the upper part of the bodies of young or middle-aged people have been accorded higher levels of prestige (Norredam & Album, 2007). This recognition of the impact of age of patient leans towards supporting the

specialist nature of paediatrics, but does not distinguish specifically between patients as adults and children.

Warnings have been raised that doctors may be unconsciously influenced by the ranking of diseases when making treatment decisions. For example, neurosurgery has been shown amongst Norwegian doctors to be the most prestigious specialty whilst they rated geriatrics as one of the specialties with the least status (Album & Westin, 2008). The suggestion that doctors' behaviours can be affected by perceived prestige may be relevant when considering the relatively positive findings in PACU in comparison to other services such as the outpatient clinic, with the apparently limited focus of the service and direction from some of the staff.

Targets

The findings reported here relating to service boundaries may be associated with imposed targets. The concept of targets applies to NHS healthcare services in a range of guises, depending upon the type of service. The government strategies outlined by the NHS Plan (Department of Health, 2000), including for example, the A&E four-hour government target, were highly visible within A&E. However, this had not transpired in such an obvious way to the respiratory clinic (or to PACU). Any targets which did exist (for example relating to waiting lists or waiting times) were not observed in the same tangible manner that they were in A&E. A&E was the only service observed to maintain a publicly viewable 'white board' which documented four-hour target times in such an open way. The consequences of this in terms of the impact this focus upon targets has had to the organisational and team culture for those staff working in the various scenarios may be significant and will be given consideration in the main discussion.

6.3.5 Information flow (clinical)

The majority of patients reported being satisfied with their overall care, although on occasion patients were observed to be frustrated by the poor information flow on a clinical level, with examples being given by patients of misdiagnosis and poor treatment (for example Patients 7 and 4) and a lack of information regarding delays. The issue of effective clinical information flow may be more apparent to the patient of an outpatient clinic by nature of their regular attendance to hospital, awareness of standard communication procedures and potentially greater knowledge of their medical condition than other patient groups (www.dh.gov.uk, 2001).

Uncertainty around future clinical information flows were expressed by the clinic consultant regarding the redevelopment changes in clinical information flow between the hospital and GPs. Due to economical constraints, certain services were being withdrawn given the serious financial implications for the hospital. The staff also expressed concerns with the future hospital systems and how patients would adapt to these. For example the registrar suggested patients who would under the new system see less of the doctor and attend hospital to a lesser extent, might prefer visiting the hospital and being seen by the doctor. The redevelopment of the hospital and the new service model of the redevelopment programme theoretically represented better care for patients. One aspect of this improvement revolved around the concept of improved integration of services, reduced inpatient beds and increased care in the community. There were indications of some mismatch between what patients indicated they wished for and the actual provision and focus of the hospital. This trend has been indicated elsewhere, in research based on Scottish PFIs where hospital downsizing and bed reductions had resulted in severe capacity constraints and planning targets and increase in clinical activity in acute specialties in the hospitals had not been achieved (Dunnigan & Pollock, 2003).

Whilst some patients felt aspects of the clinic service were lacking (for example Patients 7 and 4) or were having to wait for long periods of time (for example Patients 10 and 11) there was no certainty that the new hospital, despite being 'patient-centred' once opened would be able to prevent these issues from arising in the future. The simple approach of provision of information regarding outpatient clinic structures and estimated waiting has been shown to be a cost effective method of improving patient satisfaction levels and altering perceptions of waiting times, perhaps due to links with perceived increased control (Billing, Newland & Selva, 2007). The financial commitments made to this hospital redevelopment, however, extended far beyond the scale of such simple and proven effective solutions.

6.3.6 Information flow (organisational)

Staff morale

Feedback from staff, particularly the clinic care coordinator and the clinic registrar indicated both were apparently experiencing feelings of insecurity and concern regarding levels of staff morale in relation to the changes taking place in the hospital, specifically relating to the hospital service redevelopment and rebuild. The respiratory clinic service at the time of data collection was facing uncertainty and change. The imminent move to a new building and implementation of a new service model (albeit one which was mainly already in operation) may have drawn out the frustrations reflected in the uncertainties expressed by some staff, for example the clinic registrar. The immediate focus of the registrar in particular was around having a place to fit following the move to the new hospital (reflected in his concern over a desk).

The concerns facing the consultant as discussed under 'clinical information flow' are also in part relevant to organisational flow, where a lack of

information around the redevelopment and a perceived lack of commitment by the most senior Trust managers to the original clinical functionality was causing major frustration and anxiety.

The diagnostic testing which was an important part of the tool set of the unit was operated by the lung function technician whose views of the redevelopment programme were less concerned with job security or lack of clarity over the future of the service. In contrast to many of the other staff views, the lung function technician was encouraged about the improved organisation which the new facilities would bring, along with the benefit for the patient. The technician was located in a separate area of the hospital to the clinic location and this may have contributed to her difference in view towards the imminent changes to the service.

6.3.7 Environment

There was an initial assumption at the development stage of general research questions, that the environment within the hospital would be highly significant to the patients. At the time of data collection the old hospital was due to be demolished and it was apparent to all that the interior of the building was in need of some modernisation. The old Victorian hospital building was not designed specifically for the requirements of modern hospitals. There were observations where the old hospital facilities did not appear to serve patients in the most efficient manner, with long walks between the clinic and interrelated services throughout the hospital such as the lung function laboratory and x-ray. The new building would benefit from improved information flow and visibility of people.

Results indicated, however, that the state of the interior environment was not generally perceived as most important to patients in the respiratory clinic, but their interpretation of the standard of care was their priority. Considering that

the state-of-the-art purpose built facilities were a key benefit being publicised as significant to the hospital redevelopment, it is interesting to note that in reality the patients (at least in the respiratory clinic) were not as concerned about this as the managers and redevelopment team seemed to be expecting. In fact, there is recent evidence which indicates the simple measure of introducing plants into a hospital room has therapeutic value to surgical patients (Park & Mattson, 2009). So whilst this is evidence to support the importance of the hospital environment on patient care, it shows that a notable impact can be achieved by cheap and simple measures which do not require major investment. Whilst some respiratory patients did comment that the waiting room was dingy, generally the patients interviewed in this study indicated that they were comfortable with the old hospital and liked the familiarity of their surroundings. This finding is supported by the literature which suggests that having an awareness of physical orientation within a hospital environment is viewed as very important by patients (Douglas & Douglas, 2005).

Social Interaction

It is increasingly recognised that patterns of human interaction are directly linked to the space in which they operate (Backhouse & Drew, 1992). The implications of this in terms of hospital are clear. The impact of different structures and layouts of hospital buildings upon both patients and staff are likely to be significant. The respiratory clinic was disliked by many of the patients in attendance. With cramped seating, poor lighting and shabby decoration, the ability of the patient to wait patiently for their appointment or test and feel satisfied in doing so might have been limited. The question is raised as to whether simple re-organisation of the waiting area could not have been carried out whilst waiting for the move to the new hospital building.

Artefacts

The visible artefacts (Schein, 1985) so often immediately apparent to the patient and the observer found in the PACU and acute situations are not comparable with those in the respiratory outpatient clinic. The brightly coloured nurse's uniforms and specialist equipment of PACU were not reflected in the service offered in the respiratory outpatient clinic. The clinic itself was located along a long corridor, some distance away from the main hospital entrance with A&E housed nearby; and was most unlike the modern purpose built facilities at the hospital hosting the PACU service. The doctors (often wearing plain clothes) were not visible to the patient until they were called to be seen and at this point individual consulting rooms became private places between the doctor and the patient. Some of the chronic patients attending clearly had some awareness of their condition and knowledge of the language used in relation to their condition, which is important given that language is a major element of the artefacts within a culture (Schein, 1985).

Staff observations regarding the environment were at times also at odds with the publicity surrounding the redevelopment, as illustrated by the chronic disease nurse practitioner who stated the new hospital was "not about patients coming into hospital, even though it is an attractive building it's not about attracting them!". This is yet more evidence of the lack of vision and confusion facing staff and patients.

6.3.8 Conclusion

Patients generally were happy with the care they received from the respiratory clinic. Issues such as environment, whilst noted by a number of patients, were of secondary concern to the receipt of what patients perceived as good care. It is important to note that the patients' apparent interpretation of good treatment was not, however, based on a purely clinical perspective. Patients did not tend to mention technical aspects of their care but focused

more on issues of communication and efficiency. Aspects of teamwork, service boundaries information flow and the environment represent the areas which have been identified as contributing to an enlightened understanding of the impact and processes involved of the hospital redevelopment programme.

Clearly the state of uncertainty and imminent changes facing the respiratory clinic at the time of data collection appeared to have had some negative impact upon staff. Key to this was issues relating to a lack of collective vision for the future and the service as it stood. There was a degree of specialism in the staffing group and teamworking within the respiratory clinic, but not to the same extent as observed in PACU in particular. Some boundaries were operating around the clinic service but were not explicit. The structure of the clinic and feedback from staff contrasted with many of the features of PACU. Although not as vocally delighted with the service as many of the PACU patients and their families had been, interestingly, patient feedback was not as negative as might have been expected.

Despite the forthcoming programme of change facing the Trust as a whole, the majority of patients were generally observed to have a positive regard (satisfied or very satisfied) of the respiratory outpatient clinic overall. In the case of those patients who were not observed to be particularly satisfied with the service, this was often related to a lack of information and poor physical environment. There was little apparent evidence of patients being able to take action to resolve issues they faced on their own. Patients were most concerned to keep their doctors content and avoided confrontation.

The indications are that there was some association between the levels of awareness and clarity staff have of their own service model and how patients consequently behaved within the service, albeit unknowingly. The stage has

now been reached where it is necessary to consider in full these issues from across each of the previous empirical phases.

6.4 Limitations

Although there are some interesting findings from these studies there are some limitations relating to this series of research studies. The issue of researcher bias is something which despite efforts to minimise through triangulation of data and transparency may have influenced the interpretation of results. Whilst efforts were taken to reduce researcher effects, undoubtedly characteristics of the researcher including demeanour, accent, gender, age and so on may influence respondents' willingness to participate or answer accurately (Breakwell, Hammond & Fife-Schaw, 2000, Breakwell, 2000).

Inevitably, social desirability has the potential to influence interviewees (Fife-Schaw, 2000). This may have particularly affected patients still waiting to be seen by the doctor and those who were pre-diagnosis, as they may have been fearful of the impact of their interview involvement upon treatment. Potential bias in responses may also have come from participants hoping to please the researcher or avoid indicating something negative about themselves (Fife-Schaw, 2000). Whilst all efforts were made to reassure the participants of anonymity of responses and ethical guidelines were adhered to, clearly the fact that mappings, interviews and observations commonly took place in the clinical area may have influenced patient's perception of this.

The issue of language and a bias towards speaking with patients who were able to converse and read in English is also acknowledged. The impact of language barriers on this research has been an unavoidable factor given the

circumstances of the research, with language issues for patients acting as a barrier to satisfaction (Carrasquillo et al., 1999), there are clear implications for the exclusion of patient groups unable to take part for this reason.

The funding of this research has, in part, been supplemented by the hospital Trust in question. The approach taken in this study was of an independent, academic perspective with a clear separation between any Trust strategy and the objectives and activities of the project. Given that concerns have been raised by some (Williamson, 2006, Williamson & Prosser, 2002) of the potentially politicised nature of such research methodology, great care has been taken and full consideration given to the potential political and ethical issues affecting both the researcher and participants. The provisions for ensuring confidentiality and anonymity have been stringent and independence from the hospital organisation has been sought throughout.

Finally, despite attempts to ensure a representative sample, the involvement of certain staff in selection of potential participants to interview or observe, may have biased the type of patient included in the sample.

7 Discussion

7.1 Introduction

The aim of this research was to provide greater insight into the clinical reality underlying redevelopment approaches within an English NHS hospital Trust. This research has, therefore, reflected upon experiences and evidence gathered from patients and staff from a range of services. Particular focus has been given to considerations of those patient and staff experiences; issues of control, involvement and service culture. The lines of inquiry have mirrored this interest with additional individual questions which have been posed to drill down deeper to examine some specific characteristics of the service being studied.

This research addresses what may be regarded as a growing assumption that hospital redevelopment programmes invest millions of pounds in making changes with an apparent expectation that outcomes will bring benefit to patients and staff. The shift towards increased patient-centric services developed with user involvement also represents an approach currently receiving major government investment, as outlined in the NHS Plan (Department of Health, 2000). The main findings from this research investigating issues around patient and staff experience in the context of hospital redevelopment, suggest that whilst patients have been generally satisfied, there were some tensions for clinical staff during redevelopment. There remains a concern that the evidence base for such radical change programmes appears less than fully established. The findings which have emerged from this research indicate that the rationale for the NHS adopting such radical redevelopment approaches does not appear to be fully founded

on empirical evidence; a striking notion considering the levels of expenditure committed. This is particularly striking in the context of the abundance of governmental policy pushing agendas such as extended patient choice and control in development of healthcare, outlined in the NHS Plan (Department of Health, 2000) which are apparently unclear on precisely how such involvement should be undertaken (Fudge, Wolfe & McKevitt, 2008).

Evidence from this study identifies issues which have arisen regarding approaches taken by programme managers at the hospital to introduce changes in teamworking; with results indicating that top down approaches were less successful than anticipated, as evidenced by the case of the new acute 'night team'. A lack of consideration of the complexity of potential barriers to trying to alter working culture, for example the A&E night team concept, was evidence of this (refer to Chapter 5.1 – Acute Service). Despite the variations in service context and difficulties or benefits facing staff, there was some degree of consistency in the nature with which patients presented themselves (around the processes of negotiation linked with inherent expectation). This applied both in terms of expected and unexpected behaviour on the part of the patient and in context with the models in operation for clinical teams, and has enabled the formulation of greater understanding of emergent patient processes and thinking around a 'model' for behaviour of the patient.

This notion of a model for patients is particularly relevant for the Trust in question and the NHS as a whole given the degree of effort taken to develop clinical service models, which appear to lack full consideration of the role of the patient. The findings show that there is some consistency in terms of patient pathways and aspects of patient/staff control in various clinical services at different stages of redevelopment, but that certain elements of patient and staff control are more specific to the individual group. In addition, considering the current focus upon patient-centric services the

need for increased awareness of how patients' expectations and actions are (perhaps unconsciously) governed or influenced is important. This is particularly so given the rising unrealistic public expectations fuelled by media and education which it has been suggested will challenge doctors as they provide services from a more patient-involvement perspective (Neuberger, 2001).

7.2 Hospital redevelopment programme

It is useful at this stage to recap on the concepts underlying the hospital redevelopment programme. The original vision for the modernised hospital was centred on whole systems redevelopment and incorporated a newly fabricated hospital building. New clinical models were created for individual hospital services, in addition to the overarching themes for the redevelopment which centred upon the fundamentals of business process reengineering (BPR), focusing upon improving efficiency and effectiveness. Whilst BPR approaches have been successfully applied to redevelopments at other UK hospitals (Brown, 2004), learning from American hospitals which have adopted a BPR approach to facilitate improved service quality and enhanced financial performance warn of the potential risks of derailment by a lack of staff cooperation and skill (Ho, Chan & Kidwell, 1999).

The implementation of reengineering the hospital was observed to have brought about some inevitable instability for certain services. Often the reality of the redevelopment did not map onto the expectations envisioned by managers. During the phases of major redevelopment some clinical teams were faced with tensions between Trust management and clinical leadership to the extent that it occasionally hindered resolution of internal workings of the teams. This tension was particularly observed in the respiratory clinic and is illustrated where planned service developments were retracted by

senior Trust managers due to financial problems (see Chapter 5.3 - The Respiratory Clinic). This finding is not unique, as change is often imposed upon clinicians to meet priorities which differ from their own perceived priorities and this can lead to anger and a fear of change (Cronin & Wright, 2006). Whilst the A&E staff also indicated tensions with management over uncertainty regarding the redevelopment, this was not observed to have affected the service model delivery and thus did not overtly influence internal working of the team. Rather, the result of this tension was an impact on A&E staff morale due to uncertainty over the redevelopment programme.

There was a spectrum of change and redevelopment for each of the services studied, ranging from taking the first steps to being virtually completed. The stage of redevelopment of a service, unsurprisingly, influenced perceptions of stability and had consequences for patients and staff alike. This is highlighted by the contrast of findings from PACU which had recently experienced redevelopment compared to A&E or the respiratory clinic. In PACU staff and patients were generally comfortable and satisfied with the service and presented a seemingly more aligned unified service, both managerially and clinically. The acute service and respiratory clinic, on the other hand, both faced major change and were in a greater state of flux. Irrespective of the level of change or redevelopment facing services, staff had no choice but to continue working with the accompanying uncertainty, balancing this with the demands of their professional responsibilities. The definition of medical professionalism, as “a set of values, behaviours, and relationships that underpin the trust the public has” (p. xi) and “doctors must keep ahead of shifts in society’s expectations” (Royal College of Physicians of London, 2005, p. 1), emphasises the pressure upon staff to provide continuity of care in the face of adversity.

7.3 Service boundaries

A distinguishable aspect of all services observed which warrants discussion has been the boundaries around them; the routes of referral and access for the patients, staff and other clinical teams working within and between services. It has been suggested that from a staffing perspective, specifically that of nursing, permeable boundaries encourage ideas (and patients) to move across disciplines whilst impermeable boundaries act as barriers (Russell, 2000). The ability to move across disciplines where necessary was promoted by the redevelopment programme as one of the benefits for patients of the new service, ensuring that patients were able to access appropriate teams or specialties as quickly as possible. Permeability of services is something which was found to vary between services and respective staffing structures.

In A&E (including the subgroups of night time, general day and gynaecological patients), the boundaries in the service were observed to be the most permeable of the all the clinical services studied. In A&E patients were often referred onwards (at times with resistance from certain medical specialties) for further care from more specialist teams. In addition, other speciality clinicians physically located themselves within A&E when required. With only one route of referral and tight boundaries, PACU was typically more impermeable. The respiratory clinic had some permeability to service boundaries, in that there were a number of transfers observed to and from other services within the hospital (for example other hospital clinics and A&E), but generally these would need to be pre-arranged and due to the clinic structure would not be spontaneous in the same manner as A&E. Potential implications for the patient regarding permeability varied between services, for example, in the respiratory clinic a lack of flexibility when the need for involvement with other services arose caused patients delay (for example in waiting for further diagnostic tests or scans which tended to be

far more readily available elsewhere). The higher levels of permeability for patients in A&E allowed them to be treated by appropriate teams with less delay.

In terms of patient access to the service within PACU, on only one occasion was a patient observed to attempt to overcome the confines of the service by forcing a self referral. However, this patient was immediately informed by nursing staff that such an approach was not officially allowed (though on this occasion they were seen). The nature of the staffing group also mirrored the somewhat protective, exclusive nature of the PACU service. Paediatrics has long been viewed as a special field; high-technological types of medicine practised in the upper part of the bodies of younger people have been accorded higher levels of prestige (Norredam & Album, 2007). The visible aspects of the culture of the unit, or artefacts as Schein (1999) labelled them in his expression of culture, were more striking in PACU than in any other service. These included a range of child-friendly adaptations, for example, ward curtains, staff uniforms and medical equipment. The traditional medical hierarchy was also maintained with little overlap between the professionals and with no nurse practitioners to share responsibility with the junior doctors. This supports a trend which is found elsewhere in the medical profession of exercising a disproportionate degree of power and dominance over the nursing profession (Gair & Hartery, 2001). PACU had a more orthodox structure, potentially regarded as less modern, but which, from the researcher's perspective, was observed to be very well respected and received by staff and patients alike. This may be an example of patients rejecting some of the 'modern' patient-control focused policy which is currently emanating from government. However, it could be a feature of PACU due to the 'special' status and vulnerability of the children, where parents may be more inclined to rely on the doctor who controls a valued knowledge base (Allsop, 2006) and the parent therefore, allows this more powerful adult to take charge.

7.4 Role blurring

Permeability of services was also observed to link with role blurring to some extent in the context of the redevelopment. For example, nurse practitioners (who had been notably absent in PACU) in A&E treated patients at many stages across the patient pathway and on occasion shared tasks with junior doctors. The nurse practitioners were encouraged to take on a certain degree of the clinical work load traditionally associated with junior doctors, in particular during the process of clerking a patient. This was a development which on the whole was received positively by nurses and doctors alike. The increase of more highly trained staff to foster reductions in delay and repetition for patients in A&E was a cornerstone of the new A&E model which has evidence to support its successful application in the data collected. However, the staff themselves (in A&E and the respiratory clinic) expressed concern over the reduction in staffing numbers or the process of restructuring jobs which appeared to cause significant anxiety for some.

For the gynaecological direct referral service, the sharing of professional roles was further evidenced by nurse practitioners and registrars working side by side on different patients, with only a consultation between them after treatment for confirmation by the registrar. In some respects, evidence contradicts the notion of nurse practitioners at the Trust having a desire to take on some of the roles of doctors, where nurse practitioners did not wish to be seen as substitutes for doctors, but that they were “more patient focused” (Tye & Ross, 2000, p. 1091).

Effective management is of importance where potential role blurring or at least sharing of new responsibilities might be occurring (Brown, Crawford & Darongkamas, 2000). Despite the success in utilisation of increased clinical responsibility for nurse practitioners, managers of the night team did not fully accommodate for the overall shift in the habitual behaviour of clinicians

required to bring change into practice. As Schein (1985) identified, change is difficult due to basic underlying assumptions. It appears from a number of comments from staff that their assumption was that real change in the service was limited, for example in the night team where staff were adamant that nothing within the service had changed in reality, despite the managerial insistence that it had. Some clinical members of the A&E team expressed frustrations relating to the difficulty in successfully referring patients to other clinical teams when required. Streamlined multidisciplinary team interaction had been promoted as a benefit of the new hospital model, but the frustrations reported by some A&E staff provides an illustration where behaviour of colleagues from other departments was not viewed to have changed in line with expectations (see Chapter 5.1 – Acute Service). Managers expected changes from the clinical team which failed to materialise fully. For example if changes such as the night team developments in A&E had been allowed to evolve more from within a team there might have been better chance of success (McManus, 2003) and the understanding between other clinical teams interacting with the night team might also have had time to mature. In practical terms this finding highlights the difficult task of making change and points towards the restricted ability of a new policy to transfer into reality.

In contrast, the clinical leadership in PACU was observed to have a strong reputation and was generally well regarded by the staff. There was virtually no role blurring observed in PACU with a relatively strict medical hierarchy headed by the consultant. Nurse practitioners were not utilised and each occupational group had clear lines of responsibility. This finding perhaps supports existing concerns over a potential loss of efficiency when roles are blurred (Wall, 1998). The evidence suggests that PACU has a more 'traditional' model which was operating very successfully, but curiously, the traditional model so successfully deployed in PACU was not the focus of the main hospital redevelopment.

In the respiratory clinic, the role of the clinic care coordinator had evolved to take on responsibility for administering basic tests such as blood pressure, at the same time as nurses had been removed from the clinic. These new responsibilities for the clinic care coordinator as outlined in the new service model were beginning to be applied in practice in line with expectations and initial indications were positive (see Chapter 5.3 – The Respiratory Clinic). The extension of responsibilities for the clinic care coordinator illustrates a stark contrast with PACU operating with its more traditional structure. This finding serves to raise questions about where the potential learning from PACU (which was operating prior to the main hospital redevelopment) was fed back into the main hospital redevelopment programme with its far more modern approach to roles and responsibilities.

In summary, the new hospital model positively encouraged nurse practitioners to take on greater responsibilities in A&E and for the clinic care coordinator in the respiratory outpatient clinic to increase their responsibilities. This increase in the use of more highly skilled staff, which resulted in some blurring of stereotypical roles and responsibilities, is something which was made explicit as an intention of the new hospital model. However, PACU's success appeared to thrive upon a far more traditional approach and it is interesting that the contrast is seemingly so apparent. Whether the new hospital model was developed earlier thus restricting time to incorporate learning from PACU, or indeed whether the specialist nature of paediatrics made the service less comparable, is not entirely clear. There are a number of possible explanations for why PACU appears to operate differently. Perhaps due to the protection offered from the relatively tight service 'boundaries', and the effectiveness of the service, PACU may have been shielded from changes taking place elsewhere in the Trust. It may therefore, be unfair to suggest that the hospital Trust did not

use the opportunity to learn from its own development before investing in other areas.

7.5 Stages of the patient journey

The concept for the new night team in A&E was highlighted by the redevelopment programme as a microcosm of the full scale redevelopment changes yet to come. The process of redevelopment for the A&E service at night was intended, according to the redevelopment programme management's model, to see the introduction of a new night team to replace existing structures (as represented in Figure 5.1 and Figure 5.3) with a refined service offering patients faster access to the right treatment.

A key element of the service redevelopment was an anticipated reduction in the number of stages a patient would proceed through during treatment. Within A&E this hinged upon a hub of highly skilled clinicians termed the new 'night team'. The new night team, a concept which had been promoted by development managers in the early stages of this research project, would facilitate this by directly 'fast tracking' patients to the appropriate clinical team. In fact, when questioned about the changes to the team structure and when referring to the 'night team' label, an A&E consultant and nurse practitioner both indicated they felt nothing had really changed. Illustrating this, they claimed they had not even heard of what was identified to them by the researcher as the 'night team'. This further indicated that forcing change upon the team was not the most successful of approaches to take in order to allow the team to develop as intended. The managers responsible for this lack of appropriate consideration failed to account for the interaction of the night team with other hospital services, or the improbable task of forcing cultural change. The clinical reality of staff actions did not fit the theoretical notion of the new model in this case.

The focus by redevelopment programme managers regarding the significance of reduction in the number of stages of the patient pathway (especially for acute services) was not always reflected in the results. The stages of the patient journey were often not as linear as expected. Not only were the nature of stages quite different, but the linear focus was not always deemed congruous for patient care. Activities could well be parallel and appropriate for the patient. For example, waiting for test results could dictate an order of processes which was outside of the linear model, but this may have been clinically appropriate.

A further issue which directly related to the focus of the patient pathway in the redeveloped hospital was that of targets. This issue emerged particularly in A&E around the four-hour target for dealing with patients on arrival to the department. The systems within the unit were set up to manage this target for example, via the white board which was the focal point of patient information. Whilst clinicians were observed to do their best to adhere to this target, the impact on the patient was not necessarily an improvement in their care. The A&E department was observed to utilise a side unit referred to as ACDU which was formally classified as separate to A&E, but which was, in real terms part of the same department. ACDU was officially an observation unit. However, A&E staff were clear that the purpose of ACDU was to provide them with some flexibility and that it enabled them to work around the four-hour target. A&E staff explained (see Chapter 5.1 – Acute Service) that ACDU was set up as somewhere to move patients out of the main A&E section if they were approaching the four hour limit and were not in a position to be discharged or referred elsewhere. This action was purely to avoid breaching the target and not for the benefit of the patient. This observation is clear evidence of the change of focus in care which can be brought about due to the politicised nature of the health service, but which may not necessarily benefit the patient.

7.6 Team models

Deeper analysis has enabled an examination of the team models which link directly with service boundaries and the intended redevelopment expectations. All of the teams observed had a model of their own, ranging from a specific tangible set of expectations, policies, procedures and outcomes to something less obvious or clearly defined. Actions within the team at times matched the expectations of the individual service model, but there were also occasions where staff simply got on with their work in what was fundamentally the same manner as prior to redevelopment.

There is a distinction to be made between the clear model of a service such as PACU and the more 'fuzzy' model of acute services. The respiratory model is interesting in that originally this model was explicit and acted as the template for future redeveloped services. In the face of adversity, due to financial pressures and uncertainty, staff in the respiratory clinic found themselves in a less desirable situation than the original model might have indicated. The registrar described himself facing uncertainty over how he would fit in, "I don't have an office so I'm not sure how it will work!" (see Chapter 5.3 – The Respiratory Clinic). Despite such adversity, the staff had clearly evolved a way to cope with and continue to provide a satisfactory service to patients.

When considering the way things work in the organisation and variations between hospital services, the question arises as to what the impact might be upon the service culture. This is particularly so when considering Schein's (1985, 1991a) 'levels' of culture which define whether or not an organisation truly endorses what it says it does at the deepest level. When an organisation is managed by targets and government policy, doctors may feel they are given no choice but to operate in a time-conscious manner. However, theory does not appear to present an explanation of how to deal

with this apparent conflict of interest within the NHS as an organisation. The challenge health services face having to operate under target-related constraints which may at times seem at odds with what is best for patients, in conjunction with a lack of direction from senior staff relating to the service itself, may go some way to explaining the uncertainty expressed by the respiratory clinic staff. Examples of this might include the reported morale issues and disparity of views over the direction of the service in the future (see Chapter 5.3 – The Respiratory Clinic).

The focus upon team models becomes particularly interesting when considering the implications for patients. On occasion, procedures were observed operating in the manner they theoretically should have been according to higher level policy, but there were also examples where this was not the case. The aborted introduction to the respiratory clinic of an email consulting system for GPs was a good example of this. In terms of a conscious collective agreement of a team model, the respiratory clinic also appeared more uncertain and had less shared awareness regarding the direction the clinic would be moving in. This may have been more as a consequence of the change programme and uncertainty surrounding it, or that the team were still undergoing changes and further team development was yet to come. For example, they were still moving from the 'old' environment to 'new' environment.

Despite these challenges, there appeared to be limited negative associations for the patient. Within the respiratory clinic, staff upheld their professionalism and were not observed to express concerns over morale or uncertainties associated with the redevelopment programme in front of patients, thus ensuring that they were largely unaware. The impact upon the patient of the cancelled proposed email consulting systems for GPs cannot now be measured reliably as the system was not brought into use, however, it is most probable that there would have been improvements in waiting

times for some patients from GPs seeking advice through the proposed new scheme.

Data showed that there were some positive developments for the teamworking in the acute service, from the nurse practitioners taking on increased responsibility and in outpatient services with the clinical care coordinator's developed role. However, in general across services, the evidence suggested that staff actions for teams as a whole did not change much in real terms despite the expectations of the redevelopment programme.

It is interesting and important to note that the role of the patient was external to the team models; rather, they tended to be recipients to outcomes of the clinical model and receivers of care. Little consideration appears to have been given to the actions of the patient upon the clinical service, either in its development or delivery for any of the services involved in this study. Whilst policy indicates that the patient has a central role in healthcare (for example NHS Plan, Department of Health, 2000), the research presented in this thesis indicates that this is not always the case in reality, that policy alone cannot change behaviour.

7.7 Information flow

The challenges facing many of the staff working in and around the redevelopment programme were often compounded by problems related to information and communication. With respect to the redevelopment programme, information flow was a critical factor to achieving the programme objectives, and was something that managers of the programme insisted they had made efforts to achieve. There were a number of levels of information flow in this respect. The first level was the information for staff

relating to logistical issues around the hospital services' relocation, the new systems and procedures in the new clinical environment. The second level of information related to communication between managers and staffing teams in terms of the future strategic and operational direction of their services. Thirdly, was the information flow between managers and individual members of staff (relating to specific job roles etc). The issue of information flow was mainly linked to managerial and service information, rather than clinical or patient information (although for example, on occasion uncertainty from staff regarding the location of the respiratory clinic led to some information given to patients about future appointments becoming somewhat confused).

Much of the positive PACU teamworking might be associated with the clear lines of communication between leadership, management and the clinical team. In contrast to this, across the acute and respiratory clinics, concerns were raised by staff regarding future job security and lack of inclusion with the plans for the redevelopment itself. This may have been due to the fact that such teams have relatively more diverse work and aims, and so therefore less focus. The impact of job conditions and organisational support are well documented to be linked with commitment and performance (Rhoades & Eisenberger, 2002). Consequently, the low levels of morale reported by some staff (refer to Chapter 5.1 – Acute Service and Chapter – 5.3 The Respiratory Clinic) may have resulted in less alignment or commitment to any new organisational strategy. These potentially negative consequences might have been avoided if managers of the change programme had improved the information exchange with their staff (McNulty and Ferlie, 2002).

7.8 Environment – social interaction

The research has thrown some light on issues relating to the hospital environment. The improvement of the physical environment was a major element of the redevelopment programme, particularly in financial investment terms rather than clinical outcome expectations. Despite the considerable financial commitments to the redevelopment of the hospital, some clinical staff were insistent that the building was not what made the hospital; as a chronic disease nurse practitioner (part of the respiratory service) stated, “even though it is an attractive building it’s not about attracting them [patients].” This view perhaps links in with the uncertain direction facing the respiratory service. This uncertainty applied both in leadership terms, with the undermining of clinical leadership’s strategy by hospital executives, in addition to clinicians’ lack of clarity over the logistics of working in the new hospital. Interestingly, the view of the chronic disease nurse practitioner directly contrasted with the actions of the Trust Chief Executive in her decision to renege on the introduction of email clinics for GPs, specifically because this would have resulted in a reduction in the number of patients presenting to the hospital.

Despite the shortcomings and in the face of the insistence by some managers that the hospital building was not the main focus of the redevelopment, many of the patients felt positive regarding the prospect of a new building. The large atrium and attractive building all contributed to an implied structural message about the care patients might expect to receive inside. However, for some services there was little or no change to the service, following the move. This was particularly the case for those who had already been redeveloped, or were not expected to change following the move to the new building. For these services in particular, the benefit brought from moving to the new building, beyond its ‘newness’ is more difficult to establish.

The benefits of an improved environment were recognised by patients and parents accessing PACU, with its modernised and purpose built facilities. The enclosed, compact environment in PACU played an important role in encouraging social interaction between patients and staff. This influence of the physical environment is something which apparently did receive the same focus in the main hospital redevelopment. The atrium formed the focal point of the new hospital building. The general theme of large open spaces, rather than 'cosiness' of PACU permeated throughout the new hospital building, which may have been a reflection of the multi-purpose nature of the building as opposed to the single purpose of the PACU service.

7.9 The emergent model

The models for the various services across the redevelopment project acknowledged the patient in so far as expectations for outcomes would improve, but patients were not an explicit part of the service model development itself. However, findings from this research suggest that the patient plays a crucial role in service models and should not be excluded in this manner. Consequently the emergent, implicit patient processes are discussed. This emergence has been particularly noticeable during the process of redevelopment and change facing clinical teams across the hospital, at times when management was endeavouring to foster changes in aspects of the culture of clinical working. There have also been important issues from a patient perspective which have been of relevance irrespective of service context, such as exchanges between and communication with clinicians (in all services studied). These factors drew the patients collectively together, contributing to the notion that patients may not have fitted into the service model.

There are a number of issues which, based on the observations within this research appeared to be particularly relevant to the conceptualisation of a model in terms of the clinical services which the patient was (or was not, in fact) a part of. These factors generally related to the interactions taking place between patients and staff and processes of negotiation and influence of expectations. The complex issues inevitably had some overlap between them, but generally they were centred upon the theme of patient control, incorporating collusion, reciprocity and compliance. Whilst it may be difficult to disentangle these issues, where possible, some definition of terminology is important.

7.9.1 Control

Patient control over care includes for example, the extent to which patients are able to directly influence or make decisions over how aspects of treatment take place, which doctor they are seen by and where they choose to be treated (this is supported in policy such as the 'Choose and Book' system). These are decisions which have traditionally been associated with the healthcare professional (Kelner & Bourgeault, 1993).

There is a common assumption, as illustrated by Paper (2002), that individuals who view the receipt and delivery of healthcare as a service wherein they are the consumer and the clinician is the provider, will feel more in control and are likely to have better outcomes than those who assume the more traditional passive patient role. However, it is suggested in this research that such a perspective is overly broad and does not take account of the complexities in the processes and expectations which underpin interactions in clinical care. The complexities of the power relationship between patient and doctor have been highlighted by Freidson (Freidson, 1988) who identified the rise of the position of medicine as stemming from the demand from the general public, that "when service to

the community is defined by the profession [medicine] rather than the community, the community is not truly served” (p. 351). However, Freidson makes the following statement “Given the viewpoints of two worlds, lay and professional, in interaction they can never be wholly synonymous. And they are always, if only latently, in conflict” (p. 321). Freidson’s view illustrates and supports the unease presented in this research over the assumption that conflict and power interactions between patients and clinicians can be simply resolved, despite concerns which have been apparent for over two decades.

7.9.2 Collusion

In some circumstances, patient control may be realised through collusion. The concept of collusion has somewhat negative connotations within healthcare (Lawrence, 2002), suggesting the development of a kind of secret agreement or understanding between parties. Evidence suggests extreme consequences of unconscious collusion between a patient and doctor may potentially result in iatrogenic disease (Twemlow & Gabbard, 1981); a disease which is induced by a doctor’s manner or treatment. There have been concerns voiced from clinicians that they should not be drawn into colluding with patients’ inappropriate choices (Steer, 2006). In palliative care practice, dilemmas and conflicts about truth-telling may involve collusion between healthcare professionals and the patients’ relatives to withhold the truth from the patient (Vivian, 2006). This supports the potential severity with which collusion may influence care, thus highlighting the clinical validity of this issue.

The concept of patient-centric services poses an interesting dichotomy. Services such as PACU purported to be fully patient-centric, as stated in the PACU objectives (Chapter 5.2) in line with general NHS principles, offering choice and control to the patient. In fact, what has been seen through the observations reported in this research is a situation where patients in reality

had much less choice than might be expected. This point can be illustrated with reference to the PACU data. Staff in PACU gave the impression that with its strong sense of identity, strict boundaries and medical speciality, they were confident that the service they offered was good, providing patients with the best possible care. Effectively, the staff operated in a traditionally paternalistic manner; knowing what was best for the patient, who in turn had very little opportunity to exert control over the situation despite the parent being present to act as a patient advocate.

7.9.3 Reciprocity

Reciprocity relates to the interplay or cooperation between patients and healthcare professionals and may be defined as 'give and take' in this respect. The assumption by patients of the 'take' element of reciprocity, that they will always receive treatment when required is one which the majority of patients arrive at hospital with, and provides some context for trying to understand and develop a 'model' or map the processes of their subsequent behaviour.

Drawing from existing work in the field, it appears that the issue of reciprocity may be of particular significance for those with long-term health conditions, such as in the case of the respiratory clinic patients. There is evidence which suggests that patient-healthcare professional relationships which are based on reciprocity may facilitate adherence to treatment plans into the daily lives of patients with long-term conditions (Herring, 2006). Parkin (2001) focuses upon the role of reciprocity in the context of healthcare professionals working in patient's homes. He identifies the 'social exchange' that is reciprocity, as patients and carers become attached to regular community nurses. The emphasis is upon a beneficial exchange which Parkin outlines is either generalised (in the case of longer-term relationships) or specific (as in shorter-term relationships) and which is subject to moral

beliefs and cultural obligations. Reciprocity may be classified in three ways; as a legitimate expression of gratitude, a strategy to gain favours, or a strategy to gain status. For example, where reciprocity is exercised through the giving of a gift, “the gift may be seen as an attempt to return the balance of power to equilibrium, to reduce the inequality and to regain status and self esteem.” (Parkin, 2001 p. 153).

Expressions of reciprocity in terms of expression of gratitude were clearly observable from the relatives and patients cared for by the PACU service. An entire wall of the clinic was dedicated to postings of thank you notes and letters to the staff from past patients. There was no such visible equivalent in the A&E department. In the respiratory clinic there were no externally visible artefacts of reciprocity, however, through informal discussion with community care respiratory nursing and managerial staff gifts were mentioned in the context of needing to maintain appropriate boundaries between patients.

However, there were further complexities underlying interactions between a patient and clinician. As illustrated in the previous chapters, across all services patients went through a series of negotiations with clinicians. Bakker and colleagues suggest that demanding patients have been linked to a lack of reciprocity in GPs which in turn has been associated with burnout. Moreover, their findings suggest that GPs, who attempt to gain emotional distance from their patients as a way of coping with their exhaustion, precipitate demanding and threatening patient behaviours themselves (Bakker et al., 2000). This may have been an explanation for the doctors observed in A&E to resist interacting with a demanding patient (Chapter 5.1 – Acute service). This worrying association highlights the clear implications of issues relating to reciprocity for the wellbeing of the NHS.

7.9.4 Compliance

Whilst compliance has been studied from a wide range of scientific perspectives, there is no agreement regarding a commonly accepted definition. However, most approaches towards a definition contain references to patients' self-care responsibilities, their role in the treatment process and their collaboration with healthcare providers, particularly in relation to following recommended medical advice or treatment; where there are undertones of medical dominance (Kyngas, Duffy & Kroll, 2000).

The findings from this research indicated that patients were willing to comply in order to get what they wanted. This supports the notion put forward by Kay (2006) of the 'perfect patient' (as discussed in Chapter 5.3 – The Respiratory Clinic). Only one of the parents observed at PACU was observed behaving in a way which contravened the policy of the unit, by attempting to enter the unit without a referral. The respiratory clinic patients often had minor grumbles about the clinic environment or more serious concerns about waiting for extended periods of time and poor communication. Observations offered no clear evidence of patients explicitly exerting influence or making decisions. Despite this, in general they reported being satisfied as a group and maintained the behaviour they felt was expected of them (for example the respiratory clinic Patient 10 not wanting to disrupt the consultant).

It is suggested by the findings that interactions between clinicians and patients have been observed to be influenced by perceived control. Evidence indicates that communication in medical encounters is influenced by the beliefs of the patient and doctor about their control (Street et al., 2003). Doctors have been shown to be more patient-centred with patients they perceived as more satisfied, better communicators and more likely to adhere to treatment. In addition, doctors have displayed more patient-centred communication (informative, supportive, partnership-building) and

have more favourably perceived patients who were more involved, expressed positive affect and who were less contentious (Street, Gordon & Haidet, 2007). This effect is shown to be mediated by whether a patient is active or passive (Brown et al., 2002). The issue of patient compliance is a complex element of the negotiation process which occurs between a doctor and patient. Compliance on the part of the patient risks morphing into irresponsibility if that individual patient is overly reliant upon a doctor. Brown et al. (2002) have illustrated how a lack of training for doctors in different communication styles can lead to conflict, as was observed indirectly in this study when acute Patient 1 attending A&E was less passive than her counterparts, and demanded attention of the clinical staff resulting in an apparent mismatch of expectations by the two parties.

Across the hospital services, patients were not generally observed actively influencing their care. However, as the patients on the whole were highly satisfied with the treatment and overall experience offered by PACU, they had no need to do anything other than comply. The exceptions to this, such as the A&E patient trying to call for staff to give her information, and the PACU patient who self-referred to the unit, are examples of patients who were relatively more difficult from the staff-control perspective.

From the current study, a key emergence is that of the implicit processes of patient behaviour, and how they have operated in the context of the Trust service models whilst in hospital. This is centred upon the process of negotiations and inherent expectations (such as a patient will receive treatment or attention from a doctor as illustrated by patients in acute care) which took place between the clinician and patient at every clinical interface.

PACU presents an example of how, when the service was functioning in a way which suited the needs of both the staff and the patient, it was left to do so. When services failed to meet the needs of patients in the same way, it

would be possible that demand for greater patient control might be higher. The key here is that as evidenced by PACU, patients did not necessarily want to have increased control. When a service such as PACU offered what the patients wanted, the service worked well. There is some suggestion from other fields of healthcare that there are potential dangers in allowing patients greater choice or control around care decisions (for example elective caesareans, see Belizan et al., 2006).

A conflicting interpretation of healthcare compliance behaviour is patients who are in fact being autonomous decision-makers. However, when this is played out in reality it tends to favour who has the appropriate knowledge, experience and skills to make the 'right' or 'best' decisions. As illustrated by the case of elective caesareans, it is unlikely, as supported by the position of traditional medical dominance, that the individual with such knowledge is not the patient (they cannot all be expected to assimilate and make informed value judgements in the same way). This links with subsequent evidence-based practice where patients tend to be lower down the hierarchy, although controversy has surrounded who should be involved in decisions about health and healthcare (Baggott, 2005).

7.9.5 Implicit processes of patient behaviour

The discussion of the factors surrounding control, reciprocity and compliance leads to conceptualising the notion of the implicit patient processes and behaviours involved. The way patients have fitted into the hierarchies, teams and cultures within the various services was consistent; patients were external to this and external to any service model.

Furthermore, any consideration of patients' interpretations of what constituted satisfactory or good quality care must be understood in the context that this generally revolved around their interpretation of functional rather than technical quality. Functional quality is concerned with how the

patient receives the service rather than clinical content of care. As Lee et al. (2000) have indicated patients are not well equipped at judging quality of clinical (technical) services. In other words the patients were preoccupied with how they received the service, and more focused on judging functional quality. Examples from the data include patient's comments around efficiency and communication as positive aspects of their treatment (for example the Acute GDR Patient 3 stating the limited wait or short distance to go for a scan made her 'very happy', a sentiment which was echoed by many other patients). This was in contrast to staff who were more aware of the technical side of care provision as supported in the literature (Chilgren, 2008). Evidence came, for example, from the A&E staff who noted the potential benefit of improved clinical equipment or superior clinical interventions possible due to the move. Not only did staff and patients have differing perspectives about what represented quality or good care, but there did not appear to be much awareness of the differing perspectives between the two groups. Staff might be focused on technical quality, (which patients are commonly unaware of), and whether it was lacking or not, staff would not necessarily communicate this to the patient. This may go some way to explain differences in interpretation of services between patients and staff

PACU patients arrived and experienced very little influence over their care. The boundaries of the service and general medical dominance meant that patients were slotted into a highly controlled, pre-existing process. This diminished level of patient involvement bears a direct contradiction with the political and Trust-based strategy, both of which focused on providing patients with greater control, increased choice and involvement. However, despite this the PACU service was patient-focused and most importantly, provided patients and their families with care which they reported to be very satisfied with.

The acute patients attending A&E along with the respiratory clinic patients were both a little more involved in terms of the actions required of them to bring them into, and be treated within the service. The boundaries of the A&E department were relatively more open, but as with PACU, patients were observed to progress more smoothly through the service if they did not present difficulties to the staff. The respiratory patients, being chronic sufferers, theoretically may have had more knowledge and involvement in their care. However, in some situations this may have resulted in the observation that patients felt more obliged to avoid causing difficulty for the well known clinicians. The control and choice available to these patients was again very different to the reported policy. The processes involved patients with limited input in progressing themselves through the service. However, both groups were generally satisfied.

It is apparent that the patient was on the outside of any service model. The processes by which patients operated were greatly influenced by their unconscious expectations regarding treatment and clinical interactions.

What seemed to permeate across patient groups are the unwritten 'rules of the game' and how well patients knew and adhered to them. These rules were ones by which patients unknowingly operated. The rules were in evidence between patients and clinicians in terms of expectation of behaviours between the two parties. The rules were moderated by the expectations that patients arrived at hospital with and their behaviours during interactions with clinicians. All of these factors were important predictors for the feelings of satisfaction patients leave the hospital with following treatment (McKinley et al., 2002). It appeared from the evidence collected, that irrespective of reform or modernisation, patients would generally be satisfied with care as long as they continued to function within these 'rules'. That is, if that they received the treatment they expected and nothing went seriously wrong. It is once problems arise and patients start to behave

outside of the expected norms that difficulties will be encountered. Evidence indicates that consequences of unmet expectations adversely affect patients and clinicians alike (Bell et al., 2002), highlighting potentially far reaching implications for future healthcare provision and patient satisfaction.

7.10 Conclusion

Through examining patient experiences and staff perspectives, this research challenges some of the assumptions made by politicians and NHS managers. These assumptions relate to a strategy of increasing patient choice and the associated rationale for aspects of NHS redevelopment. This endeavour has been particularly pertinent given the concern that many aspects of patient choice are still under-researched (Greener, 2007).

The findings from this research indicate that when outcomes for patients and staff remained positive, the disparity between a processes and clinical reality in a service may not have been noticed. This suggests a lack of consideration for the underlying processes and should act as a warning that if the clinical reality is not tracked when things are going right, there will be less control or understanding to prevent things from going wrong. The current patient-centred focus is an indication of political tunnel vision overcompensating for a lack of understanding of what patients and staff really want.

The empirical evidence brought forward by this research supports the proposition that patients are 'playing the game' of "the perfect patient" as identified by Kay (2006). The 'perfect' patient according to Kay is the one who represents doctors' preference through doing as they are told by clinicians. A suggestion might be that for services with clear models (i.e. PACU) patients come into the service and perhaps unknowingly operate in

the way expected of them which ensures smooth progression through treatment. For services where there is less clarity over models, staff experience less success in getting patients to operate as they hope. Patients may be blamed for this, despite the fact that any expectation of them may be unspoken and unknown to the patient themselves. If the service model is unclear patients are unclear of how they should behave to get the best from staff.

There is a general concern that the benefits of patient participation in healthcare decision making are yet to be clearly demonstrated in research studies (Guadagnoli & Ward, 1998). McKinstry (2000) and more recently Levinson et al. (2005) have demonstrated that people vary substantially in their preferences for participation in decision making. The research presented here supports the notion that healthcare organisations should not assume that patients uniformly wish to participate in clinical decision making but equally, consideration of the role of the patient is important. In terms of patient-doctor communication style, patients have been shown to prefer a biomedical approach as opposed to a patient-centred one (Swenson et al., 2004). Although this does not address the issue of which approach is more effective, it does bring into greater focus the debate over the differences between what patients actually want in contrast to evolving patient-centric policy.

In the light of the evidenced presented, what has surfaced is the greater certainty that redevelopment and change in the NHS should not be centred so blindly on the patient having greater choice and control. The assumptions of politicians and the redevelopment programme, that heightened patient-involvement is always effective or appropriate are not as soundly based as they should be. The findings of this research showed that at times patients did not want such control, it may have been inappropriate and there are clearly dangers associated with giving it to them. Patients were satisfied

with the care they were getting (because they were receiving what they felt was satisfactory treatment). There is a delicate balance to be struck when considering redevelopment of services. The issue of managing patient expectations is also critical to finding the appropriate balance. From the evidence reported here, generally patients were more satisfied than might be expected, given the current national policy and amount of local effort invested in redeveloping the service in the first place.

The evidence presented enables increased understanding of the implicit processes of patient behaviour whereby they happily 'play the game' by unwritten rules. Readjustment of some of the political and managerial assumptions surrounding the benefits of patient choice and control can now be made. This new knowledge can help service development managers to structure reengineering for future hospitals in a manner which accounts for those unwritten rules, and grounds any future decisions in empirical evidence.

7.11 Limitations

There are a number of limitations which need to be addressed in relation to this study. The issue of researcher bias is something which, despite efforts to minimise through triangulation of data and transparency may have influenced the interpretation of results. Whilst efforts were taken to reduce research effects, undoubtedly characteristics of the researcher including demeanour, accent, gender, age and so on may have influenced respondents' willingness to participate or answer accurately (Breakwell, 2000). The impact of effects of social desirability upon participants is also acknowledged, with the potential bias in responses from participants hoping to please the researcher or avoid indicating something negative about themselves (Fife-Schaw, 2000). The impact of language barriers on this research has been an unavoidable factor given the circumstances of the research. With language issues for patients acting as a barrier to satisfaction (Carrasquillo et al., 1999) there are clear implications for the exclusion of patient groups unable to take part for this reason.

Despite attempts to ensure a representative sample, the involvement of certain staff in selection of potential participants to interview or observe, may have biased the type of patient included in the sample (for example the clinic care coordinator in the respiratory clinic or senior nursing staff in A&E). It is also acknowledged that in some service areas there were a relatively low number of participants due to lesser numbers accessing the service at the time permission was given to carry out the research within the service. Due to the passage of time whilst completing this research, inevitably there will have been developments in assumptions and expectations from managers and staff which are unable to be fully reflected in this work.

7.12 Suggested future research

Although this study has addressed some important questions, further questions related to the subject remain unanswered. These unanswered questions may, however, become more focused because of this study. As identified by Hawkes (2007) “the choice and localisation agendas have created conflicts of interest that are screaming out to be resolved” (p. 334). There is clearly need for research focusing upon issues of choice and the implications of a notion of a ‘model’ for patients (or at least patient behaviours and processes) as identified in this thesis, across the NHS. Issues around potential conflicts between patients and clinicians as a result of the choice agenda remain unanswered, as do concerns over the impact on the status of the professional. Only after long term implementation and evaluation of patient-centric services can the consequences become more fully understood.

The next important research questions revolve around attempts to resolve the uncertainty relating to the role of the patient in development and delivery of healthcare services. It seems that there is currently a delicate balance being worked upon to reach equilibrium between control and choice and what patients actually need and want which is yet to be fully realised. Patient views regarding the degree of choice over different aspects of care from proposals for new services through to choice over treatment need to be investigated further, including looking at ways of realistically managing patient expectations. Focus should also be given to the impact of staff views of the role of the patient in the functioning of services; whether the patient control being promoted politically is viewed as appropriate or beneficial by staff and whether this is being taken on board in practice.

There are a number of issues raised by this research with implications for the future of health service development, which may make uncomfortable

reading given the current political steering of the NHS. There seems to be a real risk relating to the foundation of the next set of political or NHS managerial assumptions, such as how expert and in control patients are or want to be. Assumptions made on the basis of existing reform and redevelopment programmes are that patients have assimilated all the evidence and information available to them. It assumes patients are happy to make decisions and have more control over their care, but this is not a true reflection of the reality of the situation. In fact, the findings here raise serious questions as to whether patients necessarily want such responsibility for decision making in relation to their healthcare. It would be dangerous to blindly suppose that all patients are willing and ready for increased patient-centric services, when clearly this is not always so, and more effort must be taken to ensure that any future assumptions are based on greater evidence.

8 Conclusion

This study was devised in order to investigate current healthcare policy and practice which is largely structured around patients' involvement and choice in the NHS. Recent activity has seen patient involvement and choice related to healthcare provision and the development of services increase exponentially. The redevelopment and design of healthcare services particularly, has incorporated or centred upon the choices and involvement of the patient. Undoubtedly there are benefits to be gained by select patient groups from aspects of this political agenda. However, the appropriateness of this as a generic tactic for improving all patient care and experience is unclear, and the breadth and rigour of the evidence upon which the shift in philosophy is founded is inadequate.

The research reported herein presents a programme of empirical studies in response to the questions carefully posed around gaps in understanding of the matters raised, as outlined in the introduction and described in detail in the chapters thereafter. In particular, there has been a need to address aspects of the complexities around differences between patient and staff experiences during differing stages of hospital redevelopment. The concerns of the respective groups (patients and staff) around aspects of control and care pathways, and how these might differ in distinct clinical settings, have fuelled the advancement of the research. The impact of changing patient expectations, desire (or lack of it) for control or involvement and the influence of the media are also elements which have required greater understanding.

In order to appropriately address the research questions around the disparity between the evidence base supporting and directing the continued

movement towards patient involvement and choice-based policy, a qualitative approach has been employed. This has facilitated drilling down into evidence from areas where aspects of the detail or understanding had previously been lacking. The context for the research, an acute hospital NHS Trust in England, served as an appropriate location for data collection, given that it provided the opportunity to collect evidence from within three separate clinical service areas (the acute service, a paediatric ambulatory care unit and the respiratory outpatient clinic) whilst a real time redevelopment programme was taking place.

The strategy of studying three distinct service areas enabled unique data capture from different types of patient and staffing groups and from various stages of the redevelopment programme as it disseminated throughout the Trust. This was important given the focus on patient and staff perceptions of control and change in the context of the redevelopment.

The key findings of the research were drawn from a number of themes which have informed the conclusions drawn in the context of the hospital redevelopment programme. These include aspects of clinical service boundaries, teamworking and team roles, information flow, the environment and stages of the patient journey. Specifically focusing on the role of the patient and interactions with staff, issues around control and expectation were identified as important in terms of understanding the developing notion of a 'model' or framework within which to understand the processes of the patient journey and experience.

Much of the patient evidence collected in this study indicated that patients were happy for clinicians to be responsible for, and in control of their care. The degree of actual patient control, involvement or choice, although fairly consistent between the three clinical areas studied, did vary marginally. The acute service and respiratory clinic both had similar structures in this

respect, with some flexibility in terms of boundaries and structure. However, PACU was very tightly controlled, with the most traditional medically dominated service of the three investigated, and yet the patients and their families were overwhelmingly positive about their experiences in the unit. This is clear evidence of why patients' involvement needs to be considered in a more sophisticated manner. The PACU patients and parents in particular were happy to be protected and cared for in the service without any of the responsibility of having to make decisions or be involved in treatment. The reality of the redevelopment programme was that certain patient groups were actually content without being offered a great degree of choice or involvement in the care they received.

The evidence also indicated a difference between the interpretations of both patient and staff groups in terms of functional versus technical operating in healthcare provision. This difference was a crucial part of the formation of the emergent patient processes concept. It centred upon the interpretation of experiences by patients who were concerned with issues around receiving efficient and good treatment, in contrast to the experiences of staff who were generally far more concerned with the technical nature of the clinical service provision. This was one example which illustrated the need for greater consideration to be given in the future to the patient processes involved in terms of what steers or influences patient experiences, which themselves may be at odds with staff expectations.

This thesis has provided new evidence from a hospital redevelopment context, which contributes to the empirical basis of understanding the role of the patient in redeveloping healthcare services. This emerging evidence has shown that the relationship between the patient and the clinician at the redeveloping hospital Trust was not as might have been expected considering the redevelopment programme objectives. On the whole patients were satisfied with their care. However, in contrast to the view

promoted by much policy, this was often without having much control, choice or involvement in treatment or care. Notably there was also little observed desire for this. This is somewhat at odds with the government approach indicating that control, involvement and choice are universal aspirations of all patients and represent an ideal.

It appears there is a danger of redevelopment programmes of hospitals falling into the trap of dealing with patient involvement issues in a manner which complies with government policy, without being purely structured around what is best for the patient. For example, targets particularly in A&E influenced much of the structure of patient care observed in this study, but not necessarily for ideal clinical purposes. The findings here indicate that there is a risk, both financially but more importantly to the detriment of patients and staff, of blurring the line between the somewhat crude strategy of increased patient control and involvement, with what is now more clearly understood as the necessarily sophisticated approach needed to understand where, when and to what extent such strategy is appropriate.

The evidence reported in this thesis is strengthened by consideration of both the patient and staff perspective. The findings have now broadened out what was a narrow evidence base with some gaps between existing policy and clinical reality, to show in some detail elements of patient and staff experiences which points towards the true nature of patient involvement in the hospital redevelopment programme. The findings do not negate the fact that there are likely to be areas where patient involvement and choice have an important role to play, rather they highlight the need to consider and understand the significance in appropriateness of application of such a strategy.

The novel findings which have emerged from this research indicate specific areas where the rationale for the NHS adopting radical redevelopment on

the basis which they currently do, requires some further examination or extension of the empirical evidence base. The new light now thrown onto issues around patient control, involvement and interactions with staff, advances the knowledge and position from which to view meaning in practical terms. Particular focus should be given, in future, to greater consideration around appropriateness of control and of the patient processes involved. This might include understanding more about the potentially contrasting staff perceptions and experiences of major redevelopment as such change programmes are increasingly being embarked upon.

It is important for the redevelopment of healthcare services of the future that government policy should distinguish more closely what is meant by phrases such as 'choice' and 'involvement', and where or at what stage they might be appropriately applied. Strategic consideration needs to reflect the range of potential from conception of new service design through to the involvement of patients in treatment decisions. Government bodies need to listen to the patient, but recognise that they are not one homogenous group which can be treated with one broad approach. The different patient groups and their varying expectations are both factors which should be incorporated into political thinking in relation to this issue.

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APPENDICES

Appendix I Patient mapping tool

PATIENT MAPPING TOOL

Patient Name: _____ Hospital Number: _____

Age: _____ Gender: _____ Date: _____

Reason for attendance
(key symptoms and/or diagnosis): _____

If patient has known chronic
condition/s (e.g. COPD), please state: _____

If current problem is related to chronic
condition, state in what way (e.g. exacerbation of COPD): _____

Step No.	Description of Action and Who	Start Time	Completed Time	Comment on: Why this action/professional, if known? Key outcome, if any? Problems for patient? (e.g. waiting) Problems for staff? Include any staff or patient comments if relevant
				<i>Form continued as necessary, this illustration is compressed for efficiency of space</i>

Appendix II Topic guide for observations

Observation Topic	Guide for observations	Application
Reduction of repetition and waiting; focus on stages of the patient journey	<ul style="list-style-type: none"> • Are staff repeating their colleagues' activities? Is this clinically appropriate? • Are patients left waiting? Reasons? • What are the consequences? 	For use in all clinical service areas and with all patients and staff
Patient control	<ul style="list-style-type: none"> • Do patients (or staff) display any behaviours suggesting they are, or are attempting to, take control? 	
Professional group involved	<ul style="list-style-type: none"> • Is it clear which professional is involved in a patient's care? • Do the patients notice this? 	
Teams/roles and working cultures and service boundaries	<ul style="list-style-type: none"> • Where and how are (new) teams working? • What are the interactions between other services? • Are service boundaries observable? 	
Communication and information	<ul style="list-style-type: none"> • Observations of communication and/or information giving between patients and staff, between staffing groups or management 	
Environment and equipment (incl. the Private Finance Initiative)	<ul style="list-style-type: none"> • General observations to be made regarding the physical environment 	
Patient choice and involvement in treatment/care decisions	<ul style="list-style-type: none"> • Observations of patients being offered choice/involvement and how this is perceived by patients and staff 	

Appendix III Topic guide for interviews

Interview Topic	Questions asked	Application
Participant background/ demographics	<p>PATIENTS:</p> <ul style="list-style-type: none"> • What is the reason you are attending the hospital today? • Is this your first visit to hospital in relation to this condition? • Do you have an existing chronic condition? Is your visit related to this? How long diagnosed? • Could you tell me your age? • How would you describe your ethnicity? • How did you attend the hospital/who referred you to the hospital? (were you given choice?) <p>STAFF:</p> <ul style="list-style-type: none"> • What is your job description? • Which clinical service do you work in? 	<p>All patients (apart from patients already mapped, as demographic /background details already gathered). Referral questions especially useful for respiratory patients.</p> <p>All staff</p>
Perceptions of the focus on stages of the patient journey and impact on waiting	<ul style="list-style-type: none"> • Have you observed, or do you expect to observe, any changes in the patient journey as a result of the redevelopment? • What is the significance to you of 'stages' in the journey? 	All staff
Views of the redevelopment programme	<ul style="list-style-type: none"> • Could you give me your thoughts on the redevelopment programme? 	All staff (Except those in PACU)
Communication (incl. Awareness of which professional involved for patients and information flow around the redevelopment for staff)	<p>PATIENTS:</p> <ul style="list-style-type: none"> • How do you feel about the communication from the staff looking after you? (Did you know who it was communicating with you?) • What type of information have you been given by the doctors and nurses from the hospital? <p>STAFF:</p> <ul style="list-style-type: none"> • How do you feel about the information provided to you regarding the move to the new hospital? • How do you feel about communication with colleagues within your service and elsewhere? 	<p>All patients</p> <p>All staff</p>
Views of the physical environment	<p>PATIENTS:</p> <ul style="list-style-type: none"> • What do you think of the environment here at the hospital? (Is it easy for you to get around, e.g. going for tests? Do you 	All patients

Interview Topic	Questions asked	Application
	find it a clean environment? Any obstacles or positives?) <ul style="list-style-type: none"> • How does it make you feel? <p>STAFF:</p> <ul style="list-style-type: none"> • What are the implications of the environment for your work? 	All staff
Perceptions of interactions between clinical teams (where appropriate) and service boundaries	<ul style="list-style-type: none"> • How do the different clinical teams work together? (Impact of service boundaries?) • How do different professional groups work together? Problems or positives? • What are the processes involved in the direct referral system and what role do the specialised facilities have? 	All staff GDR staff only
Perceptions around opportunities for patient involvement or decision making	<p>PATIENTS:</p> <ul style="list-style-type: none"> • Do you feel you have appropriate input or choice over treatment? • Who would you consider to be the main professional involved in your care, if any (e.g. consultant, nurse, GP, other)? <p>STAFF:</p> <ul style="list-style-type: none"> • What are your views of patient involvement and choice? 	All patients Respiratory patients only All staff
Concluding questions	<p>PATIENTS:</p> <ul style="list-style-type: none"> • Generally, what have been the positive and negative aspects of your care? (Have you felt satisfied overall?) <p>PATIENTS AND STAFF:</p> <ul style="list-style-type: none"> • Are there any other comments you would like to make? 	All patients All participants

If you are willing to take part, then please sign the Consent Form. A researcher (Sarah Pajak) will then conduct an interview with you lasting around 25 minutes. The questions will be focused around your views towards the changes that have been made and/or proposed at [REDACTED]. You are free to decline to answer any question, or withdraw from the interview, without giving a reason.

Confidentiality

Interviews may be tape-recorded and/or notes taken. All tape recordings and notes will be kept confidential and unidentifiable. This means no names will be written on the tapes or transcripts. The information held on the tapes will only be used for research purposes. On completion of the study all information held on tapes will be stored in a secure place and destroyed after 6 months. All information you provide will be kept strictly confidential and will only be known to the researchers (and not the other professionals you work with). You will not be identified in any future report of the findings.

How will the findings be used?

The findings may be published in professional journals, presented at conferences and may also be used for a PhD (academic course, resulting in a final PhD report focusing on the way in which the NHS is organised) being undertaken by Sarah Pajak at Brunel University - but remember that your name will not be mentioned. This may help the hospital and other hospitals develop and improve the services they provide in relation to meeting the [REDACTED] requirements. The findings will be made available to those who wish to see them.

**Thank you very much for your time and
please keep this information sheet in a safe place**

If you need more information, please contact:

(Research Lead, [REDACTED] Evaluation Team)
on [REDACTED]

Appendix V Sample staff consent form

Trust Logo

RESEARCH PROJECT STAFF CONSENT FORM

Title of Project: Evaluation of the [REDACTED]

Ethics Committee (EC) No.: BEC1001 Principal Investigator: [REDACTED]

PART A: TO BE COMPLETED BY THE INVESTIGATOR:

I confirm that I have explained this research project to the respondent in terms which, in my judgement, are suited to his/her understanding.

Name of Researcher	Signature	Date
--------------------	-----------	------

PART B: TO BE COMPLETED BY RESPONDENT: Please tick

1. I confirm that I have read the Information Sheet dated May 2005 for the above study and have had the opportunity to ask questions
2. I understand that my participation in being interviewed is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected
3. I understand that my identity will not be disclosed in any published or written data resulting from this study
4. I understand the Information Sheet and agree to take part in the research

Name of Respondent

Signature	Date
------------------	-------------

Appendix VI sheet

Sample patient information

Trust Logo

Feb/March 2006

PATIENT INFORMATION SHEET (Outpatients: Observation/Interviews)

Study of the Care Provided to Patients at [REDACTED]

The research study

We are a team of researchers conducting a study looking at changes being made to [REDACTED]. As part of this study, we would like to observe what happens to people as they are cared for at the hospital to see what sorts of tests and treatments they receive from professionals, and how long these procedures may take. A researcher employed by the hospital will do the observing, but this person is not involved in providing your medical care. This study will help us to see whether improvements are needed to the service and assess what the impact of the new hospital being built here (called [REDACTED]) is likely to be. Please read this Information Sheet before deciding whether you are happy for your care to be observed.

Why have I been chosen?

We wish to study what happens to patients attending 'outpatients' services at [REDACTED], and as you are a person who has attended this hospital, we would like to include you in the study. Overall, approximately 20 patients may be studied in this way.

Do I have to take part?

No. Taking part in this research is entirely your own choice. If you decide to take part, you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part in the first place, will not affect your medical care in any way.

What are the risks and benefits of taking part?

Allowing us to observe your care will not affect your care in any way, but will help us with planning changes and improvements to the service in the future. We may ask you a few questions while you are at the hospital and also conduct a short interview with you before you go home which will give you the opportunity to express your views and any concerns you may have.

What should I do now and what happens next?

If you are willing for your care to be observed, please sign the consent form. Your care will then be watched by the researcher (Sarah Pajak). For example, she may see how long it takes for you to wait for a test and then see where you are referred next. You will not be constantly observed, but the researcher will return to see you from time to time and may ask you a few questions as you go along. If you have any medical questions you will need to ask your own doctors or nurses about these. The researcher may also wish to consult your medical records, but will only have access to these records while you are being observed as part of the study and not afterwards.

At the end of your care, the researcher may conduct a short interview with you (approx. 20-30 mins) to ask you about your experiences and what you thought were the 'good' and 'bad' things about the care you received. Even if you agree for the observation to take place, you do not have to take part in this short interview afterwards. We will leave this up to you at the time. Please note that the researcher may only observe a part of your care up to a certain point and may not interview you.

Confidentiality

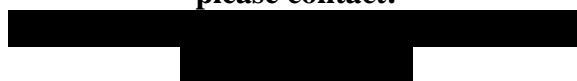
All information you give us will be kept strictly confidential and will only be known to the **researchers** and not given to the doctors and nurses who are actually treating you (they will not know anything you have said to the researcher). Your name will not be mentioned in any future report of the findings.

How will the findings be used?

The findings may be published in professional journals and presented at conferences, but remember that your name will not be mentioned. This may help the hospital and other hospitals develop and improve services they provide in relation to meeting patients' needs.

Thank you very much for your time. Please keep this information sheet in a safe place

If you need more information regarding this research study at any stage, please contact:



Appendix VII Sample patient consent form

Trust Logo

RESEARCH PROJECT PATIENT CONSENT FORM (outpatients)

Title of Project: [REDACTED]

Ethics Committee (EC) No.: BEC1001 Principal Investigator: [REDACTED]

PART A: TO BE COMPLETED BY THE INVESTIGATOR:

I confirm that I have explained this research project to the respondent in terms which, in my judgement, are suited to his/her understanding.

Name of Researcher	Signature	Date
--------------------	-----------	------

PART B: TO BE COMPLETED BY PATIENT (OR RESEARCHER IF INSTRUCTED BY PATIENT):

Please tick

1. I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving any reason
2. I understand that my identity will not be disclosed in any published or written data resulting from this study
3. I understand the Information Sheet dated Feb/March 2006 and agree to participate

Name of Respondent

Signature

Date

Completed by researcher:

- Observation
Interview
Both

Appendix VIII Acute Service raw data

Patient data

Phase One: Acute day time Patient data:

Acute Day Patient 1

Gastro-enteritis patient. This 32 year old female patient was in attendance at A&E with her brother who had arrived to join her following her admission.

Number of stages in patient journey: 5. Length of stay: 3 hours 10 minutes (discharged home).

The patient was admitted to A&E at 6.30 am - she was brought in by her friends by car as she was feeling dizzy and sick. She had attended A&E the previous week as she had felt unwell and tests had been carried out then. She felt that this current episode was related to her illness of the previous visit, where things were not resolved properly. She had to wait 5 minutes in reception before being seen by a nurse. The patient was assessed and brought into majors. Feedback from the patient regarding her attendance of the hospital identified that for this patient her main concern was that she was being seen, that she was through the gateway of admission, and that she had a bed in A&E. Once in a bed she had blood and urine tests taken, though when asked by the researcher was unable to decipher whether it had been a doctor or a nurse who had administered the tests, but was not concerned by this, purely that she was being treated (these tests were administered by a nurse).

This admission was relatively short – the patient’s results came through and she was diagnosed as having gastro-enteritis then told she could go home. Much of patient 1’s time was spent waiting for the test results (approx 90 minutes), following which she was told by the doctor she was to be discharged. It was unclear how much the patient felt fully aware of what was happening during the time she waited to go home. She called out to several doctors who evaded responding to her and caused her some frustration, finally managing to get the attention of a nurse who reassured her she was just waiting for a taxi to be booked and to arrive to collect her. The patient had most contact with and was responded to more by the nurses whilst being observed. The patient was discharged at 9.40am.

The patient appeared on the surface to be a passive recipient of the medical care she received; however she did demand the attention of staff when she felt the need. She accepted the staff instructions in relation to her medical condition without question.

Acute Day Patient 1			
Stage	Action	Who?	Time
1	Patient arrived at hospital and registered at reception	Patient was dropped off by friends, registered by the A&E receptionist	6.25am
2	Patient was assessed by a nurse and admitted to the majors department of A&E - Blood test and urine sample taken	Nurse	6.30am

Acute Day Patient 1			
Stage	Action	Who?	Time
3	Doctor initial assessment	Doctor (with nurse)	
4	2 nd Doctor gives diagnoses of gastroenteritis – encourages patient to drink fluids	Doctor	
5	Discharged home	Doctor	9.40am

Acute Day Patient 2

Gall stone patient. This patient was in an A&E bed accompanied by her daughter. She had felt sick during the evening prior to admission, which developed into severe pain in her stomach and side. The patient was brought to hospital by car and arrived at A&E at 7.30 am.

Number of stages in patient journey: 6 Length of stay: 4 hours in A&E then moved to the Acute Care and Diagnostic Unit (ACDU)

The patient felt she had only to wait for a short time in reception, approximately five minutes. She was then met by a nurse who took her to be triaged. She was asked questions and basic tests were administered. The patient recalled being seen by two nurses at this stage which spanned around 15 minutes. The patient stated that at this time she 'felt rough' but was confident with the service she was receiving. At around 8.45am the patient was brought to a bed in majors where more tests were carried out by a different nurse (including blood and urine). At around 9am the patient was seen for the first time by a doctor who sent her for a chest x-ray, which did not incur any delay. The hospital porter assisted the patient to the x-ray room situated adjacent to the far end of the A&E department. The results of this investigation were returned quickly according to the patient and were normal. At 9.35am the patient was given one litre of oxygen by a nurse.

The patient felt that both the doctor and nurses had been “very good”. At 9.40am the House Officer spoke to the patient, gave her an injection and topped up her drip. The doctor made several attempts to take blood from the patient (the patient commented that this was “even though she had good veins” indicating her surprise at the doctor being unable to perform the task). The nurse came to successfully take the blood from the patient and told her to rest. During this time, junior and senior doctors in the department were observed discussing the patients’ symptoms amongst themselves.

The patient had a good deal of interaction with both doctors and nurses. By 10am the patient was suspected as having a gall stone and was told by a nurse she would need an ultra sound as they need to confirm her condition, and need to establish the size of the stone to asses whether surgery will be necessary. As the 4 hour target approached, the decision was made to move the patient to the Acute Care and Diagnostic Unit (ACDU) (effectively another room which functions as an offshoot of A&E where patients are moved to avoid breaches of targets). At 10.25am the patient was moved to ACDU where her treatment continued.

At 10.40am the surgeon arrived on ACDU to discuss the situation with the patient. The patient felt very involved and reassured by the visit from the surgeon who she said “was really very nice and answered her questions”. The patient waited to go for her scan and from 11.30am was asleep up until she was admitted to the ward at 2.25pm. Overall this patient was very happy with the care she received. At times she was waiting for test results and to go for a scan but did not feel this was a problem as she was in the process of receiving the care she needed.

The patient was extremely willing to cooperate with the staff. This patient was relatively passive to her care, a situation which appeared to result from an understanding of what was happening. On occasion where the patient

felt unsure, she was also expressive of her opinion. She readily accepted the decisions of the medical staff who were treating her.

Acute Day Patient 2			
Stage	Action	Who?	Time
1	Patient arrived at hospital via car and registered at reception	Patient accompanied by daughter – registered by receptionist	7.30am
2	Patient was assessed by 2 nurses and admitted to the majors department of A&E at end of this stage - Blood test and urine sample taken	Nurse	7.35am – 8.45am
3	Doctor initial assessment and patient sent for chest x-ray. Results returned (normal)	Doctor/hospital porter	9am- 9.35am
	Patient was given 1 litre of oxygen. Doctor returned to speak to patient – attempts to take more blood were made but nurse was required. BP also taken.	Doctor/nurse	9.35am- 9.40am
4	Patient informed that she had suspected gall stone and required ultra sound scan to confirm – due to time pressure patient	Nurse and 2 nd Doctor	10am- 10.25am

Acute Day Patient 2			
Stage	Action	Who?	Time
	moved to ACDU		
5	Surgeon arrived to discuss situation with patient	Surgeon	10.40am
	Patient slept whilst waited for scan		
6	Patient was admitted to the ward where her care continued		2.25pm

Acute Day Patient 3

Chronic Diabetic patient. This patient was admitted on the same day the first two patients were traced, however, the nurses felt that he was too ill to be approached initially, so when he was still present on ACDU two days later, he was traced retrospectively. On this occasion the patient was brought into hospital by his sister. The patient had been admitted to hospital before in relation to his diabetes, but had never been admitted for such a long period of time.

Number of stages in patient journey: 6 Length of stay: In A&E 4 hours then moved to ACDU and discharged home on the third day with an outpatient appointment.

The patient was a long term diabetic whose blood sugar reached dangerous levels. Normally he controlled his condition by taking tablets at home. He had been self-medicating as normal, but felt very unwell and so came to the hospital. The patient stated that he had no wait at reception; he was brought straight into A&E. As his sister was present on admission, she was able to help communicate the patient's symptoms and also as he had a pre-existing

condition, the nurses were quick to establish the necessary procedures and tests to relieve the symptoms. The patient recalled that he was seen by both nurses and doctors throughout the two days and he did not have to repeat himself to each healthcare professional regarding his symptoms. He felt very positive about the levels of care he received, "they have all been good". The patient particularly referred to the good care he had received from the doctors.

The patient was unaware how long he would be waiting before he could go home. The nurses caring for him had been trying over the few days of his time in hospital to return his blood sugar levels to normal but without success. Having felt very unwell on admission, the patient was now waiting for news but felt much more comfortable. The consultant visited the patient whilst being observed. Following this visit he was still waiting for a return to normal blood sugar levels. A couple of the nurses were observed discussing the fact that they had been unable to do achieve any drop so far. The patient was used to being in control of his own treatment, but did not feel excluded in decision making during this episode. Initially he was too unwell to be very outspoken about what happened, but a few days later was awake and able to communicate clearly with those around him.

The consultant visited the patients on ACDU during the observation period – this was a more 'traditional' round, the nurse attended along with the consultant and updated the consultant on the patient conditions. It was noted that each patient seen by the consultant including patient 3 had the curtains around their bed drawn. This was of interest due to the fact it did not occur when other doctors and nurses had been treating the patients, unless privacy was required. During the time spent on ACDU the majority of care given to the patient was from a nurse.

Initially this patient was too ill to be involved in much consultation regarding the care he received. As a patient with a long term condition he clearly had a greater understanding of his condition than the other patients who were traced in this study. However this was the first time that he had been brought into A&E long term as a result of a crisis in his condition. It did seem that both the patient and the nursing staff were unsure as to why the patient's blood sugar levels were not returning to normal.

The patient's stay in ACDU was unusual, he was not admitted to the ward, but yet remained on the observation unit for over two days. The patient was not always aware of which professional (ie whether someone was a nurse or doctor) was treating him, but was unconcerned about this.

Acute Day Patient 3			
Stage	Action	Who?	Time
1	Patient arrived at A&E after being seen by reception was taken straight to A&E majors	Patient was accompanied by his sister	Weds am
2	Assessment of patient by nurse	Nurse	
3	Doctor assessed patient – as a diabetic the main concern was the patient's abnormal blood levels	Doctor	
4	Patient moved to ACDU – nurse commented that the abnormal blood levels had not normalised and they were unsure why	Nurse	

Acute Day Patient 3			
Stage	Action	Who?	Time
5	Patient seen by Consultant in ACDU	Consultant	Fri am
6	Patient was discharged home from ACDU with instructions to visit the outpatient diabetic clinic		Fri am

Acute Day Patient 4

This patient attended A&E with his daughter as he was experiencing right-sided numbness and was unable to stand normally.

Number of stages in patient journey: 6. Length of stay: In A&E 4 hours, then moved to ACDU before being discharged home 2 days later.

This 65 year old male patient arrived at the hospital A&E via taxi with his daughter. He had recently had an operation due to a brain haemorrhage and was clearly concerned that his symptoms were in some way related to this. The patient explained he had been suffering from neck pain in addition to his other symptoms and had also, as a precautionary measure, been prescribed epilepsy medication. The patient arrived at the A&E reception where he and his daughter waited for around 15 minutes to be seen by the triage nurse. The patient was immediately given a bed in the majors section of A&E. At this point the patient was given an ECG and a note was taken of all the medication which the patient's daughter had brought with them, enabling a full list to be given to the clinical team. Thirty five minutes after seeing the nurse, the patient was seen by the SHO and the Registrar, who spent an hour speaking with the patient and his daughter. This visit involved a full run down of the patient's history and checking in relation to the patient's previous episodes in hospital. A final doctor then visited the patient

and explained that he would need to be kept in over night and observed. The patient had his blood pressure checked again by the nurse shortly before being moved to ACDU, where he then spent the next two days before being sent home.

The patient and his daughter reported: “We feel very happy with the care we’ve received and as someone who has been in this position before, had an idea what to expect which has made it easier to deal with...also less repetition due to the doctors knowing us...satisfied with the communication with staff and don’t mind waiting whilst they’re trying to fix me!”

Acute Day Patient 4			
Stage	Action	Who?	Time
1	Patient arrived at hospital via car and registered at reception	Patient accompanied by daughter – registered by receptionist	1.15pm (day 1)
2	Patient was assessed by a nurse and admitted to the majors department of A&E at end of this stage - Blood test and urine sample taken	Nurse	1.25pm- 1.40pm
	Patient waited to be seen by a doctor		
3	Doctors initial assessment – full clerking and write up of notes	A&E Doctor	2.15pm -
4	Second doctor joins the assessment of the patient	2 nd A&E Doctor	3.15pm
5	Third doctor sees patient and explains that all	3 rd Doctor	

Acute Day Patient 4			
Stage	Action	Who?	Time
	physical tests have now been completed but that he will be admitted over night		
	Patient is moved to ACDU for further observation		6pm
6	Patient was discharged home from ACDU		5pm (day 3)

Acute Day Patient 5

This patient attended A&E on his own suffering with chest pain.

Number of stages in patient journey: 4. Length of stay: In A&E 3 hours.

This male patient aged 38 years had felt a slight chest pain early that morning, but went to work despite this. Whilst at work he experienced more severe pain and was sent home. Once at home the pain intensified and radiated to his shoulder and back, becoming unbearable, so the patient called an ambulance. Recalling his time in the ambulance, the patient was unable to remember exactly what happened to him due to the pain he was experiencing, but believed that there was some suspicion that he was suffering from a heart attack.

The patient recalled that on arrival into the hospital he was seen immediately by the doctor who attached him to an ECG machine and took blood samples. The patient was then given an injection for pain relief and sent for an x-ray. There was no wait for the x-ray, but some wait for the blood test results. The patient reported that he was entirely happy with the care he had received, that he respected the clinical staff irrespective of whether they were doctors or nurses. When the results of the patient's tests were returned, the patient

was told by the doctor he was well enough to go home. He was given tablets, but told there was nothing significantly wrong with him. The patient explained that he was surprised that his condition was not serious, but the doctors had told him he should stop smoking.

The patient felt the staff had been well organised and things had happened very quickly “the doctor spent a lot of time with me”

Acute Day Patient 5			
Stage	Action	Who?	Time
1	Patient arrived at hospital via ambulance		4.09pm
2	Patient was directly taken to the majors area of A&E and assessed by a doctor.	Doctor (suspected heart attack)	4.10pm
	Blood taken and patient sent for an x-ray then given ECG plus injection for pain relief	Doctor/nurse/porter	
3	Doctor gives patient results of x-ray which were normal	Doctor (heart attack ruled out)	5pm
	Other results are returned as normal – patient is given tablets to go home with and advised to stop smoking	Doctor	
4	Once drip has finished, patient discharged home		7pm

Acute Day Patient 6

This patient attended A&E with her husband who brought her to hospital in the car.

Number of stages in patient journey: 5 Length of stay: In A&E 2 hours.

This female patient had suffered from back pain during the previous night and had been unable to breathe properly. She did not have any known chronic conditions. The patient arrived at A&E reception at 2pm where she waited for 10 minutes to be seen by a nurse. Blood and urine samples were taken from the patient by the nurse and the patient reported that a doctor also saw her to listen to her chest. The patient was then taken to a bed in the majors area of A&E, where she waited for 15 minutes to be seen again. On this occasion a medical student joined a senior nurse who directed the student on various questions to ask the patient. Once the results of the tests taken were returned a doctor briefly came to see the patient and told her she was well enough to go home. At 4pm the patient was discharged with a management plan to control her pain and referral back to her GP to review the patient in the future.

The patient reported that her experience in the hospital had been a positive one. She felt that the time she was in A&E was quick and that this was excellent as she had expected she would be required to wait.

Acute Day Patient 6			
Stage	Action	Who?	Time
1	Patient arrived at A&E via car where she registered at reception	Patient was accompanied by her husband	2pm
2	A nurse assessed the patient (blood and urine	A&E nurse/ doctor	2.10pm

Acute Day Patient 6			
Stage	Action	Who?	Time
	tests) and brought her to a bed in majors where she was told to wait to be seen		
3	A student doctor came to assess the patient	Student doctor accompanied by A&E nurse	2.40pm
4	A doctor came back to check the patient with the blood and urine results, at which stage the patient was informed she could go home	A&E doctor	3.55pm
5	Patient discharged home with management plan for MSK pain and for GP to review	Doctor	4pm

Phase Two: GDR Patient data:

Acute Gynaecological Patient 1

This patient attended A&E with her partner who brought her to the hospital by car. As a gynaecological patient she was initially given her own room adjacent to the main majors section of A&E, following on from this she was moved to ACDU whilst waiting for admission to the ward. Number of stages in patient journey: 4 Length of stay: In A&E 4 hours then moved to ACDU whilst waiting for a bed and discharged home after 2 days on the ward.

This 20 year old female patient was pregnant and arrived at hospital with her partner as she had repeatedly been sick over the past month and was suffering from dehydration. The patient arrived at A&E at approximately 11.35am. She reported not having to wait long in reception (around 40 minutes). After registering at the reception desk, the patient was called into the majors unit where she was given a private room leading directly from the main A&E majors area. On arrival (approximately 12.30pm) a nurse practitioner immediately took the patient's history, (lasting around 20 minutes). Following on from blood and urine tests, the SHO came to visit the patient. The patient recalled being asked some similar questions to the nurse practitioner but with the addition of some further questions. Once it was established that the patient would be admitted to the ward overnight, the patient was moved to ACDU to wait for a bed, which she did for just over 4 hours. This move was to avoid breaching time targets in A&E, but the patient reported that she did not mind being moved as she felt reassured she was being provided with the best care possible.

The patient was moved to ACDU which in theory is intended only for observational purposes, when she was waiting to be admitted to the ward.

Acute Gynaecological Patient 1			
Stage	Action	Who?	Time
1	Patient arrived at A&E where she registered at reception and waited to be seen	Patient was accompanied by her partner	11.35am -12.15pm
2	Patient taken straight to majors (private room) and assessed with full history	Gynaecological Nurse practitioner /	12.30pm -1pm

Acute Gynaecological Patient 1			
Stage	Action	Who?	Time
	and blood/urine tests taken		
3	Patient is informed she would be admitted overnight for observation and is moved to ACDU for observation	Gynaecological Doctor	3.30pm-4pm
4	Patient admitted to ward – discharged home after 2 days		8.50pm

Acute Gynaecological Patient 2

This patient attended A&E via emergency ambulance. As a gynaecological patient she was initially given her own room adjacent to the main majors section of A&E, following on from this she was moved to ACDU whilst waiting for admission to the ward.

Number of stages in patient journey: 4 Length of stay: In A&E 4 hours then moved to ACDU whilst waiting for a bed on a ward, following from which she was discharged home.

This 19 year old female patient was pregnant and attended hospital due to a loss of appetite, having not eaten for 5 days. The patient had attended the hospital in the previous week. Hospital procedure requires such patients to be referred back to the original team who treated them, thus ensuring the consistency in patient care and also reducing any potential delays in waiting to be seen by the gynaecological team. Consequently, on the patient's arrival at A&E she was not obliged to wait in reception, but was brought

straight to a bed in majors, in a private room. The patient recalls the ambulance crew transporting her asking a number of questions to establish her condition, her responses to which she noted were passed on to the clinicians in the hospital without her having to repeat herself unnecessarily. The patient was informed by the doctor that she would be seen by the gynaecological nurse practitioner (GNP). The GNP carried out a full examination of the patient and the decision was made by the GNP to admit the patient to the ward for re-hydrating and observation. In order to meet the 4 hour target, the patient was observed in ACDU whilst waiting for her bed. The patient commented that she was happy and reassured by the speed at which she was initially seen and treated.

The patient was moved to ACDU which in theory is purely for observation, when she was waiting to be admitted to the ward.

Patient: "I'd rather not have to stay in hospital for a long time, that's the worst bit, but I know it's for the good of my baby."

Acute Gynaecological Patient 2			
Stage	Action	Who?	Time
1	Patient arrived at A&E via ambulance	Ambulance staff took the patient straight to a bed where hand over to a nurse occurred	1pm
2	Patient taken straight to majors (private room) and assessed with blood/urine tests taken	Gynaecological Nurse practitioner /Gynaecological Doctor	1.20pm

Acute Gynaecological Patient 2			
Stage	Action	Who?	Time
	Patient was informed a GDR nurse practitioner would be coming to see her shortly	Doctor	2.20pm
3	Full examination of patient took place and patient informed she would be admitted overnight for observation – waits in ACDU	Gynaecological nurse practitioner (GNP)	2.55pm
4	Patient admitted to ward		8pm

Acute Gynaecological Patient 3

This patient attended A&E with her partner who brought her to the hospital by car. As a gynaecological patient she was initially given her own room adjacent to the main majors section of A&E, following on from this she was moved to ACDU whilst waiting for admission to the ward.

Number of stages in patient journey: 4 Length of stay: In A&E 3 hours then moved to the ward.

This 23 year old female patient was pregnant and arrived at hospital with her partner. She had been repeatedly being sick over the past month and was dehydrated. The patient arrived at A&E where she reported not having to wait long in reception. After seeing the nurse, the patient was immediately brought into the majors unit where she was provided with a private room. Within an hour of arrival, the gynaecological nurse practitioner saw the

patient and carried out a full examination. Urine and blood samples were taken for analysis by the nurse. Following on from this the patient was given a scan to rule out the potential risk of ectopic pregnancy. The nurse practitioner was briefly joined by the gynaecological registrar who confirmed the nurse practitioner's assessment. This resulted in reduced waiting for the patient and less repetition, as the doctor avoided repeating what the nurse practitioner had effectively done, and purely acted as a point of confirmation. Five minutes after the doctor and nurse practitioner left the patient the GNP returned to inform the patient that she would be admitted to the ward for at least the night. The nursing sister brought the patient a blanket to make sure she was comfortable. The patient then waited for a further 2 hours to be admitted to the ward.

Patient: "I'm very happy that I didn't have to go far, they did a scan very quickly to rule out ectopic pregnancy which was reassuring and I'm really happy it has happened so quickly"

Acute Gynaecological Patient 3			
Stage	Action	Who?	Time
1	Patient arrived at A&E via car and registered at reception	A&E receptionist	5.20pm
2	Patient seen in minors by a nurse and immediately is referred to the GDR	A&E nurse	5.25pm
3	GDR nurse practitioner (GNP) assessed the patient and took blood and urine samples then carried out a	GNP and briefly GDR registrar	5.50pm- 6.20pm

Acute Gynaecological Patient 3			
Stage	Action	Who?	Time
	scan to rule out ectopic pregnancy		
	Patient informed she would be admitted overnight for observation	Gynaecological nurse practitioner (GNP)	6.25pm
4	Patient admitted to ward		8.30pm

Acute Gynaecological Patient 4

This patient attended A&E alone and arrived at the hospital by taxi. As a gynaecological patient she was given her own room adjacent to the main majors section of A&E, following on from this she was transported on to another hospital for speciality care.

Number of stages in patient journey (at the hospital only): 4 Length of stay: In A&E 4 hours.

This 42 year old patient had a history of gynaecological problems which may have influenced her experience in the hospital on this occasion. The patient had previous interaction with a different hospital for her fibroids condition. She was clearly concerned and unsure what was wrong. She arrived at hospital shortly before 4pm complaining of heavy bleeding which she believed to be related to her existing fibroids. The patient had telephoned her GP earlier in the day and had been told to come to A&E. The patient waited approximately 30 minutes in reception to be seen by a nurse, which she was happy with.

A nurse called the patient and following a few questions the patient was taken to an allocated gynaecological patient room. A different nurse then came to see the patient in the majors area and took blood pressure and samples from the patient. At 5.50pm (1 hour 40 minutes after arrival) the patient was seen by the gynaecological nurse practitioner (who arrived at A&E together with the registrar, each seeing a different patient). At this point full clerking of the patient took place. The nurse practitioner was able to seek advice from the registrar, who then saw the patient and made the decision that it would be necessary to transfer her to another hospital where the consultant could be involved.

The patient was diagnosed as having been pregnant but suffering from a miscarriage without realising. She waited for approximately 40 minutes for patient transport to arrive to take her to a second hospital within the Trust, by which point her partner had also arrived. She left the hospital A&E at 8pm.

The patient reported that she had felt things had happened relatively quickly and she was generally happy with the process. However, prior to being informed of her pregnancy she was distressed with what she referred to as the staff's view that she should be "happy not to have cancer", when she felt "depressed and worried all the time" not knowing what was wrong.

Acute Gynaecological Patient 4			
Stage	Action	Who?	Time
1	Patient arrived at A&E via car and registered at reception	A&E receptionist	3.35pm
2	Patient seen by a nurse and immediately is referred to the GDR	A&E nurse	4.05pm

Acute Gynaecological Patient 4			
Stage	Action	Who?	Time
3	GDR registrar assessed the patient (joined by GNP) and took blood and urine samples then carried out a full assessment of the patient	GDR registrar and GNP	5.50pm
	Gynaecological registrar consults on the telephone with the consultant at a sister hospital as it is felt the patient needs to be transferred. Patient is informed this is the case	Gynaecological registrar	6.40pm-7.20pm
4	Patient is transferred		8pm

Phase Three: Night Patient data:

Acute Night Time Patient 1

This 81 year old patient had been referred to A&E by his GP. He arrived at A&E with his son.

Number of stages in patient journey: 4. (short no. of stages due to GP letter, rather than the night team activity) Length of stay: 3hours 50 minutes (discharged home).

The patient was admitted to A&E at 7pm - he had been advised by his GP to attend A&E. As the patient had arrived at A&E with a letter from his GP, the process of accessing the majors department was relatively simple, and following reception, the patient was taken straight to a bed in majors where initial medical assessment took place. The patient was clerked by a junior doctor and a number of blood samples (five) were taken. The patient had been informed by his GP that previous blood test results had been abnormal and with an existing condition of high blood pressure, referred the patient to the hospital. The junior doctor informed the patient that there would be approximately one hour to wait for the blood results. Prior to the return of the results, the SHO and Registrar discussed the patient's condition. The doctors were unhappy about the GP referring the patient to A&E when they felt the GP should have more knowledge and be able to deal with such cases themselves. However, they also conceded that they were unsure what the problem was with the patient and that may have explained the GP's actions. When the blood results arrived, the doctor explained to the patient, with reference to a printed results page, what the situation was. The doctor confirmed that there were unusual potassium levels in the blood, but that this was not dangerous and the patient could go home. The patient was discharged home at 10.50pm.

The patient relied on his son to support him during his stay in hospital and appeared to be a willing recipient of the care provided. The SHO expressed a general concern over the practice of back-dating of blood test results, whereby they were at one point still waiting for the results to come back at the time they were recorded to have been returned. "We were sitting here talking about them and waiting for them at the time they say they came out!" (SHO)

Acute night time Patient 1			
Stage	Action	Who?	Time
1	Patient arrived at hospital and registered at reception	Patient was accompanied by his son	7pm
	Patient was sent straight to majors as a result of his GP letter	Nurse	7.15pm
2	Doctor initial assessment	Doctor (SHO)	7.30pm
	5 blood samples taken	Doctor (SHO)	8pm
3	Doctor discussed patient's condition with the Registrar	Doctor(SHO and Registrar)	
	Blood results are returned and Doctor discussed results with colleague and then patient	SHO	9.30pm
4	Discharged home	Doctor	10.50pm

This 83 year old female patient arrived at A&E accompanied by her daughter. She had been experiencing sickness and was unable to swallow. She arrived at A&E at 8.40pm. Number of stages in patient journey: 6. Length of stay in A&E: 4 hours 10 minutes (then admitted to the ward)

The patient arrived at the reception of A&E and was sent straight through to A&E where she was seen by a nurse who carried out an initial assessment and blood tests were taken. At approximately 9.05pm the SHO visited the patient and carried out a full examination, establishing the patient's condition. The patient explained that she had not been to visit her GP for some time and that she felt sick all the time and was unable to eat very much. The SHO completed the assessment and promised to return to see the patient once her blood results had come back. He also ordered an injection for her to calm the feeling of sickness.

At 9.25pm the nurse administered the injection as requested and the doctor returned five minutes later to explain the blood results indicated that the patient had low potassium levels and would require an overnight stay in hospital. The doctor was also concerned about the patient's low weight and together with the nurse they weighed her. This was a delicate procedure which was observed to have been carried out with great dignity towards the patient, who was very frail.

At 10.15pm the nurse administered a drip to the patient. At 10.20pm the surgeon arrived to assess the patient. At 10.25 the SHO and nurse discussed the patient with the surgeon and it was decided that the patient required a chest x-ray. The doctor also discussed with the patient her previously undisclosed smoking habits which he had assumed based on her

examination and she was clearly surprised he knew about. The patient was then sent for a chest x-ray.

The surgeon returned to speak further with the patient until approximately 11pm and explained that she would be staying overnight and further treatment would be occurring on the ward. At 12.50am the patient was transferred to the ward to complete her care. Due to the patient's age and fragility, the staff appeared to work in a manner which was sensitive to the specific requirements of this elderly patient, maintaining her dignity throughout. The arrival of the surgeon was observed by the researcher to present a certain level of frustration for the patient who was required to repeat the answers to many of the same questions asked of her by the SHO. This was particularly difficult for her as she was somewhat hard of hearing and frail.

Acute night time Patient 2			
Stage	Action	Who?	Time
1	Patient arrived at hospital and registered at reception	Patient accompanied by daughter – registered by receptionist	8.40pm
2	Patient was assessed by a nurses and admitted to the majors department of A&E at end of this stage - Blood test and urine sample taken	Nurse	8.45pm-8.55pm
3	Doctor initial assessment	Doctor	9.05pm
4	Nurse administered injection for sickness	Nurse	9.25pm

Acute night time Patient 2			
Stage	Action	Who?	Time
	Patient informed that she had low potassium	Doctor	9.30pm
	Patient was weighed	Doctor and nurse	
	Patient was given drip	Nurse	10.15pm
5	Surgeon arrived to discuss situation with patient	Surgeon	10.20pm
	Patient's case was discussed	Surgeon, doctor and nurse	10.25pm
	Surgeon explains situation to patient	Surgeon	10.55pm
6	Patient was admitted to the ward where her care continued		12.50pm

Acute Night Time Patient 3

This patient 18 year old patient arrived at A&E via ambulance with her mother, complaining of stomach pain.

Number of stages in patient journey: 5 Length of stay: In A&E 3 hours 10 minutes then discharged home, with follow-up via GP.

The patient was a young adult who had been experiencing recurrent vomiting and stomach pain for a few months. She arrived at A&E at 7.45pm and waited for 10 minutes with the ambulance crew before being placed in a bed in majors. At 8.17pm the nurse arrived to assess the patient, carried out a blood test and requested a urine sample from the patient. At 10 pm the patient was seen by a junior doctor who was aware of the results of the

assessment previously carried out by the nurse, and completed an additional assessment. By 10.25pm it was established that the patient was pregnant but did not wish to continue with the pregnancy. The patient was fit to go home, but insisted on only talking further to one specific nurse and not the doctor. At 10.45pm the nurse and patient discussed the pregnancy and her option of having a termination, which could be arranged with her GP. The patient was discharged at 10.55pm.

The patient was fully cooperative with the staff but became slightly agitated once it was established she was pregnant and had indicated she would like details on how to arrange a termination. The patient insisted on dealing mainly with one specific nurse, which within reason the staff allowed for (this request was made after being seen by the doctor, so it was possible to carry out the patient's wishes in the main)

Acute night time Patient 3			
Stage	Action	Who?	Time
1	Patient arrived at A&E via ambulance	Patient was accompanied by her mother	7.45pm
2	Assessment of patient by nurse, initial tests administered	Nurse	8.17pm
3	Doctor fully assessed patient	Doctor	10pm
4	Patient discussed condition with nurse	Nurse	10.45pm
5	Patient was discharged home with a follow up appointment with her GP		10.55pm

Acute night time Patient 3			
Stage	Action	Who?	Time
	planned		

Field notes (including staff data)

The key field notes made by the researcher are contained in the following section, as recorded during the acute phases of data collection. This section includes the relevant comments made by staff from formal interviews and casual conversations during the time spent in the clinical environment. It was not always feasible to go through the process of informed, written consent with staff whilst working within the A&E department in which case, verbal consent was given in accordance with the research ethics approval.

November 2005 Phase One Day time:

Redevelopment managers spoken to indicate the redevelopment is expected to reduce unnecessary repetition and delay in care. There is also an expectation that the changes in the A&E service model represented a 'microcosm' of the clinical and team systems which would be operationalised after the move on a hospital-wide basis. They also stated that the new night team is working well.

The A&E matron has overarching responsibility for both the major and minor functions within A&E. The A&E sister on this occasion was based mainly in the majors function.

The A&E Sister on duty during the day had responsibility for staff located in the majors area of A&E. There was also general leadership over the majors team from the ward Sister at all times of day. The sister was observed

preparing drips and going through the necessary checks of counting and cross-checking drugs and dosage levels with another nurse. An example of a clear role definition between the nurses and doctors was evident, and also reflected the fact that nurses contributed to the work irrespective of their level of seniority, whilst doctors always carried out activities such as discharging the patient. The sister commented that patient experience was highly influenced by a patient's expectations of what care they would receive and the potential involvement or choice they might have. The example of transport and waiting to be collected was used, whereby patients do not always understand they must wait for a group of patients to be ready to use the transport.

A nurse is interviewed who explains how the ACDU works. Officially ACDU is an observation unit within A&E but the nurse makes it clear what their view is of the purpose of the unit "it is used to ensure that patients don't breach the 4 hour target, it's playing the system but we're not the only hospital that does it. I used to work in another London hospital where they renamed a corridor to have somewhere to put patients that would ensure on paper that target times were met!"

The consultant treating patients on ACDU for the Day Acute patients was not visible during observation until the rounds took place on ACDU. The Sister was a visible leader of the majors nursing staff, and was observed to direct doctors to some extent. However, the control of the consultant over all staff (both doctors and nurses) became visible when they were present on the unit. The lines of reporting for staff from a patient perspective were far less clear for doctors than for nurses, who do not have a comparably visible figure head, apart from any rounds that took place (such as on ACDU).

The A&E consultant was briefly spoken to in order to gain her views on the service in A&E at the time of observation. She highlighted that current

concern with targets and patient throughput was not always appropriate, that if senior managers listened to what they said it would be more apparent that just because a few number of beds are being used doesn't mean staff have a lower work load, as these patients might be extremely sick and need greater attention. "I only wish we could get the powers that be to understand that we could be more busy with just 4 patients who are very sick and need great care and time given to them, than when there are 10 patients who are less sick. The number of patients being treated is not a fair reflection of how busy we are."

There were also concerns raised by staff regarding the development of the new hospital model, particularly in relation to A&E at night time and the suggestion of the introduction of a new night team. Despite the suggestion from programme management that the night team has been successfully operationalised with teams generally working well together, the opinion of a doctor spoken to was one adamant this was not the case. This individual commented that they had not heard of the new night team, and it was just a label which had not changed the way in which staff were working. "The night team is not different to the day apart from in name; I don't see it as a fixed set of people who make up the night team." This view was supported by some other clinicians within the service. Some frustration reported over clinical information flow between the A&E department and pathology. Also frustrations raised by an A&E doctor between A&E and the medical team who had been viewed as becoming resistant to taking on referrals from A&E.

One of the focuses of the new hospital model as reported by the redevelopment programme managers was a reduction in unnecessary stages in the patient journey. However, this may also have led to some frustration by clinicians who reported that repetition could well be necessary where more information is being gathered. "Repetition is necessary in some

cases where more information is being gathered, especially where patients don't speak English.”

A nurse practitioner working in bed management during the shift suggested in response to what her views were on the new hospital model for the service that irrespective of new models being introduced what made a difference to effective teamworking in A&E was to some extent a result of how well the staff knew each other. It was noted by the researcher that non-A&E doctors were not based within the A&E department and could effectively disappear onto the ward, making it difficult for others to contact them.

Some staff approached the researcher and reported not feeling fully engaged with the redevelopment of the hospital, with some indirect comments relating to future job security and poor morale. A group of the nursing staff reported feeling as if communication around the change has not been as good as it might have been. Given the looming scaffolding structure and building site directly adjacent to the still functioning old hospital building the presence of the change programme and the imminent changes afoot are unmissable. Despite some of the scepticism, a more consistently positive view was gathered from staff in general about the new facilities which would be available in the hospital building. Improved cleanliness, access, clinical equipment and space were all expected by the staff from the new hospital building.

November 2005 Phase Two GDR time:

The physical environment is noted to be the shared with other A&E 'majors' patients, so is the same generally as Phase One. However, the key differences are that GDR patients tend to get admitted into side rooms for increased privacy and that the staff serving patients are distinct from those caring for the general A&E patients.

The gynaecological nurse practitioner (GNP) was interviewed to gain her views on the GDR service. She explained how the key to the successful operation of the GDR in her view was teamwork, with a flat hierarchy and the respect between her role and that of the gynaecological registrar. The GNP is able to make decisions and then simply verify or confirm decisions with the registrar rather than the registrar needing to repeat work. The GNP explained that it is accepted that in their role, GNPs are unable to diagnose patients, but that the effective teamwork ensures the system works well. The GNP went on to explain how in some circumstances, other specialities will take advantage of the smooth running system operated by the GDR team, and refer patients purely because they are pregnant, even though the presenting complaint is unrelated. The GNP also commented that the quick access to scanning and dedicated sonographer for the GDR makes a significant contribution to the GDR system and the quality of care available to patients. The gynaecological registrar was also very positive regarding the GDR team and the system under which it worked, with reliance upon nurse practitioners working to the advantage of the service. A different GNP spoken to regarded herself as a patient advocate, purely in a position to support and provide for patients using the service. The GDR team did not report feeling significantly influenced by the redevelopment programme or issues around the changes having impact on staff in other clinical areas.

November 2005 Phase Three night time:

The environment at night time is identical in physical terms to the day time. It is noted however, that the A&E majors area is relatively quiet at night and there appear to be fewer staff, and an increase in the presence of security staff. There is a period from 8pm to 9pm where the doctors are less apparent, due to change over in shifts. The consultant spoken to during the night shift expressed some doubt over the difference in function in real terms

between the new and old night teams. The nurse practitioner was fairly confident about the relationships within the team, “They [the doctors] know we know our stuff as we know them individually. We have a good rapport with the doctors.”

Appendix IX The Paediatric Ambulatory Care Unit - raw data

Parent/patient data

PACU Patient 1

This patient attended PACU as he had fallen and was experiencing right-sided numbness. The patient, an 18 month old boy, was with his parents.

Number of stages in patient journey: 5. Length of stay in PACU: 7 hours (followed by admission to the children's ward).

The patient was brought to A&E by his parents at approximately 10am. He had suffered an accident and fell over, banging his head. His mother took him to the generic A&E department where he was given an x-ray to assess any injury. The decision was made by A&E staff for the patient to be referred to PACU. A nurse from A&E accompanied the patient and his mother to PACU at approximately 2.15pm where his arrival was expected, and he was immediately given a bed. A PACU nurse saw the patient at 2.30pm for an initial assessment and the doctor came to see him shortly afterwards (2.45pm). The doctor made the decision that the patient needed to be seen by an orthopaedic doctor. There was a short wait for this (around one hour). Having seen the orthopaedic doctor, the family was informed that their son would require admission to the children's ward. Admission to the ward occurred at approximately 9.15pm.

The patient's mother was happy with the care her son had received and appreciated the consideration of the staff. She commented that she was impressed that her son had been provided with a yoghurt and water and she had been able to make a phone call to her husband to come to the hospital.

PACU Patient 1			
Stage	Action	Who?	Time
	Patient arrived at A&E where X-ray took place	Patient was accompanied by his mother	10am
1	Patient referred and taken to PACU	Escorted by A&E nurse to PACU bed	2.15pm
2	Assessment of patient	PACU Nurse assessed, then patient waited to be seen by doctor	2.30pm
3	Doctor assessment	Patient was seen by a doctor who decided an orthopaedic doctor should examine the patient	2.45pm
4	Orthopaedic doctor assessment	Patient was reviewed by the orthopaedic doctor who informed the family that he will require admission to the children's ward	4pm
5	Admission to children's ward		9.15pm

PACU Patient 2

This patient attended PACU as he was suffering from shortness of breath, wheezing and vomiting. The patient, a 22 month old boy, was with his mother (later joined by his father). Number of stages in patient journey: 4. Length of stay in PACU: 3.5 hours (followed by admission to the children’s ward).

The patient was brought to PACU by his mother at approximately 1.30pm. He was referred to PACU by his GP whom he had attended an appointment with earlier that day (12.30pm). Within an hour the patient had arrived at PACU with his mother where they were expected at reception and were brought straight into the unit by a nurse. The nurse took the patient to a cubicle where he was initially examined and was then seen at 1.55pm by the doctor and was given a nebuliser. Over the following two hours the nurses and doctor caring for the patient visited him regularly. Attempts were made to encourage the patient to drink (which he did). The patient’s father joined him and his mother at approximately 3pm. By 4.10pm the family had been informed that their child would require admission to the children’s ward. They waited until 5pm when the transfer to the children’s ward took place.

At 4pm the mother was feeling relatively relaxed and extremely happy with the timing in which events had occurred. They reported feeling “very happy” with the care their son was receiving.

PACU Patient 2			
Stage	Action	Who?	Time
	Appointment with GP	GP contacted PACU to book patient in	12.30pm
1	Patient brought to PACU by mother – checked in at reception and collected immediately by the nurse	Referred by GP	1.30pm

PACU Patient 2			
Stage	Action	Who?	Time
2	Assessment of patient	PACU nurse	1.35pm
3	Doctor assessed patient and gives nebuliser encourage patient to drink fluids	Doctor and nurse attended	1.55pm-4pm
	Parent informed that patient required admission to the children's ward	Doctor	4.10pm
4	Transfer to children's ward		5pm

PACU Patient 3

This patient, a 2 month old baby boy was brought to PACU by his mother due to her concerns regarding his constipation, colic and sickness.

Number of stages in patient journey: 4. Length of stay in PACU: 5 hours 15 minutes (discharged home).

The patient was referred to PACU by his GP (who he saw at approximately 12.30pm) as a consequence of what his mother termed "three weeks of problems with the baby being all blocked up." The patient arrived at PACU at 1.40pm, where he was booked in by reception and waited for ten minutes to be collected by a nurse and assessed. The nurse carried out an initial assessment (brief history, blood pressure, weight etc). The patient then waited until 2.15pm to be seen by a doctor who spent approximately fifteen minutes examining the baby. Following on from the assessment, the mother reported feeling fully aware of what was happening, whilst waiting for the doctor to decide whether any treatment was to be given. At 3pm the doctor

returned to continue his assessment and take further notes from the patient's mother. In order to confirm his decision, the doctor (SHO) requested consultation with the registrar and the decision is reached to administer a glycerine suppository. The nurse returned at 3.20pm to apply cream to the baby and medical students also attended to speak with the mother and observe the patient. At 3.40pm the mother fed her baby to encourage him to move his bowels. At 4.05pm the doctor returned to speak to the mother and explain that all medical intervention was now complete and the baby would be free to go home once he had produced a stool sample. The patient was discharged home at 7pm.

The mother felt happy with the care she had received "I travelled beyond my local hospital to get to PACU, which I was more than willing to do to ensure I got the best care."

PACU Patient 3			
Stage	Action	Who?	Time
	Appointment with GP	GP contacted PACU to book patient in	12.30pm
1	Patient arrived with Mother at PACU where they were expected and booked in at reception	PACU receptionist	1.45pm
2	PACU nurse collected and carried out an initial assessment		1.50pm
3	PACU doctors fully assessed the patient and gave diagnosis	The SHO & SpR	2.15pm - 3.20pm

PACU Patient 3			
Stage	Action	Who?	Time
	of colic		
	The patient was regularly attended to, for skin cream and a glycerine suppository to gather a stool sample	Nurse and student nurse	3.20pm – 4pm
	Mother was told that all treatment was complete, and her son would be able to go home as soon as a stool sample was collected	Doctor	4.05pm
4	Patient discharged home	Doctor	7pm

PACU Patient 4

This 12 year old male patient attended PACU for a review of a known existing condition (Nephrotic Syndrome) which affects his kidneys.

Number of stages in patient journey: 3. Length of stay in PACU: 3 hours 20 minutes (followed by admission to the children's ward).

The patient attended PACU as a self-referral with his mother. As a patient with a long-term condition he was able to self-refer when necessary for review, to test for protein in his urine and be observed. The patient arrived at 11.10am and was brought to a cubicle in PACU shortly after arrival (approximately 11.15am). At 11.25am a doctor visited the patient, where no medication was administered but observations continued. By 2.10pm the patient and his mother had been informed the patient would be admitted to the children's ward for more prolonged observations. At 2.30 this admission to the children's ward took place. The patient explained that he was able to attend PACU when necessary without being referred by A&E or his GP as

he was part of a special white band system which identifies patients with long-term conditions that require easy access to the unit.

Self referral is more unusual but through the correct channels for patients with pre existing conditions this is an accepted route. Both the patient and his mother were regular visitors of the unit and felt satisfied with the service provided.

PACU Patient 4			
Stage	Action	Who?	Time
	Arrival at PACU reception		11.10am
1	Patient given cubicle in PACU	Nurse	11.15am
2	Doctor visited patient to assess and began observations		11.25am
	Patient was informed that he would require admission to the ward for further observations	Doctor	2.10pm
3	Patient was admitted to ward		2.30pm

PACU Patient 5

This patient attended PACU as he had a high temperature and a rash. The patient, a 4 year old boy, was with his mother. Number of stages in patient journey: 4. Length of stay in PACU: 6 hours (discharged home).

The patient was brought to A&E by his mother at approximately 10.20am. He had been to see his GP at 9.40am and was referred immediately to PACU. On arrival at PACU the patient was checked in by the receptionist and went straight through to a cubicle with a nurse, as the unit was expecting him. The nurse assessed the patient over a period of ten minutes

and almost immediately he was seen by a doctor (10.35am). The doctor prescribed medication to the patient which included antibiotics. The mother was aware at this stage of the possible diagnoses and was waiting for the results of the blood tests to be returned. Approximately one hour later the mother approached the doctor to ask if the blood results were back and was told they were. She was informed that she needed to keep an eye on her son for a return of any symptoms, and to bring him back on Friday for a follow-up check. At 3.35pm the doctor informed the mother that her son had a bacterial infection and as he had already been given antibiotics could go home with medication to continue taking himself. Rather than wait any longer, the mother decided to go to her own pharmacy to collect the medication her son needed, to avoid waiting in the hospital. The nurse supported the mother in her decision to do this and explained to her which medication she needed to buy. The parent left the unit with her son at 3.40pm

She was happy at this stage and the staff had been very friendly and reassuring. The issue of waiting for blood results was not a problem at this point, and the mother commented “if I have to wait much longer than 2 hours I may get annoyed, but am happy at the moment.”

PACU Patient 5			
Stage	Action	Who?	Time
	Appointment with GP	GP contacted PACU to book patient in	9.40am
1	Patient arrived with Mother at PACU where they were expected and booked in at reception	PACU receptionist/N urse	10.20am

PACU Patient 5			
Stage	Action	Who?	Time
2	PACU nurse collected and carried out an initial assessment		10.25pm
3	PACU doctors fully assessed the patient		10.35am
	Doctor prescribed medication		
	Patient was informed that he had a bacterial infection, and was ready to go home (with prescription)	Doctor	3.35pm
4	Patient discharged home	Doctor	3.40pm

PACU Patient 6

This patient, a baby girl 5 days old, attended PACU with her parents as she had jaundice. Number of stages in patient journey: 5. Length of stay in PACU: 5 hours 10 minutes (followed by admission to the children's ward).

The patient was brought to PACU by her parents following referral from their midwife. The baby's parents expressed that they had been worried since the recent birth of their daughter who had lost 12oz from her birth weight and was jaundiced. The family arrived at PACU at 4.20pm and were given a bed immediately as they were expected (no cots were available at the time). The nurse carried out an initial assessment of the patient and reassured the parents that it is normal for some babies to lose weight after birth. At 5.05pm following an update from the nurse and review of notes, the doctor

informed the nurse that blood samples would be required (although at this stage the doctor had not seen the patient). At 5.25pm a student nurse took further details from the parents to update the records. At 5.50pm the nurse collected the baby from the cubicle to take her for a blood test. The blood test was carried out by a doctor. The mother was asked whether she wanted to accompany her daughter through this process (she was warned it may be distressing for her to watch). The mother chose to go with her daughter into the room where the blood was taken. Following on from this procedure, at 6.10pm the doctor took further information from the parents regarding their own medical history and that of their daughter. At 6.30pm the doctor carried out a full examination of the baby. Shortly after this examination a cot became available and the baby and her family were moved. At this stage the parents were informed by the nurse that their baby would be admitted to the children's ward over night for further observations. At 9.30pm a bed became available on the ward and they were moved.

The parents reported their high satisfaction with the facilities provided by PACU. As users of the maternity unit, they made the comparison between the two services with PACU rated as far better, in that it appeared to them to be cleaner and warmer. The parents were grateful that they had been given a bed straight away and appreciated the fact that their arrival had been expected. The colourful surroundings, toys and friendly staff eased their minds regarding the concerns for the welfare of their daughter.

PACU Patient 6			
Stage	Action	Who?	Time
1	Patient was brought to PACU by her parents (referred by maternity) and registered	PACU receptionist	4.20pm

PACU Patient 6			
Stage	Action	Who?	Time
2	Immediately provided with bed and patient given initial assessment	PACU nurse	4.25pm
3	Communication between staff regarding patient	Doctor and student nurse	5.05pm-5.25pm
	Blood samples and further patient information taken	Doctor and nurse	5.50pm-6.10pm
4	Full examination of patient – family informed patient required admission to ward , patient moved to cot	Doctor and nurse	6.30pm
5	Patient admitted to the ward	Nurse	9.30pm

PACU Patient 7

This patient, a 1 month old baby boy attended PACU with his mother, who had brought him in with a rash covering his body.

Number of stages in patient journey: 4. Length of stay in PACU: 3 hours (discharged home). The patient was brought to A&E by his mother at 3.05pm. The patient's mother stated that she was informed by her health visitor that PACU was a walk-in centre and she did not require a referral to attend. The nurse who received the patient was displeased that this information had been given to the mother, as it was inaccurate that PACU was an open service to walk-in patients. The nurse felt strongly about non-acute babies who have been inappropriately self-referred. However, the nurse continued to admit the patient and highlighted to the researcher that the fault did not lie with the patient or his mother. At 3.20pm the nurse

assessed the patient, who appeared to have eczema. At 5.30 the doctor visited the patient to carry out a full examination and was joined by a second doctor. The doctor explained to the mother that it was very common for babies to have eczema and that she just needed to use a baby oil to keep the skin moisturised. The doctor described which products should be avoided, including nut oils, until the baby was two years old. The mother asked to be given something to take home with her baby for bathing and the doctor requested aqueous cream for the baby. At 5.40pm the doctor reassured the mother that the baby was well and could go home. At 6pm they were discharged. Approach from patient's mother to PACU as a walk in centre was at odds with the formal operation and structure of the service, but the patient was satisfied with the care received.

PACU Patient 7			
Stage	Action	Who?	Time
1	Mother brought patient directly to PACU without referral through the expected route	Mother	3.05pm
2	Initial assessment carried out	PACU nurse	3.20pm
3	PACU doctor fully assessed the patient and gave diagnosis of eczema along with prescription which mother has requested	Doctor	5.30pm
	Doctor gave advice to mother regarding moisturising her child's skin and informed the mother the patient would be discharged	Doctor	5.40pm

PACU Patient 7			
Stage	Action	Who?	Time
4	The patient was discharged home	Doctor	6pm

PACU Patient 8

This patient attended PACU as she was feeling sick and had a rash on her hands. The patient's mother, aunt and older sister accompanied the 3 year old to PACU.

Number of stages in patient journey: 4. Length of stay in PACU: 5 hours 50 minutes (followed by admission to the children's ward).

The patient was brought to PACU by her mother directly from their GP who made the referral. They arrived on the unit at 1.20pm and at reception were booked straight in and collected from reception by a nurse, who was expecting them. The nurse immediately carried out an initial assessment and the doctor came to see them directly after this. The doctor informed the mother that blood samples would be required and that results of these would take approximately 30 minutes. The doctor returned at 3.15pm to take the patient to carry out the blood test. The patient appeared distressed at this stage and the nurse advised the doctor that it would not be wise to allow the older sister to watch the blood test being carried out so, she was looked after by her aunt. By 5pm the family were told that the patient would probably need to be admitted to the children's ward. All of the blood results were back at this point, except for one which the doctor explained they were still waiting for. He also explained to the family that despite this result not being available he would still like to admit the patient for further observation to the children's ward overnight. At 5.30pm the doctor who has been treating the patient brought the consultant from the ward to see her. A student nurse arrived to ask the family and patient questions in preparation for her

admission to the ward (sleeping patterns etc) and offered to answer questions about the mother being able to stay overnight with the patient. At 7.10pm the patient was admitted to the ward.

Shortly prior to admission onto the children's ward, the mother was feeling positive about her experience in PACU.

PACU Patient 8			
Stage	Action	Who?	Time
	Appointment with GP	GP contacted PACU to refer patient	
1	Patient arrived with Mother at PACU where they were expected and booked in at reception	PACU receptionist	1.20pm
2	PACU nurse collected and carried out an initial assessment	Nurse	1.25pm
3	PACU doctor fully assessed the patient and informs mother that blood samples will be required	Doctor	2pm (approx)
	Doctor returned to carry out blood test (nurse advised older sister be looked after by her aunt)	Doctor and nurse	3.15pm
	Blood results returned except one outlier, and family told patient needs admission to ward; ward consultant was		5pm-5.45pm

PACU Patient 8			
Stage	Action	Who?	Time
	brought to speak with family		
4	Patient admitted to ward	Doctor	7.10pm

PACU Patient 9

This patient attended PACU as she has asthma and had been suffering from wheezing and a cough. The patient, a 4 year old girl, is a white-card holder which means she is a regular user of the service and is able to self-refer.

Number of stages in patient journey: 4. Length of stay in PACU: 3 hours 15 minutes (discharged home).

The patient was brought to A&E by her parents in the evening of the previous day. A&E referred her to PACU with a specific appointment time of 10.30am the following day. The patient arrived at the specified time and was collected immediately from reception by a nurse. The nurse carried out an initial assessment of the patient. A doctor then came to fully assess the patient at 12pm. The doctor administered medication and informed the patient and her family that he would return one hour later to reassess the situation, but that it was likely she would be able to go home. At 1.45pm the doctor returned to reassess the patient and having apologised for the delay due to the misplaced notes, informed the patient and her parent that she was able to go home.

The mother of the patient was extremely pleased with the care her daughter had received and appreciated the specialised service provided by PACU. She recognised that the adult world of a generic A&E department is not a pleasant environment for a child, unlike PACU. Particularly as a regular user of PACU, the mother credited the kind staff. However, during her time on

the unit, the patient's notes from a previous visit were lost. The mother expressed her dissatisfaction at the lack of communication between staff which she felt was not acceptable considering how regularly her daughter used the service. This was felt to be a particular problem between A&E and PACU, between doctors, rather than an issue focused upon the staff within PACU.

PACU Patient 9			
Stage	Action	Who?	Time
	Attendance to A&E during the previous evening who referred the patient (who was also able to self refer due to pre-existing condition) to PACU the following day	A&E staff	
1	Patient arrived with Mother at PACU where they were expected and booked in at reception	PACU receptionist	10.30am
2	PACU nurse collected and carried out an initial assessment of the patient		10.35am
3	PACU doctor fully assessed the patient and administered medication in relation to the pre-existing condition (informed should be able to go home)	Doctor	12pm
4	Patient re-seen by doctor and as expected, was discharged home	Doctor	1.45pm

PACU Patient 10

This patient, a 4 month old baby girl attended PACU as her mother was concerned she was not eating properly.

Number of stages in patient journey: 4. Length of stay in PACU: 1 hour (discharged home).

The patient was brought to PACU by her mother having been referred by the A&E department. The patient's arrival was expected and she was taken straight to a cubicle where the nurse assessed her (2.20pm). The mother repeatedly explained to the nurse that she was worried that her baby had not eaten anything since 8pm the following evening and was frequently crying. The doctor arrived and fully assessed the patient. He was interrupted by his bleep (at which stage all doctors were called to an emergency in A&E leaving no doctor on the ward and the consultant was called in), but asked the nurse to give the baby a bottle of milk, which she drank. The mother was relieved that her child then appeared well. At 2.55pm the doctor returned and completed the assessment of the patient. The doctor explained to the patient's mother that the baby would be fine and that she was well enough to go home, but should the problem persist to bring her back to hospital. The patient was prescribed re-hydration salts which the nurse explained to the mother how to administer. At 3.15pm the patient was discharged home.

This patient was initially rather anxious about her child and sought reassurance from staff, which she received to her satisfaction.

PACU Patient 10			
Stage	Action	Who?	Time
	Referral by A&E	A&E staff	

PACU Patient 10			
Stage	Action	Who?	Time
1	Patient arrived with Mother at PACU where they were expected and booked in at reception	PACU receptionist	2.15pm
2	PACU nurse collected and carried out an initial assessment		2.20pm
3	PACU doctor fully assessed the patient, but is interrupted to attend an emergency elsewhere	Doctor	2.30pm
	Doctor returned to complete assessment and prescribed re-hydration salts for the patient	Doctor	2.55pm
	Nurse explained how to administer salts to mother		
4	Patient discharged home	Doctor	3.15pm

Field notes (including staff data)

The field notes made by the researcher observations are contained in the following section, as recorded during the data collection. Staff interviews were informal during the PACU work; any notes have been recorded here.

Day 1

The unit has a calm feel and appears to be running very smoothly and in a systematic manner. Patients and their families are generally expected on arrival and take direction from the receptionist. Nurses lead the families and patients into the unit and they are allocated a bed. It would appear that doctors are at the top of the hierarchy. No nurse practitioners appear to operate within the service. The receptionist is very helpful and provides some details around the functionality of the service (as incorporated into the service detail in the chapter). She is positive about the staff working relationships and feels the environment is a positive one for both patients and staff.

The Consultant spoken to is very proud of the service, feels the teamwork is good and the clinical service excellent. He provides a detailed account of the service structure and systems, including the strict rules around referral and patient access. The environment for the both the patients and staff was carefully considered to improve the patient experience and provide staff with a comfortable working environment.

Day 2

Again the unit is running smoothly overall. Some of the service notices pinned to the board are noted, which relate to processes of referral.

A nurse comments that whilst the unit provides a good service to the patient, the toilet facilities are limited within the unit and that it would be nice to have more toilets in order to increase hygiene. A doctor on the unit is positive about PACU and recognises they are relatively lucky as a service to have such good facilities, which are a good support to the work done and help to ensure patients experience less delay. Generally patients fit well into the service structure and do not present a problem to staff.

Day 3

On this final day of data collection the environment is fairly consistent with observations made on the previous days. A second nurse comments that as PACU is a referral-only unit, not only should patients not be able to turn up without being expected, but also that any other health care professionals, either internal to the hospital, or in a community setting, should be aware of and comply with the rules by which PACU operates for its admission of patients (which generally they do). She also noted the good teamworking within the unit and the pleasant working environment, despite the limited toilet facilities.

Appendix X The Respiratory Clinic - raw data

Patient data

Respiratory Clinic Patient 1

This female 58 year old asthmatic patient was attending the respiratory clinic as a follow-up patient; her previous appointment had been mid way through the preceding year. The patient was originally referred to the clinic from another clinic within the hospital (ENT clinic). This patient was attending hospital for her second appointment with the clinic to discuss her respiratory condition and for what she explained was her expectation of a diagnosis for her current condition. The patient expressed views that GP visits were seen in her eyes to be “an extra unnecessary phase, when the hospital specialist is very good...better.” When asked her views towards the way in which she had been referred to the clinic, she felt the timings for the appointment were good, but her only problem had been tests and waiting to have them done, rather than anything else causing delay. The patient reported that the hospital clinic “tell you straight away when an appointment has to change...but it is difficult to get through on the phone and it takes ages to get to talk to someone.” In terms of the patient’s views of the physical environment, she felt it was not particularly pleasant “it’s dingy and dark doesn’t make you feel good. Toilets are atrocious, meant to be hygienic but I’m worried about what I might catch!” The patient did not feel anxious on her arrival to the hospital, but did report this was due to having her husband accompanying her. The patient regarded the consultant as the main professional involved in her care “My GP is too general, the consultant doesn’t fob me off – he investigates and I feel comforted I’m under a skilled person. I’m BUPA paid member but I choose the NHS and this hospital as I know they don’t give unnecessary treatment, x-rays. They do a marvellous job, the care is what matters above all and

they do their very best in the circumstances. It's a nice atmosphere and I'm lucky to be under them!"

Respiratory Clinic Patient 2

This 55 year old female patient was attending the respiratory clinic as a follow-up patient; she was a lifelong asthma sufferer who was having further investigations carried out. The patient was originally referred to the clinic by her GP. This patient was attending hospital for her second appointment with the clinic to discuss her condition as a diagnosed asthmatic experiencing more severe symptoms than usual. "Straight away when I went to visit my GP and I asked to be referred to the hospital which happened and was good, I was actually offered an appointment in 6 weeks which I couldn't make and it was put back. It's been brilliant, at my first appointment I had an x-ray in my time slot, no problems only a 5 minute wait. I was early to see my consultant today so got the blood test I needed fitted in early no waiting which was very good. I've been seen quickly, efficiently and it's not rushed." With regards to information from clinicians the patient reported: "It's been helpful, I've understood it, asked questions and been given answers." The patient regarded herself as the main professional involved in her care.

Respiratory Clinic Patient 3

This 62 year old male patient was attending the respiratory clinic as a follow-up patient; he was suffering with a chest condition and was having further investigations carried out. The patient was originally referred to the clinic by another clinic within the hospital. The patient reported that he felt he had been referred to the clinic at the appropriate time, this being his fourth visit. In consultations with his hospital doctor he found his doctor dealt with the situation sensitively. Having not yet received any treatment and remaining somewhat uncertain about his current condition

he reported "I did feel some anxiety when entering the hospital." The patient was satisfied with the physical environment of the hospital. He stated "I have fully understood all of the information I have been given, I have received very good care and am satisfied overall."

Respiratory Clinic Patient 4

This 70 year old female patient was attending the respiratory clinic as a follow-up patient; she was a long term sufferer of back and chest pain with coughing who was having further investigations carried out. The patient was originally referred to the clinic by her GP. This patient was attending hospital for an appointment with the clinic to discuss her condition as it appeared a resolution on her situation had not been reached. "Well I've had a cough for 5 years - have had different tests and scans but seems there is nothing more we can do or have. Alternative medicines were tried last year then came back in September and have been here every 3 to 6 months since. We're baffled so are trying one more test (a tube up my nose and into my lungs) to check acid levels for 24 hours (monitor). It's life affecting and I'm exhausted...no sleep. I had a change of hospital doctor here at the clinic and the new doctor said he couldn't believe I've had my condition for 5 years he said I'd been neglected and should have had this 'tube up the nose test' I'm about to have ages ago!"

"The information regarding tests has been ok, but I've got to live with it, it feels like they think it's a silly cough and don't realise what I'm going through. You have to live with it."

The patient reported feeling more positive since her change of hospital doctor, who she viewed as the main professional responsible for her care and she felt the staff had been very kind and the scans good. In terms of negatives from the patient perspective she stated "the worst bits are that I'm made to feel like I'm making a big deal of something and I have to live with

it.” The patient’s views of the physical environment were “to be brutally honest it’s very cramped, I only just managed to get a seat and in the summer it gets very hot despite the fans.”

Respiratory Clinic Patient 5

This 61 year old male patient was attending the respiratory clinic as a follow-up patient; he had recently experienced coughing up blood and via A&E and his GP had been referred to the clinic. This patient was attending hospital for his third appointment with the clinic to discuss his condition. “The first time I visited I was told to pack up smoking which I’ve done and then went for a scan and am waiting for the results today” He felt slightly anxious about being in hospital “not really seen the doctor much so felt worried.” The patient reported that the receptionist had been friendly but before receiving any treatment it was too early to make any further judgements on the care he had received.

Respiratory Clinic Patient 6

This 44 year old female patient was attending the respiratory clinic as a follow-up patient; she had other pre-existing chronic conditions including being epileptic and having an irregular heart beat for which she was also being cared for by the hospital. The patient was originally referred to the clinic by the hospital’s A&E department. This patient was attending hospital for her appointment with the clinic to check up on her condition, in light of the fact that she had recently been admitted to the A&E department. “My sister [who helps with the patient’s understanding of treatment] has to be with me all the time because of my condition, the leaflets we’ve been given are sensitive” She reported that the physical environment was “ok, we know where we’re going in the hospital so it’s ok to find things.” Also due to her sister being present her anxiety levels were

reduced and she felt satisfied overall with the care she had received and had no comment to make regarding other aspects of the service.

Respiratory Clinic Patient 7

This 34 year old female patient was attending the respiratory clinic as a follow-up patient; she had previously been misdiagnosed by the hospital and felt that overall her treatment had not reached the level she expected. The patient was originally referred to the clinic by her GP on her first visit in relation to her respiratory illness. This patient was attending hospital for her regular appointment with the clinic to discuss her condition “I was initially wrongly diagnosed by the hospital who then referred me to another hospital as here they were unable to deal with my condition, I wasn't given much information by this hospital and had to wait 3 months to have an echo done. I never see the same consultant twice. My first (incorrect) diagnosis was from a female doctor who didn't answer my questions. I left the room with a diagnosis of a potentially very serious condition with no information, no leaflets and then had to wait for 6 months for my referral to the other hospital to come through (the second hospital then correctly diagnosed me and sent me back here).”

There was some frustration and anger from the patient about the fact she had been left ill-informed and misdiagnosed, “I feel anxious here now that I have been misdiagnosed by this hospital and wonder if things are being done right.”

The patient's regular visits to the hospital were felt to have influenced her views towards the environment “I've been here such a lot, it's ok” this familiarity was also said to have reduced her anxiety levels. When asked to comment on which the patient felt was the main professional responsible for her care, she stated: “The doctor is in charge of your care, but I feel as a

patient just as equally responsible. Ask questions and follow instructions, but when you get home it's up to you." When asked about her overall views of the service the patient commented, "Not sure if there is anything good I can say! - Generally there's not much good about coming to hospital. Waiting for appointments and information, not seeing the same consultant every time is frustrating." An overall view of "dissatisfied" was given by the patient of the hospital clinic care she had received.

Respiratory Clinic Patient 8

This 53 year old female patient was attending the respiratory clinic as a follow-up patient; she was an asthma sufferer. The patient was originally referred to the clinic by another clinic at the hospital after collapsing at an appointment. The patient stated that the most important person involved in her care was herself. She viewed her GP and clinic hospital doctor as both important in terms of her care, but rated her GP as the more important professional looking after her. "My GP is very good, sensitive and understands my situation. I get more from my GP, I tend to ask them more - my doctor here is also very good, I can discuss here what I'd like to change and the clinic doctor is very good and I can relate to him."

The views of the patient were not entirely positive. "Seeing the same doctor is a good thing, it would put me off if I had to see a different doctor every time. I'm comfortable with my clinic doctor as he knows me and explains it to me so I understand. However the consultant [different doctor] in the clinic is rude - he leaves a lot to be desired!"

There was the feeling from the patient that the information she had been provided with by the hospital clinic could have been improved somewhat, "I would have liked someone to talk me through what I have - maybe using TV programs about asthma to help. Leaflets are not always understandable." Her views towards the clinic waiting room were "It's warm, access is good

but it's not sensible that there are so few windows. People need to learn to cover their mouths when they cough!"

Respiratory Clinic Patient 9

This 35 year old female patient was attending the respiratory clinic for the first time as a new patient and was hoping to receive a diagnosis. The patient was originally referred to the clinic by her GP. This patient was attending hospital for her appointment with the clinic to discuss her condition she had been experiencing a sensation of having a heavy arm and also reported a lung problem. The patient reported experiencing a "quick referral from my GP [to the clinic] - it was very good." The patient felt that her GP in conjunction with the hospital clinic doctors were both responsible for her care.

For this patient, the physical environment of the hospital was less important than the treatment she received "It's a bit old, puts you off but that's not what matters! I found it ok and felt relaxed when I got here." With regards to the information given to the patient by the clinic, the patient reported, "I've fully understood the information given by the clinic and overall am satisfied with the care."

Respiratory Clinic Patient 10

This 53 year old female patient was attending the respiratory clinic for the first time as a new patient and was hoping to receive more information regarding problems she had been having with her heart murmur. The patient had experienced a high level of contact with other areas of the hospital being in remission after a diagnosis of leukaemia. The patient was originally referred to the clinic by another service within the hospital. "I was meant to come 2 or 3 weeks ago but my son

was unavailable so had to wait - come to the conclusion things take a long time (though can't fault them on care). I'm here for investigations at this stage rather than treatment. The environment is pleasant enough, the receptionist is friendly and I don't feel anxious." The patient felt her GP was the main professional responsible for her care, and that her experiences in the respiratory clinic, being very satisfactory so far, were not advanced enough to comment further on the service.

The patient did add to her comments after waiting for some time to see the doctor for her appointment:

"I've had a long wait - sitting waiting and then saw doctor who then told me to go for x-ray - why didn't he tell me to go for x-ray as soon as I got here? I felt I couldn't cause unpleasantness for him so didn't want to complain."

Respiratory Clinic Patient 11

This 50 year old female patient was attending the respiratory clinic as a follow-up patient; she had been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) 6 years previously. The patient was originally referred to the clinic from the hospital's A&E department.

The patient had been given various tests in the past. "Lung function tests, scans etc a few months ago but been cared for here for years. I get appointments almost straight away when I need which is good."

The patient felt her hospital consultant rather than her GP was the main professional involved in her care.

The patient reported feeling well informed by the clinic regarding her condition "I don't like being in hospital! [However] I've been supported, information has been given and I've asked questions and been told all I

needed to know. In the clinic doctors are good and I've been looked after.” To the patient these factors and the quality care she received was what mattered to her, rather than the physical condition of the clinic. “The care is what's important.”

Respiratory Clinic Patient 12

This 59 year old male patient was attending the respiratory clinic as a follow-up patient; he had an auto immune blood syndrome which had been diagnosed 7 years ago. The patient was originally referred to the clinic by his GP. This patient was keen to give generally positive reviews of the care he had received from the clinic. He reported having struggled for some time in the past prior to diagnosis, not being able to uncover what was wrong with him. He felt this may have had something to do with the rarity of his condition “[referral to the clinic was] not quick, 18 months I tried to get my GP to refer me.” Although the referral process was frustrating for him he reported feeling “Jolly relieved...I was at death's door, could hardly walk. I'm under the best care now and the doctors are absolutely outstanding.”

He reported having had “All sorts of scans as an in-patient; tests etc for the clinic which are pre-arranged in advance so I arrive having had them.”

The patient referred to his diagnosis and the process involved: “The doctor in the clinic did this brilliantly; top notch exceptionally friendly and supportive, couldn't have felt better. A double gold star for [clinic care coordinator].”

On first entering the hospital the patient felt little anxiety, simply “Happy by then I was getting regular care.” The information given to the patient was “Top rate 100% everybody told me what I wanted to know.” The patient viewed the hospital consultant as the main professional responsible for his care. “The [clinic] doctor saved my life! It is medical care which is great

versus the rest which is not.” This refers to the aspects of the hospital service which the patient had been displeased with which he went on to explain.

There were elements of the clinic experience the patient was not satisfied with, particularly with regard to the physical environment: “[I’m] not happy really, [the waiting room is] uncomfortable, drab, dark [it] irritates me that the TV is on all the time. I don't like my name being yelled out when it's time for my appointment; I find this quite embarrassing (GP surgery electronic style is better).”

“Nobody warns you if there is a delay - 2 hours wait is unacceptable. A young man [previous clinic receptionist] called me by my first name in the past which I found offensive. Car parking in the hospital becomes a major problem when appointments run late. During treatment when my consultant changed no one told me this would happen, it wouldn't take much to do, information makes all the difference.”

In terms of medical care, the patient was very satisfied.

Respiratory Clinic Patient 13

This 29 year old female patient was attending the respiratory clinic as a follow-up patient. The patient had small lungs and was a regular clinic attendee. The patient was originally referred to the clinic by another hospital clinic. The patient reported feeling positive about how she was referred to the clinic “I think I was happy - I wanted tests so was happy to be referred.” The main concerns for the patient related to the physical environment and comfort levels when having to wait, “It was cramped and small when I came in, too crowded and chairs uncomfy, feels like 2 clinics in one and not clear which clinic is where. Waiting is the worst thing.” The

patient felt more aligned to the clinic which had referred her and which had been treating her for longer, than the respiratory clinic, “the other hospital consultant I have is the main professional responsible for my care, although the doctors here are good and I am satisfied.”

Respiratory Clinic Patient 14

This 38 year old male patient was attending the respiratory clinic as a follow-up patient; he had been diagnosed 10 years previously with Multi System Sarcoidosis. The patient was originally referred to the clinic by his GP. “My GP didn't know what was wrong so I was referred here after one GP visit which I had no choice over at the time but it was quick and ok.” He reported being happy with the process of diagnosis and didn't feel the physical environment in the hospital clinic was important to him “it's not a big issue really.” The patient reported being given a good deal of information regarding his condition, jokingly stating “they beat me with it!” The patient felt the hospital doctor was the main professional involved in his care “I do choose to come all the way from where I've moved to in Derby” also “the nurses are blinding, the admin staff are good.”

Respiratory Clinic Patient 15

This 61 year old male patient was attending the respiratory clinic as a follow-up patient; he was a COPD patient attending his regular visit to the clinic to see the consultant. The patient was originally referred to the clinic by his GP. “On the same day as I visited my GP I passed out in surgery and got an ambulance to the hospital and was in for 3 weeks then was given regular appointments at this clinic.” The patient felt the care he had received since diagnosis had “been good, been to A&E a few times and also had stays in hospital.” With regards to being given a diagnosis and information he “didn't know what was wrong, couldn't climb the stairs. I had

to ask rather than being told. After that it was ok, lots of information given and I could ask questions.”

The patient felt the hospital consultant was the main professional involved in his care, he was generally very satisfied “things have been very good, apart from being very ill I'm happy.”

Respiratory Clinic Patient 16

This 72 year old female patient was attending the respiratory clinic as a follow-up patient; she was an asthma sufferer who was having further investigations carried out. The patient was originally referred to the clinic by her GP. “My GP was very good, my inhalers weren't working and so she referred me to the clinic which was very quick. I've been sent for every test on this earth! But some waits have been long. The thoracic department is very good and I do ask questions and I want to be given answers to questions!”

The environment of the clinic was not important to this patient “I don't care once they see me! The staff are always friendly and it's easy to find.” Anxiety was expressed as experienced upon arrival as the patient “just wanted to know what was wrong. They answer questions and I have some control and make sure I get the information I need - if you don't ask you don't get! I've got no complaints but I don't like waiting.”

This patient felt the GP and hospital doctor were jointly the main professionals responsible for her care.

Respiratory staff data:

Respiratory clinic care coordinator

The clinic care coordinator had been working at the Trust for 2 years, as a clinic administrator. She explained that as part of the developments taking place in the Trust, her role had evolved and would soon include aspects of care beyond purely administration “now we will be doing clinical health care assistant things, we’ve done NVQs and so can take blood pressure etc.” With regard to her thoughts of the changes taking place at the Trust, she responded confidently “as long as patients get seen, it should be fine, as long as they understand and will be followed at home not just at clinic necessarily, it will be ok but we need to wait and see for sure. We work all together as one big team...morale is a bit low at the moment as we don’t know what’s going on, there has been little explanation (from line management) we are just told. It is important to keep staff up to date on what’s happening.”

When questioned about how the patients were allocated between the clinicians working in the clinic, the clinic care coordinator explained “the doctors like to share the patients, the registrar has his and the consultant has his, but the patients should always be seen at least once by the consultant. Dr ‘X’ keeps his patients; they love him, especially the elderly ones who don’t like change.” Field note quotes relating to the central patient booking service within the hospital which was observed not to be operating as effectively as required:

“The booking centre needs to be spoken to!”

Respiratory clinic registrar

The Registrar working in the clinic had been doing so for 1 year. He reported that regarding information around the changes at the hospital and

the respiratory services he had been given “no information what-so-ever, I will have to hot desk in the [new] outpatient clinic, but I don’t have an office so I’m not sure how it will work! I’m sceptical until I’ve experienced the service change, I’m sure there will be teething problems, as we are about to move and there has been no information on the patient’s letters they don’t know [regarding the hospital relocation]. It is a good idea but in practice it’s a different matter. There may be a problem with chronic disease patients who will be happy at home, but some will prefer to see a doctor [in hospital] and feel more secure with this as it is how they have been brought up.”

Chronic disease nurse practitioner

One of the two chronic disease practitioners working jointly between the local primary care trust and the acute hospital trust was interviewed, having been in this new post for 9 months. “This new hospital is about putting services in the community and not about patients coming into hospital, even though it is an attractive building it’s not about attracting them! It is a brilliant idea providing there are the resources and support necessary. It is good that chronic disease practitioners will be able to manage their own group of respiratory patients, but this is a small group of a larger area which needs to be managed – more practitioners are needed. There may be problems with other groups of patients not being looked after with community input. Outpatients are doing their bit, but people being treated in the community and their expectations of the new hospital actually means that there will be more work in the community. For the staff working here the new hospital will be a breath of fresh air – a new building and new equipment encourages new ideas and new ways of working. For patients the benefits will be that they can see where the money is going and should make their experiences as a patient much more pleasant. There is some confusion regarding community care commissioning and the new hospital, will GPs choose it?

There are issues of accountability, records and access for us and coordination can be messy.”

Lung function technician

The lung function technician was interviewed regarding her views towards the changes taking place in the hospital, but also gave a brief explanation of her role “I see patients in the lung function lab and also in the outpatients clinic for basic lung function testing and assessment for oxygen needs. The doctors see them, but we follow up with mask fittings etc. We deal with nebulisers, and order and look after supply parts. ” With regards to the changes in service model the technician reported, “it has been good in that it has forced us to become more organised, it has encouraged us to set up of a fixed routine, I don’t think the changes will really change my role much, but for the patients it will be better, easier way-finding and a new environment. The new equipment for us is positive.”

Respiratory consultant

The senior consultant involved in the development of the respiratory service model was interviewed for his views regarding the service. “Payment by results has been problematic, NHS finance allocation does not encourage community care activity – we have developed a model with a reduced need for staff, done what the government asks but we don’t get payment if the patients don’t come into the hospital. A phone call by the GP to the consultant, or use of the email clinic avoids admissions or the need for patients to come into outpatients. An outpatient clinic appointment costs £250, an A&E visit costs £600, an A&E admission £2000. We are ahead of the game, the first trust to get this sorted, but are now realising the financial implications – it is cheaper in the long run but there is no mechanism in place now to remunerate us for the support we provide in the community.

The training and support for GPs we provide in the model has no remuneration for it in the system. Choose and book is also an issue, patients go to their GPs, are told they need to see a specialist and so the patient can choose where they are referred to, but they choose the hospital with the best reputation (not ours), even though we are providing the best service. The service level agreement with hospitals for N appointments means that once the service level agreement is exceeded, there is effectively no choice. Choose and book and payment by results didn't exist when the hospital model was designed, but they told us 'don't worry something will be developed'." The trust chief executive has told him not to do the email clinic as it prevents outpatient and A&E admissions which does not bring in the money for the hospital ("even though it is best for the patient!").

General field notes

Patients arrived at the reception desk in the clinic with the letter they had been sent confirming their appointment time. The clinic care coordinator (CCC) often referred to by patients as the receptionist, was the first point of access to the service for patients. Patients were either attending the clinic for the first time as new patients, or were follow-ups with regular appointments approximately every three, six or 12 months.

Observations supported a lack of assertion by patients with the clinic staff regarding involvement over their care. The dynamics of teamworking within the respiratory clinic were not immediately evident. The staff were physically separated in their work, the clinic care coordinator dealt with patients in the waiting area, and the clinical staff called patients from the waiting room to the consultation rooms. The roles of the staff were observed to be quite distinct from one another with little overlap.

The clinic care coordinator was seen working mainly as the administrator. The supporting clinical services such as the lung function technician's role were entirely separate (in location and functionally). The registrar and consultant were the clinicians treating patients in the clinic and the managers of the service were located upstairs from the clinic with no involvement in day to day clinic activities. The clinic care coordinator was the most visible staff member and appeared to hold together the operational side of the clinic, whilst also proving to be popular with patients.

No targets or systems governing the clinic were visible within the clinic (for example on posters, signs or clinic memos). General observations of staff in the clinic, specifically the clinic care coordinator, indicated frustration with reference to the central patient booking service which had failed to inform patients when they required certain tests. However, some good examples were also observed of successful information flow for example when a translator was pre-booked for a patient who did not speak English, they arrived as scheduled.

The managerial staff had posted notices in public areas of the hospital relating to forums or presentations to inform staff regarding the changes taking place. In contrast to this, through informal conversations or from general observations, some staff were observed to be unhappy with the degree of effort which had been made by the trust to inform them of what developments were taking place.

The hospital environment was notably tired (and the new hospital building being erected adjacent to the old building a stark visible contrast to this). The respiratory clinic waiting room and facilities in general were observed to be out-dated and in need of some repair. The waiting room was observed to be cramped and dark.