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**A CASE STUDY OF CONSUMERISM IN HEALTHCARE:
USERS AND STAFF IN TWO MINOR INJURY UNITS**

by

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**Thesis submitted
for the Degree of Doctor of Philosophy**

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Abstract

- Background** Choice has become the defining characteristic of service users' relationship with the National Health Service (NHS) in the UK. Decades of market-orientated policy have encouraged greater customer focus, and the NHS is now subject to the same consumer drivers that can be identified elsewhere in society.
- Aim** The aim of this study is to understand whether the introduction to the NHS of market reforms designed to encourage and improve choice and experience have influenced the way in which service users access care and interact with service providers when receiving it.
- Method** This study utilises an ethnographic approach to data collection combined with the structure, theoretical under-pinning and replication logic afforded by comparative case study. Both approaches allow for the inclusion of qualitative and quantitative data and use multiple data collection instruments in a triangulating fashion. Two minor injury units (MIUs) were selected as research sites/cases since they serve a large community with multiple and diverse needs and provide a crucial stepping-stone between primary and secondary care services.
- Results** Although very few service users at either case identified themselves as 'customers' or 'consumers' of healthcare per se, there was general consensus that high standards of customer service were both important and desirable in a healthcare context. Similarly, regardless of whether service providers believed that service users *should* be viewed as 'customers' or 'consumers' of healthcare, they consistently demonstrated modes of behaviour that *treated* them as such.
- Conclusions** Through careful analysis of the data, it is possible to identify five different healthcare consumer typologies: passive, reluctant, assertive, pragmatic and knowledgeable.

The broad range of views and positions demonstrated by these typologies in relation to healthcare consumption seem to be the result of social values and practises that have developed in response to consumer culture and society as well as previous experience of healthcare services.

Acronyms and Abbreviations

A&E	Accident and Emergency
AHP	Allied Health Professional
AHRC	Arts and Humanities Research Council
BMA	British Medical Association
CHC	Community Health Council
CQC	Care Quality Commission
DH	Department of Health
DHSS	Department of Health and Social Security
ECC	Emergency Care Centre
ENP	Emergency Nurse Practitioner
ENT	Ear, Nose and Throat
ESRC	Economic and Social Research Council
FN	Field Note
FFT	Friends and Family Test
GP	General Practitioner
GPC	General Practitioner Collective
HC	House of Commons
IMD	Indices of Multiple Deprivation
LSOA	Lower Super Output Area
MIU	Minor Injury Unit
MRI	Magnetic Resonance Imaging
NHS	National Health Service
NIB	National Information Board
NICE	National Institute of Clinical Excellence (before 1 April 2013); National Institute for Health and Care Excellence (after 1 April 2013)
OPA	Out Patient Appointment
PA	Patients Association
PALS	Patient Advocate and Liaison Service
PIS	Participant Information Sheet

PO	Participant Observation
PPI	Patient and Public Involvement
QALY	Quality Adjusted Life Year
RCEM	Royal College of Emergency Medicine
R&D	Research and Development
REC	Research Ethics Committee
RSC	Regional Specialist Centre
SP	Service Provider
SU	Service User
UK	United Kingdom
US	United States
USS	Ultra Sound Scan

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- (i) Sturgeon, D. (2013) 'There and back again: a short history of health service reform in England from 1909-2012', *International Journal of Arts and Science*, 6 (2), pp.19-30

- (ii) Sturgeon, D. (2014a) 'The business of the NHS: The rise and rise of consumer culture and commodification in the provision of healthcare services', *Critical Social Policy*, 34 (3), pp.405-16

- (iii) Sturgeon, D. (2014b) 'Markets, mergers and mixed messages', *British Journal of Healthcare Management*, 20 (2), pp.71-75

- (iv) Sturgeon, D. (2017) 'Convenience, quality and choice: patient and service-provider perspectives for treating primary care complaints in urgent care settings', *International Emergency Nursing* (in print)

Chapter 1: Introduction to the study and literature search

1.1 Introduction to the study

The purpose of this thesis is to understand whether the introduction to the National Health Service (NHS) of market reforms designed to encourage and improve choice and experience have influenced the way in which service users¹ access care and interact with service providers when receiving it. The study was inspired by the work of Professors John Clarke and Janet Newman who, with others, have written widely about the impact of managerialism on public services and their reform. I was first introduced to their work by the book *Creating Citizen Consumers: changing publics and changing public services* which outlines the findings from the research project *Creating Citizen Consumers: Changing Relationships and Identifications* (Clarke et al, 2007). The project ran between April 2003 and May 2005 and studied three public services (health, policing and social care) at two urban locations. The key questions and findings from the study (discussed in chapter 2) encouraged me to consider how my own practice as a nurse, and healthcare provision in general, continues to be shaped and influenced by neoliberal policies that promote increased consumer choice and competition. As a nurse/educator and member of the public, I had been aware of the drive to reconceptualise patients as customers or consumers of healthcare in order to promote choice and responsiveness. However, it was not until I read *Creating Citizen Consumers* that I began to question how this might influence and alter the relationship between healthcare service users and providers and the implications this change may have for the delivery of care in the future. This encouraged me to read more widely and critically about healthcare reform and begin to formulate the research questions outlined below. Although there are similarities between this study and the *Creating Citizen Consumers* project, there are also a number of important differences. Firstly, this is a much smaller

¹ For the purposes of this study, the term 'service user' refers to an individual who accesses and uses healthcare, public and independent sector services. The term 'patient' is also used to refer to an individual who accesses and uses healthcare services since both words frequently appear (and are used synonymously) in Department of Health, NHS and other healthcare literature. This issue is discussed in chapters 2 and 7.

unfunded study that took place over a shorter period of time. Secondly, it only explores attitudes to health and healthcare provision. Finally, participant observation and semi-structured interview were the primary data collection instruments (rather than questionnaire and focus groups) which reflects the choice of ethnographic and case study methodology. These issues are discussed in greater detail in chapters 2 and 3.

The principle aim of the research is to investigate what drives individual and collective consumer behaviour in healthcare, how this behaviour is expressed, and what advantages/disadvantages it provides for service users and providers. Two minor injury units (MIUs) were selected as research sites since they operate on a walk-in basis, serve a large community and provide care for a wide range of illnesses and injuries. They offer a unique opportunity to sample and observe spontaneous consumer behaviour in a healthcare environment with minimal risk of causing further distress or inconvenience. Secondary research questions and objectives are:

- Do service users view themselves as ‘customers’ or ‘consumers’ of healthcare and, if so, is this reflected in their relationship with service providers?
- Do service users participate/wish to participate in healthcare decision making during clinical consultation/treatment?
- Why do service users choose to attend MIUs rather than an alternate healthcare provider?

A qualitative design was chosen since the research seeks to understand healthcare service users and providers attitudes towards choice and shared decision making. The two MIUs selected represent bounded systems or ‘cases’ in which the behaviour being studied takes place. Case study is also recommended when the research relates to contemporary issues where the researcher has little control of the behaviours and events being investigated (Yin, 1994). Ethnography was considered to offer the best opportunity to observe and interpret the service user/provider interaction that takes place within them. Ethnographic research seeks to study people in naturally occurring settings, undertaking ordinary activities, using methods which capture their social meanings and values

(Brewer, 2004). Both approaches allow for the inclusion of supporting quantitative data and use multiple data collection instruments in a triangulating fashion.

Data collection took place in three concurrent and complimentary stages. The first stage involved close analysis and review of healthcare policy dating back to the inception of NHS in 1948. This explores why changes have occurred in the organisation of the NHS and why service users have been encouraged to become more assertive in their relationships with healthcare services. The next stage of data collection took place at two nurse-led MIUs (case A and B) over a period of eight months (October 2014 - May 2015). Service users and providers from case A and B were interviewed regarding choice, decision-making and consumer attitudes when accessing healthcare services. All interviews were semi-structured and lasted approximately 30 minutes in the case of the former, and 45 minutes in the case of the latter. The final stage of data collection involved direct and participant observation in case A and B to sample interactions between service users and providers in-situ and provide insight regarding organisational culture. The data collected from these encounters provided an important point of comparison with the policy analysis and interviews. The use of multiple data collection instruments allows the activity that occurs at both sites to be evaluated in a sequential manner and analysed from a number of different perspectives.

The originality of the study lies in both its design and the findings. A number of UK and international studies (discussed in chapter 2) investigate choice and decision making in healthcare but only one adopts an approach that combines case study with participant observation (Glasdam et al, 2015). However, even here, the authors select two 'exemplary cases' from previous research, only one of which uses participant observation as a data collection instrument. The reason for the apparent under-representation of this data collection tool (most qualitative studies use interview and/or focus groups) may be because it is time consuming to undertake and because of ethical concerns regarding covert observation. The inclusion of participant observation in this study proved extremely contentious when seeking NHS ethics approval and a number of additional assurances (principally

regarding informed consent) had to be provided before the committee agreed that the study could proceed. Another way the research provides an original contribution to knowledge is that it identifies 5 healthcare consumer typologies that broadly reflect and predict the predominant behaviours exhibited by service users when accessing healthcare and interacting with healthcare providers. These are formulated from the different data collection strands and help to inform the research recommendations. Other consumer typologies have been formulated in the past. These are discussed in chapter 2 but they are broad in their scope and do not help to predict or explain healthcare decision making. Whilst other studies have identified convenience and trust as important considerations when service users make decisions about healthcare provision, there is little evidence to indicate how policy, and other factors, contribute to this process and what effect this has had on expectation of care and service delivery. Finally, a small number of international studies/papers have assessed how service user choice and co-production of care is influencing the relationship between service users and providers (see chapter 2). However, currently, there is no research on this topic from the UK.

Chapter 2 provides an overview of healthcare policy developments that have informed and contributed to the increasing marketisation of the NHS over the last thirty years or so. Since this is a large and complex topic, it is not possible to include discussion of all healthcare reforms from this period and much of the information is summarised in table 1. Chapter 2 also investigates individual and collective consumer motivation in relation to healthcare and its wider social context. This includes exploration of what is meant by the term consumption, what drives consumer behaviour and why it is increasingly important in terms of healthcare provision. Whilst this provides context for the research it is impossible to address all of the issues that influence and impact upon consumer behaviour in relation to healthcare. Consequently, although there is some discussion of funding and finance in relation to healthcare provision this has not been addressed in detail. Similarly, it is not possible (or necessary) to include detailed evaluation of the legal implications of competition and consumerism in relation to closures, mergers and acquisition of healthcare services. Chapter 3

identifies how the research questions and problems identified in the preceding chapters are addressed by the research design. It provides an overview of the methodology and how this was operationalised in relation to case A and B. This includes explanation of the settings for the study and discussion of practical considerations such as gaining access and preparation. The chapter concludes by explaining how the typologies were derived and developed.

Chapters 4 and 5 present the data from case A and B in a way that broadly reflects the service user journey at each case. For example, following brief discussion of the demographic data relating to the service user/provider interview participants, evidence is presented regarding the reasons why service users choose to attend case A or B and whether they viewed themselves as customers of healthcare etc. Service provider views are presented next since they complement the service user data and provide an alternate perspective regarding their journey. This is followed by evaluation of the quantitative and qualitative data derived from the Friends and Family Test (FFT) short message survey (provided retrospectively). The participant observation data is presented last since it provides an overview of service user and provider interaction from the point-of-view of the researcher over the course of the data collection period.

Chapter 6 provides cross-case analysis and summarises the similarities and difference between case A and B. Chapter 7 provides discussion of the evidence and outlines how it makes an original contribution to knowledge. The typologies are analysed in relation to service user behaviour, motivation and level of engagement when accessing healthcare in case A and B. It also provides recommendations for practice, education, policy and further research.

1.2 Literature Search

The literature search for this study was a fluid and ongoing process that spanned the duration of the research as new policy, reports, critical reviews, empirical evidence and insights were published. It involved frequent searches on a wide variety of topics including consumerism, consumer behaviour, commodification, customer service, marketing and choice. The initial literature search was

undertaken between 2011 and 2012 to identify the theoretical basis of the study from healthcare policy documents dating back to the Royal Commission on the Poor Laws and Relief of Distress (1909). This included primary material sourced from Government and other archives as well as secondary policy analysis and critical reviews (updated annually). This provided the basis for an exploration of why a comprehensive system of healthcare was considered necessary and how it was brought into being. It also examined the factors that affected the development of the NHS following 1948, paying particular attention to the market-based reforms enacted by the Conservative, New Labour and Coalition Governments of the last thirty years. However, since this policy analysis was extremely lengthy and frequently descriptive in terms of the historical context, it was eventually summarised and incorporated into the current chapter 2.

The next stage of the literature search process was to identify and critique the theory associated with consumer culture, commodification and, more specifically, how this related to healthcare. It was informed and directed by the primary and secondary research questions although formulating the search terms was complicated by the fact that words such as 'service user' and 'care' are highly generic and likely to generate an unmanageable number of results. Consequently, the terms 'consumer' and/or 'customer' were preferred (combined with a variety of secondary terms) in order to maximise the chances of identifying and locating the most relevant information. Appendix 1 outlines some of search terms (and Boolean operators) applied when using the Cumulative Index to Nursing and Allied Health (CINAHL) database and records the results for each combination. When returns numbered in excess of a hundred the search was refined using others terms or filtered by 'most recent' or 'UK entries'. Other databases used to search for literature included: Applied Social Sciences Index and Abstracts (ASSIA), BMJ Journals, British Nursing Index, Internurse, Journal Storage (JSTOR), Medline and PubMed. In order to track and organise the large number of results generated by these database searches it was necessary to employ a system to collate and structure the potential resources. Consequently, a modified version of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow-diagram was used to assist with

identification, screening, eligibility and inclusion criteria (Moher et al, 2009). Although this tool was originally designed to record the flow of information through the different phases of a systematic review or meta-analysis, in its modified format it was of great value for managing and tracking different types of evidence.

Complementary searches for grey literature were also conducted using Canterbury Christ Church University library search and institutional repository, Google, GOV.UK (publications), BBC News and independent archives and databases (e.g. The King's Fund). These searches were often informed by literature identified from previous searches. It is important to reiterate, therefore, that the literature search was constantly updated and revised as the research developed and emerging themes became apparent. This led to the creation of new search terms (e.g. 'healthcare AND marketisation') as the project progressed and evolved. New literature and evidence was identified and incorporated into the thesis as late as the summer of 2016 in order to inform the discussion and conclusions. All eligible empirical evidence was critiqued using an evaluation tool/framework for qualitative and quantitative research (Letts et al, 2007).

Chapter 2: Consumerism and consumer behaviour in healthcare and society

2.1 Introduction

The aim of this chapter is to outline how consumer culture and society influence notions of convenience and choice in healthcare, to provide historical and social context for the introduction of market reforms to the NHS, and to explore how service users engage with healthcare when making choices. This will help to identify the factors that encourage individual and collective consumer behaviour in healthcare and to what extent service users participate/wish to participate in healthcare decision making. Consequently, in the first part of this chapter (2.2-2.9) I will explore what is meant by the term consumption and how consumer culture and society have transformed the relationship between the citizen and the state. In the next sections (2.10-2.14) I discuss healthcare reforms that have contributed to current NHS objectives and philosophy. This does not provide exhaustive analysis regarding consumerism and healthcare but explores key policy developments that have informed and contributed to increased marketisation of the NHS over the last thirty years or so. This sets the scene for the following sections (2.15-2.19) which examine the types of choice that healthcare consumers can make and how consumer choice and voice have been presented as a mechanism for reforming and improving healthcare services.

The penultimate sections (2.20-2.24) include discussion of service user participation in the production and delivery of care and how this may or may not contribute to consumer empowerment. They also explore whether choice and competition encourage equity and equality of service provision for all. Finally, in sections (2.25-2.29) I examine whether healthcare service users want greater choice and, if so, what types of choices are they making. I will also discuss whether healthcare marketisation and customer service models of care provision are changing the relationship between service user and providers. This provides valuable context for the following chapters and helps to clarify the impact policy and social changes have had on the delivery of

healthcare and how this affects service provision from the point of view of service users and providers.

2.2 Consumption and commodification

In order to understand how consumption has become such a ubiquitous and influential ideology it is necessary to explore and evaluate the complex relationships that have led us to characterise our society as a consumer society. In its simplest form, consumption refers to the process of consuming, eating or using-up. This may be an item that is freely available or it may refer to goods and services that can be purchased or exchanged for other goods and services (e.g. a commodity). However, the transformation of almost everything into a commodity is a phenomenon that has become increasingly widespread in contemporary society (Edwards, 2000). Goods and services that previously had not been considered commercial or profitable have become progressively more marketable (e.g. domestic waste as recycling, knowledge as intellectual property). The cultural sociologist Peter Corrigan (1997) notes that even the physicality of the human body 'has become a machine to be kept in good working order, so that the body as appearance can be maintained as a marketable commodity' (p.147-8). The tradable value of a commodity is determined and influenced by a variety of concrete and socially-determined factors including intrinsic value, utility, resale value, desirability and taste. The difference between a commodity from one producer, and the same commodity from another producer, may be very small. Electricity, for example, is essentially the same product regardless of the producer. Electronic goods, on the other hand, may vary considerably in terms of quality, reliability and the intrinsic value of the components depending on the producer/manufacturer. Karl Marx (1887) commented that:

"A commodity is, in the first place, an object outside us, a thing that by its properties satisfies human wants of some sort or another. The nature of such wants, whether, for instance, they spring from the stomach or from fancy, makes no difference" (p.43).

For Marx, the consumption of commodities was understood more in terms of the development of 'commodity production' but he was also aware of the growth of new commodities being produced and consumed (Paterson, 2006). He believed that as the labour process was deconstructed and divided into separate tasks, workers became increasingly disconnected or 'alienated' from the products they made (Billig, 1999; Edwards, 2000). Marx argued that the usefulness (or 'use-value') of the product became increasingly subordinated to its monetary or exchange value once it had been removed from its place of production and sent to market. He described this process as 'commodity fetishism' since, just as religious fetish-objects are imbued with inherent or supernatural powers, commodities are attributed monetary value and status not necessarily present at the point of production (Marx, 1887). Rather than satisfying our needs, Marx proposed that the continual desire to possess commodities creates an illusion that consumption is the way to happiness when, in reality, we simply want more (Paterson, 2006; Evans et al, 2009). As Galbraith (1998) puts it: 'the more wants that are satisfied, the more new ones are born' (p.126). The term consumption also elicits a number of negative connotations, therefore, including greed, wastage and exhaustion of resources. According to Campbell (2004) the process of 'wanting' or 'desiring' (p.28) is at the heart of modern consumerism and our ability to repeatedly experience these emotions underpins the economies of contemporary developed societies. As a social and economic activity, consumerism encourages the consumption of goods and services in ever greater quantities in order to fulfil individual and collective needs or wants. The increasing centrality of consumption to people's lives marks the transformation of 'consumption to consumerism' (Bauman, 2007, p.26).

2.3 Conspicuous consumption

Later social theorists developed and expanded Marx's views on the objectification and commodification of human experience (Edwards, 2000). However, it was the nineteenth-century sociologist and economist Thorstein Veblen, who first described the idea of 'conspicuous consumption' as a means of establishing and maintaining social status. Veblen (1899) believed that

social position and reputation were directly proportional to the possession of wealth. He argued that:

“When accumulated goods have...become the accepted badge of efficiency, the possession of wealth presently assumes the character of an independent and definitive basis of esteem...The possession of wealth, which was at the outset valued simply as an evidence of efficiency, becomes, in popular apprehension, itself a meritorious act. Wealth is now itself intrinsically honourable and confers honour on its possessor” (p.29).

Veblen proposed that there were two ways to demonstrate individual status and monetary strength: conspicuous leisure and conspicuous consumption (Corrigan, 1997). The commonality between the two is the ‘element of waste’ (Veblen, 1899, p.85). In the case of the former, it is the act of wasting time; for the latter, the waste of goods. The ability to engage in wasteful activity is dependent upon the evolution of a leisure class whose members are not required to work since they had appropriated a surplus produced by those who do (Trigg, 2001). However, Veblen (1899) points out that conspicuous consumption is not simply confined to a wealthy elite since each social-strata attempts to emulate (in a limited fashion at least) the consumer behaviour of the strata above. He writes:

“No class of society, not even the most abjectly poor, forgoes all customary conspicuous consumption. Very much of squalor and discomfort will be endured before the last trinket or the last pretence of pecuniary decency is put away” (p.86).

Veblen’s theory suggests that consumption practices are not explained solely in terms of utility or practicality but rather in terms of their symbolic activity (Edwards, 2000). Emphasis is placed not on what is purchased but on the meanings associated with the purchased goods (McCracken, 1986, 1990). Consumption patterns become indicative of social position, and goods are frequently replaced not because they are obsolete or damaged but because the consumer wishes to signal that they are *able* to replace them with something new.

2.4 Consumer society

Consumer related activities such as the production, storage, distribution and sale (or exchange) of objects for consumption have provided the necessary 'raw materials' for personal, social and cultural development throughout human history (Bauman, 2007). Despite the fact that consumption activities can be identified in all human cultures, it is only since the beginning of the twentieth-century that consumption on a truly mass scale has begun to appear as 'a foundational, rather than epiphenomenal characteristic of society' (Corrigan, 1997, p.1). According to Trentmann (2006):

"All societies have been engaged in consumption and have purchased, exchanged, gifted or have used objects and services, but it has only been in specific contexts in the nineteenth and twentieth centuries that some (not all) practices of consumption have been connected to a sense of being a 'consumer' as an identity" (p.2).

The onset of industrialisation and the concentration of large numbers of people into urban centres both contributed to the emergence of consumer society and consumer identity (Miles, 1998).

Horkeimer and Adorno (1973)² refer to the idea of 'mass society' in which the urban population is increasingly exposed to an abundance of consumer goods. Veblen (1899) had already identified that:

"Conspicuous consumption claims a relatively larger portion of the income of the urban than of the rural population, and the claim is also more imperative. The result is that, in order to keep up a decent appearance, the former habitually live hand-to-mouth to a greater extent than the latter" (p.87).

However, it was not until Henry Ford introduced the assembly-line system for automobile construction in 1913 that goods could be inexpensively produced in sufficient quantities to be available to a truly mass market. Ford offered a compromise in which workers undertook repetitive and mechanistic tasks in return for stable, well-paid employment (Miles, 1998). He understood that

² First published in 1944 as *Dialektik der Aufklärung*.

the key to ensuring a mass market for his product was to stimulate working-class purchasing power and observed that 'if you cut wages, you just cut the number of your customers' (cited in Barnett and Cavanagh, 1994, p.260-1).

Another factor that was crucial to the success of Fordism was generous Government investment in infrastructure (and other large-scale projects) which helped to ensure widespread employment and prosperity. This economic philosophy was championed by the British Economist John Maynard Keynes who argued that, in order to encourage the growth of capitalism and moderate cycles of boom and bust economic activity, Governments and central banks must actively intervene to increase employment. Put simply: employment encouraged consumption and consumption promoted employment. Fordism, therefore, embraced both production and consumption and signalled the transformation of consumerism from an elite to a mass activity in advanced capitalist societies (Gabriel and Lang, 2006). In contrast to Veblen's idea of 'trickle down' consumption from one social hierarchy to the next, the pioneers of consumer behaviour could now be found at the bottom of the traditional social pyramid (Trigg, 2001). However, in order for this economic model to succeed, two factors or prerequisites were necessary. Financial security must be sustained through continued employment, and the working population must be exposed to a constant supply of new needs and wants that could only be satisfied in commodity form (Slater, 1997; Gabriel and Lang, 2006). Hochschild (2003) warns that this self-perpetuating cycle of consumer activity has the potential to cause 'collateral damage' to social and familial relationships. He argues that:

"Consumerism acts to maintain the emotional reversal of work and family...workers are persuaded to 'need' more things. To buy what they now need, they need money. To earn money, they work longer hours. Being away from home for so many hours, they make up for their absence with gifts that cost money. They materialize love. And so the cycle continues" (p.209).

Today, the term 'consumer society' indicates a society in which competitive markets ensure that producers remain sensitive to consumer preference and provide a mass of consumer goods and services that are readily available to choose or reject (Shaw, 2009). The Labour Party Home Secretary, David Blunkett, drew attention to the fact that Britain had transformed into a consumer society in the forward to a 2003 police policy document:

"No institution, be it private business, voluntary association or public service, can be immune to the changes in British society. The pace and scope of change - to the way we work, to our family life, and to how we live - present a huge range of challenges for public services. Added to these demographic and technological changes is a rise in people's expectations and aspirations for their services" (Home Office, 2003).

2.5 Consumer culture

According to Miles (1998) consumerism did not become a way of life for the majority of the population of the developed world until after the end the Second World War. He argues that:

"Encouraged...by the rise of advertising, a whole new world of consumerism was on offer to the working majority...What was emerging was not merely a consumer society, but a consumer culture" (p.9).

From an early age, we begin to acquire knowledge, values, beliefs and customs from our social environment that help us to interpret experiences and behave in a manner that is acceptable to other members of our culture. Cultural values include shared beliefs about how people should behave in certain circumstances, common understanding of what is right or wrong, and collective recognition of desirable life goals and aspirations (Arnould et al, 2004). These principles provide a framework which enable members of that culture to understand and interpret the wide variety of experiences they encounter on a day-to-day basis. However, these cultural norms are themselves influenced by a number of other factors and variables including: nationality, geography, ethnicity,

age, gender, personality-type, social-status, political, religious and sexual orientation. This results in the creation of sub-cultures, whose members possess beliefs and values that set them apart from other members of the same society. However, even when their beliefs are not entirely in agreement with some of the normative values of their culture, they are usually able to synthesize and extract aspects valuable to them and adhere to most of the dominant cultural beliefs and behavioural patterns of the society as a whole (Schiffman et al, 2012). Consumer culture refers to the totality of these learned values and beliefs and how they help to direct the consumer behaviour of members of a particular society or group. According to Arnould et al (2004) consumer culture is the:

“Social arrangement in which the relations between lived culture and social resources, between meaningful ways of life and the symbolic and material resources on which they depend, are mediated through markets (p.605).

Consumer culture also refers to the tendency for more-and-more aspects of human life to be made available through market mechanisms including services that were previously provided by the state such as housing, health and education (Lury, 2011). No matter what our nationality, gender, age, or socio-economic status, we are united by the common characteristic that, in order to live, we must consume in one way or another. Moreover, the consumption decisions that we make (whether it is food, clothing, housing, education, necessities, luxuries or ideas) effect the demand for raw materials, transport, production, manpower and finance at a local, national and global level (Schiffman et al, 2012). Consumer culture encourages a recurring cycle of acquisition, use and disposal since commodities can only satisfy for a limited period of time in order to avoid economic stagnation (Slater, 1997).

2.6 Cultural homogenisation

Another factor that has encouraged global consumer commonality and convergence is the increasing sophistication of communication technology (Levitt, 1983). According to Solomon et al (2013) the importance of the digital revolution on consumer behaviour cannot be overstated and will continue

to expand as more-and-more people around the world are connected to the Web. They also highlight how the internet has evolved to incorporate user-generated content where everyday people voice their opinions about products, brands, companies etc using social networking platforms such as Facebook and Twitter (Ibid). This important development (known as Web 2.0) marks the transformation of the internet from static, one-way communication between producers and consumers, to a more interactive and co-operative means of communication. Levitt (1983) also argues that people's needs and desires have become progressively 'homogenised' and that the world is increasingly viewed as one big marketplace. The term 'McDonaldization' is often used to conceptualise the spread of homogenised culture and predictability across the globe (Ritzer, 1993; Nederveen Pieterse, 2009). According to Ritzer (1993, p.3) McDonaldization is 'the process by which the principles of the fast-food restaurant are coming to dominate more and more sectors of American society as well as the rest of the world'.

An increasingly pervasive feature of homogenised culture (in the developed world at least) is the introduction of self-service check-ins/outs at airports, health centres, supermarkets, libraries etc. They are intended to reduce time and increase efficiency for consumers but they also require the consumer to undertake unpaid work on behalf of the service provider. Koeber (2011, p.205) terms this type of activity 'consumptive labour' since the work-like tasks consumers perform (whilst at the same time consuming) constitutes an important part of production. Koeber et al (2012, p.21) argue that many people 'prefer a McDonalized form of self-service' and consent to 'participate in a form of consumptive labour...in the manner of a quasi-employee because they believe that in doing so they are rewarded by a self-beneficial McDonalized form of consumption'. In general terms, therefore, consumer culture emphasises the value of individuality and privacy rather than collectivity, collaboration and the public.

2.7 Globalisation and the rise of neoliberalism

At the heart of the changes to the global economy is the decentralisation of labour processes, contracting-out of services, the growth of computer-based industries, greater emphasis on choice and the targeting of consumers by lifestyle, taste and culture (Hall, 1988). The increasing sophistication of mass-communication and advertising has provided a means to capture the attention of millions of potential customers, and to shape their thoughts and actions, in a way that has not been possible before (Gabriel and Lang, 2006). The rapid movement of money, information, media and people, all ensure that consumers have become - and remain - globally interconnected (Arnould et al, 2004). According to Sonderegger and Gabriëls (2012) globalisation has provided an enormous boost to consumerism and, since 1950, worldwide private consumption expenditure has increased six times. It is important to emphasise, however, that consumption patterns and consumer behaviour are not simply the result of demographic, technological and economic factors. Since the 1980's, consumerism and consumer-choice have increasingly been depicted as the driving-force behind personal and political freedoms. Miles (1998) remarks that consumerism has provided an apparently democratic value-structure that political parties from both ends of the spectrum have been able to exploit for their own political ends.

The idea of promoting consumer choice as a means to secure personal self-determination finds its fullest expression in the political-economic theory of neoliberalism first expounded in the UK in the late 1970's and early 1980's (Arestis and Sawyer, 2005; Palley, 2005; Bevir and Trentmann, 2007). Neoliberalism proposes that individual well-being is best advanced by liberating entrepreneurial freedoms and skills within an institutional framework, characterized by strong private property rights, free markets, and free trade (Harvey, 2005). It is also associated with maximised competition and a radically free market, achieved through economic deregulation and a range of monetary and social policies favourable to business (Brown, 2006). This approach is diametrically opposed to the Keynesian view that growth and prosperity are cultivated and advanced by strong Government and

the protection afforded by the welfare state. Margaret Thatcher (and other proponents of the New Right) rejected the idea of 'community' and replaced it with the concept of 'individual responsibility' whereby individuals were encouraged to find solutions to their own problems or needs. In an interview with Douglas Keay, she famously commented that:

"There is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first. It's our duty to look after ourselves and then, also to look after our neighbour. People have got the entitlements too much in mind, without the obligations, because there is no such thing as an entitlement unless someone has first met an obligation" (Thatcher, 1987).

The welfare state, originally conceived by Beveridge as a means to protect the most vulnerable in society, was now judged to foster dependence, inhibit self-reliance and de-incentivise social mobility. Supporters of neoliberal policy championed behavioural explanations of poverty and unemployment, and Thatcherism drew clear distinctions between the taxpayer, the consumer and the scrounger (Clarke et al, 2007; Wiggan, 2012). In order to liberate the market and create prosperity, neoliberalism advocated greater competition, increased accountability, economic deregulation and privatisation (Edwards, 2000). The private sector was considered to be more effective and efficient than the public sector in supplying individual needs and services to a high standard. For neoliberalism, the efficient allocation of resources was the most important purpose of an economic system, and the most efficient way to allocate resources was through market mechanisms (Munck, 2005). This included public sector services where increased emphasis on individual choice and public accountability led to the gradual transformation of service users from passive recipients to active customers and welfare-consumers (Beresford, 2009). Pollitt (1987) observed at the time:

“Consumerism has become an officially approved fashion. In hospitals, schools, housing schemes...and many other aspects of public administration managers are being exhorted to pay more attention to consumer wishes, offer consumers wider choice, and develop techniques for ‘marketing’ their particular service” (p.43).

2.8 The third-way and beyond

In the UK, neoliberalism entered a second phase during the 1990's with the 'third-way' politics of New Labour (Arestis and Sawyer, 2005; Hall, 2010). The third-way approach to public policy encompassed the state working in 'partnership' with the private and voluntary sectors in order to find new forms of public intervention in the economy and society (Driver and Martell, 2000). However, whilst the third-way was presented as neoliberalism 'with a human face' it remained committed to a managerial and consumer approach to healthcare reform and continued to emphasise a strong role for the market and private sector (Saad-Filho and Johnston, 2005). In terms of public service reform, the third-way positioned the Government as mediator in the relationship between the public and public services, acting on behalf of service-users when confronted by inflexible or incompetent service-providers (Clarke et al, 2007). It accepted the dominance of the market in economic life but also acknowledged a role for Government in the correction of 'market failure' (Arestis and Sawyer, 2005). The third-way was above all a pragmatic approach to public service reform and the White Paper *The New NHS, Modern, Dependable* (DH, 1997) sums up the prevailing philosophy of the day with the phrase: 'what counts is what works' (p.10). New Labour continued the reforms started by the Conservatives and introduced a system of 'new public management' which involved a combination of centralised control over the 'targets' that public agencies were required to achieve, audit and inspection regimes which would monitor compliance, and the introduction of internal markets to encourage a more business-like approach (Rustin, 2010). In 2002, the Office of Public Services Reform stated:

“The challenges and demands on today’s public services are very different from those post-war years. The rationing culture which survived after the war, in treating everyone the same, often overlooked individuals’ different needs and aspirations...Rising living standards, a more diverse society and a steadily stronger consumer culture have...brought expectations of greater choice, responsiveness, accessibility and flexibility” (p.8).

According to Clarke et al (2007), by 2004-5 choice emerged as both the defining feature of the consumer experience and the ‘lever’ for reforming stubborn public services. However, the global financial crisis that followed the collapse of the US sub-prime mortgage industry in 2008 plunged economies around the world into recession and the UK entered a period of profound financial uncertainty (Taylor, 2009). New Labour were defeated in the 2010 general election and the Conservative-Liberal Coalition Government that emerged shortly after, sought to embed an even stronger neoliberal approach to social policy (Grimshaw and Rubery, 2012). According to Wiggan (2012) the intensification of economic rationality in welfare under the Coalition Government served to:

“Reinforce messages of personal responsibility, self-motivation and the superiority of market rationality, which are presented as an economic and moral imperative if growth in the British economy is to be restored...and a broken society fixed” (p.384-5).

The promotion of choice as a defining value of contemporary society, and as an important mechanism for social amelioration, was presented as vindication for the increased role of the private sector in state institutions such as health and education and their continued assimilation into the competitive world of the consumer marketplace (Edwards, 2000).

2.9 The citizen consumer

According to Clarke et al (2007) the concept of citizenship is one of shared responsibility that embodies the democratic principles of social, political and legal equality. It is outward looking,

embraces the public interest and provides a sense of commonality and social cohesion (Harrison, 2005). The citizen embodies what Esping-Anderson (1990) describes as the 'decommodification' of public rights, goods and relationships. He argues that:

"Decommodification occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market" (p.21-22).

Messner and Rosenfeld (1997) also stress the relationship between social rights and citizenship and claim that decommodification refers 'to the empowerment of the citizenry against the forces of the market' (p.1394). Consumerism, on the other hand, represents the individual rather than the collective, and the private rather than the public or the state (Scammell, 2003; Newman and Vidler, 2006). The consumer chooses how to further their own interests, possibly at the expense of other consumers, through the mechanism of the marketplace. They still enjoy freedom and equality but in a very different way to the citizen. Freedom, for the consumer, refers to what MacPherson (1962) terms 'possessive individualism' whereby the individual is conceived as the sole proprietor of his or her skills and owes nothing to society for them. Equality alludes to the fact that, providing they have the necessary capital, consumers are 'free to choose' and engage with the market on an equal basis (Clarke et al, 2007, p.3). Seemingly then, the concepts of citizenship and consumerism are mutually exclusive since the former involves a sense of shared rights, entitlements and obligations to society as a whole, whereas the latter promotes a system of individualism, self-determination, privacy and commodification.

However, this is perhaps an oversimplification and Powell and Greener (2009) point out that health and social care consumer groups frequently lobby on behalf of their members providing them with 'a citizen role as much as a consumer role' (p.101). The line between the two has certainly become increasingly blurred as successive Governments have encouraged a consumer society in which freedom is expressed through market determination. The neoliberalism of Margaret Thatcher and her successors has had a profound influence on the relationship between the state and individual

and has entailed what Harvey (2005) describes as ‘much creative destruction’ (p.3) of prior institutional frameworks, social relations and welfare provision. According to Bauman (2007) consumer values undermine social cohesion by ensuring that the consequences of choices and actions rest fully on the shoulders of the individual. He argues that consumption has replaced production as the basis of moral worth and individualised choice has become the most important indicator of value. He writes:

“Contemporary society engages its members primarily as consumers, only secondarily, and partly, does it engage them as producers...First and foremost, the poor of today are ‘non-consumers’, not ‘unemployed’: they are defined in the first place through being flawed consumers” (1998, p.90).

The shift from citizen to consumer, individualises relationships to collective services and depoliticises choice by subjecting the collective ethos of the public domain to the conventions and rules of the marketplace (Needham, 1983). It becomes increasingly difficult, therefore, to separate the economic from the political environment since one is often the manifestation of the other (Evans et al, 1996). Citizens are encouraged to adopt ‘a consumer mentality’ when engaging with Government and urged to evaluate state-services ‘like any other purchased goods, by the personal benefit they derive from them’ (Cohen, 2001, p.220). The assumption underpinning the image of the service user as ‘discriminating customer’ is that people have ‘become used to flexible, responsive, user-centred services delivered in the market place and want...the same when it...[comes]...to the NHS’ and other public services (Clarke et al, 2007, p.54). Health Secretary, Alan Milburn, drew attention to changing attitudes and expectations to welfare provision in a speech at a social services conference in 2002:

“Thirty years ago the one size fits all approach of the 1940’s was still in the ascendant...The public were supposed to be truly grateful for what they were about to receive. People had little say and precious little choice. We live in a consumer age. People demand services tailor

made to their individual needs. Ours is the informed and inquiring society. People expect choice and demand quality”.

To summarise this section, whilst all societies have engaged in the consumption of goods and services to a greater or lesser extent, it is only in the 19th, 20th and 21st centuries that consumption practices have become associated with the idea of being a ‘consumer’ as an identity. Today, the term ‘consumer society’ indicates a society in which competitive markets ensure that producers remain sensitive to consumer preference and provide a mass of consumer goods and services that are available to choose or reject. ‘Consumer culture’ refers to how learned values and beliefs help to direct consumer behaviour as well as the tendency for more-and-more aspects of human life to be made available through market mechanisms. The idea of promoting consumer choice as a means to secure personal self-determination finds its fullest expression in the political-economic theory of neoliberalism first expounded in the UK (and elsewhere) in the late 1970’s and early 1980’s. Neoliberalism advocates greater competition, increased accountability, economic deregulation and privatisation in order to encourage free trade and create individual prosperity. This includes services that were previously provided by the state such as education and healthcare, and those who support a neoliberal approach, argue that increased emphasis on individual choice and public accountability helps to transform welfare service users from passive recipients to active customers and consumers. In general terms, consumer culture emphasises the values of individuality and privacy rather than the collective, public or the state. Consequently, citizens are increasingly encouraged to adopt a consumer mentality when engaging with public services and urged to evaluate them like any other purchased goods or services. In the next part of this chapter (2.10-2.14) I will provide concise explanation of how the NHS came into existence in 1948 and highlight the conflicts, dilemmas and attempted solutions that foreshadow many recent policy initiatives - particularly in relation to funding and efficiency. This builds on the previous section and demonstrates how consumer society and culture have encouraged many healthcare policy decisions that have contributed to the

increasing marketisation of the NHS. This will also help to inform the following sections (2.15-2.19, 2.20-2.24) which explore the complexity of choice and consumer empowerment in healthcare.

2.10 Born from adversity: the advent of the NHS

The NHS was established on the 5th July 1948 and marked the conclusion of a series of events and reforms that had been gathering momentum for a number of decades (Sturgeon, 2013). Prior to 1948, health service provision had been poorly coordinated and standards of care were highly variable from region-to-region. From the point of view of the service user, therefore, the quality of their hospital, and the standard of treatment provided, was largely dependent on geographical location and socio-economic status. Mold (2015) suggests that:

“It could be said that patients operated as consumers in the medical marketplace that predated the establishment of the NHS...using the ‘power of the purse’...[to] pick and choose from an array of practitioners” (p.1286).

From July 1948, the NHS promised to provide standardised healthcare to all citizens equally on the basis of medical need and not the ability to pay. It is estimated that in July 1948 about 75% of the population had registered with the NHS and within five years only 1.5% remained outside the service (Gray and Cartwright, 1953). However, the most pressing concern for the NHS at this time was spiralling expenditure in relation to demand for services. The Beveridge Report of 1942, like the Minority Report (of the Royal Commission on the Poor Laws and Relief of Distress) and Dawson Report before it, had predicted that the creation of a National Health Service would increase overall levels of health and fitness which would lead to an increase in national prosperity as levels of sickness declined (Timmins, 1995). In actual fact, health service expenditure in the years following 1948 was much greater than parliamentary estimates had anticipated and supplementary funding was necessary almost immediately (Ham, 2009). As Webster (2002) points out, short-term action to provide false teeth etc on a large scale was merely the first step towards a hugely expensive long-term programme of modernisation that would stretch NHS resources beyond expectation.

2.11 The genesis of the patient consumer

The birth of the NHS coincided with the advent of more sophisticated methods of diagnosis and treatment. Hardy (2001) comments that the second half of the twentieth century was a period in which medicine appeared to achieve astonishing victories over infectious disease and many other pathological conditions. New and more sophisticated methods of diagnosis changed the way disease and illness were viewed but also increased overall cost as healthcare professionals used every technique at their disposal to ensure the best care was available to all (Watkin, 1978). The ever-accelerating pace of these developments required the creation of a much larger and more skilled workforce as well as significant increases in funding (Webster, 2002). As writer and physician Ffrangcon Roberts remarked in 1952, the NHS is faced with 'the paradox of unlimited progress towards an unattainable goal' (p.200). Politicians and policy makers were forced to consider how the NHS could be made more efficient and cost-effective without withdrawing services. In 1961, the Economist Dennis Lees published *Health Through Choice* in which he argued that there was fundamentally no difference between medical care and any other consumer goods (Lees, 1961). Lees argued that 'consumer choice' would help to make the NHS more efficient and rid it of its fundamental weaknesses, 'the dominance of political decisions, the absence of built-in forces making for improvement and the removal of the test of the market' (Lees cited in George and Miller, 1994, p.8). His vision of a system that actively encouraged competition and consumer choice was not popular at the time but it was not entirely without support. The same year, Geoffrey Howe, future Conservative Deputy Prime Minister, argued that the state must 'strive for a large reduction... [in]...public services' (1961, p.61). He also proposed that people should be allowed to 'contract out' of the health service and increasingly encouraged to provide for themselves and their families.

Another important consumer development that occurred around this time was the establishment of Consumer Association in 1956 and the Patients Association in 1962 to promote a greater role for patients when accessing care and treatment. Furthermore, two hundred Community Health Councils

(CHCs) were established following the 1972 *National Health Service Reorganisation Act* 'to represent the views of the consumer' and to identify 'potential causes of local complaint' (Department of Health and Social Security, 1972, para. 107, 109). CHCs could act on behalf of the medical profession - drawing attention to failings in the service and supporting their demands for resources - and they could act against it if they believed the needs of the service user were not being met. According to Mold (2015) the creation of CHCs marked the beginning of the 'voice of the consumer' (p.1286) in relation to healthcare services.

2.12 Change of culture

In 1979 Margaret Thatcher was elected Conservative Prime Minister and from the outset maintained that the public and private sectors were in direct competition (Backhouse and Middleton, 2000). Public services were seen as a drain on the political and economic strength of the country and the reversal of post-war welfare expansionism was considered a key element in reducing reliance on the state (George and Miller, 1994). The Conservatives' plans for the health service were first outlined in the consultative paper *Patients First* (DHSS, 1979) that sought to position patients/service users at the centre of the NHS and expressed concerns that previous organisational reforms had not provided the 'best framework for the effective delivery of care to patients' (para.1). Health Authorities were also required to put catering, cleaning and laundry services out to tender with the result that in-house workers were forced to compete with private contractors for their jobs (Powell, 1997). The Conservatives also established an Internal Management Review chaired by Roy Griffiths, managing director of Sainsbury's (DH, 1983). The central theme of the report was the need for the introduction of general management at all levels in the NHS and Griffiths stated that:

"Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question" (para.2).

This emphasis on delivering a product to the patient-customer was to determine much of the health care policy agenda over the coming decades and Edwards (1993) remarks that:

“There is little doubt that without the development of general management it would have been difficult, if not impossible, to deliver the later reforms” (p.122-3).

Citizens were gradually reinvented as ‘consumers’, a development which shifted emphasis away from the duty of the state to provide universal coverage and reinforced the rights of the individual to make choices about the services that they used (Mold, 2011). The Conservatives also embraced the idea, proposed by US academic Alain Enthoven (1985) that NHS hospitals should compete for resources in an internal market in order to increase efficiency and drive up standards. The parliamentary journalist John Warden (1987) predicted at the time that, if the Conservatives won a third term in office, their motto would be ‘the customer comes first’ (p.1240). However, it would not just be the Conservative Government of Margaret Thatcher that supported the introduction of market principles to the NHS and, in the interest of brevity, the main policy developments introduced by all political parties between 1979 and 2014 are summarised (with brief explanation) in Table 1 below.

2.13 Reconstructing consumer-orientated healthcare

According to Professor John Spiers (2003) the Government attempted to abolish the individual healthcare consumer in 1948 when it created the NHS. Webster (1990) remarks that health policy development between 1918 and 1948 involved ‘a gradual erosion of market-related mechanisms and a transition to forms of health care less related to the market and consequently more universal and comprehensive in their provision, and more redistributive in their effects’ (p.150). He also notes that many of the benefits of increased state intervention which occurred following the creation of the NHS have subsequently been eroded by the on-going drive to impose the laws of the marketplace onto the NHS. Consecutive Governments (from the 1980’s) have implemented an increasingly competitive and pro-market model of healthcare service provision in order to address

Table 1

Title of policy document	Year of publication	Principle focus of policy
Conservative: Margaret Thatcher		
Patients first: consultative paper on the structure and management of the National Health Service in England and Wales	1979 (DHSS)	Delegation of responsibility to hospital and community service managers to ensure decision-making was closer to the patient. Simplification and decentralisation of organisational tiers to reduce bureaucracy.
NHS management inquiry: report to the secretary of state for social services (Griffiths report)	1983 (DH)	The introduction of general management at all levels in the NHS. Establishment of an NHS management board (with members drawn from the NHS, business and civil service) which would maintain overall responsibility for strategic decisions, budget and resource allocation.
Working for patients	1989 (DH)	The introduction of managed competition (internal market) through the separation of healthcare purchasing from its provision. GPs were offered the option to become fund-holders, free to purchase most services on behalf of their patients from public or independent sector suppliers. This created the necessary structures for the introduction of greater competition and choice.
Conservative: John Major		
Patients Charter	1991 (DH)	Defines, in consumer terms, the rights and standards to which the public are entitled regarding the delivery of healthcare services. Also provides the basis for the development of performance tables showing how NHS Trusts compared in areas such as waiting times and cancelled operations.
The health of the nation: a consultative document for health in England	1992 (DH)	Set out a range of targets to improve health in five key areas: coronary heart disease and stroke, cancer, mental health, HIV/AIDS and sexual health. Characterised a clear shift of emphasis from curative to preventative care and placed increasing responsibility on the individual to make healthy lifestyle choices.
The National Health Service: a service with ambitions	1996 (DH)	Restated the Conservative's commitment to the founding principles of the NHS and outlined a future in which priority would be given not to the internal market but to information technology, professional development and managing for quality.

Table 1

Title of policy document	Year of publication	Principle focus of policy
New Labour: Tony Blair		
The new NHS, modern, dependable	1997 (DH)	Stated that there would be a 'third way' of running the NHS - 'a system of partnership...driven by performance' that would build on 'what has worked but discard what has failed' (p.10). It proposed that cooperation would replace competition and that the internal market would be replaced by a system of 'integrated care based on partnership' (p.5).
A first class service: quality in the new NHS	1998 (DH)	Promised a new hospital building programme and the introduction of the 24-hour telephone advice service NHS Direct. Standards of care would continue to be monitored by a national framework for assessing performance and an annual national survey of patient experience. It pledged that since 'each patient is different...treatment must be tailor-made to their specific needs' (p.7).
Saving lives: our healthier nation	1999a (DH)	Outlined plans to promote public health and extend life expectancy. Identified the role of the 'expert patient' (p.3). Promised to provide an additional £21 billion of funding in keeping with the recommendations of the Comprehensive Spending Review completed in July 1998.
Patient and public involvement in the new NHS	1999b (DH)	Advocated a closer working relationship with patients, carers and local communities in order to make services more responsive to the needs of both individuals and local communities.
The NHS plan: a plan for investment, a plan for reform	2000 (DH)	Openly acknowledged the role of the private sector and proposed that Community Health Councils (CHCs) should be replaced by a new Patient Advocate and Liaison Service (PALS). Included a commitment to provide patients with new powers and more influence over the way the NHS works in a 'consumer age' (p.26).
Shifting the balance of power in the NHS - securing delivery	2001a (DH)	Proposed devolving power and budgetary control away from central government towards frontline staff, communities and service users. Established Primary Care Trusts (PCT) to take control of over 75% of the NHS budget (by 2004).
The expert patient: a new approach to chronic disease management for the 21st century	2001b (DH)	Encouraged patients and carers to use their knowledge and experience of chronic conditions to take greater control and responsibility for the management of their condition in partnership with health and social care providers.

Extending choice for patients	2001c (DH)	Promised that by 2005 all hospital patients should be able to opt for treatment in local NHS hospitals, NHS hospitals or diagnostic and treatment centres elsewhere, private hospitals, private diagnostic and treatment centres, or even hospitals overseas.
Delivering the NHS plan: next steps on investment, next steps on reform	2002 (DH)	Advocated greater use of private and voluntary sector providers, the implementation of payment by results and the creation of NHS Foundation Trusts. All of these themes were united by the common objective of increasing patient choice and the document stated 'these changes are all about shifting the balance of power towards patients in the NHS...Patients will be in the driving seat' (p.24).
Securing our future health: taking a long-term view final report (Wanless report)	2002 (Wanless)	Concluded that the current tax funded system was both fair and efficient. It also argued that the projected cost to the health service varied considerably according to the extent to which people became engaged with improving their own health.
Building on the best: choice, responsiveness and equity in the NHS	2003 (DH)	Confirmed New Labour's commitment to drive improvements in service provision by stimulating choice for service users and - by implication - competition between providers. It promised to place 'real power' (p.12) in the hands of all service users and reminded readers that 'today's society expects any organisation in the business of customer service to take real care over how it treats its users' (p.23).
Securing good health for the whole population (Wanless report)	2004 (Wanless)	Recommended that an NHS capable of facilitating a 'fully engaged' population would need to shift its focus from 'a national sickness service, which treats disease, to a national health service which focuses on preventing it' (p.183).
Choosing Health: Making Healthy Choices Easier	2004a (DH)	Focused on specific risk factors (smoking, obesity, sexual health and alcohol use) and the strategies that could be employed to encourage people to make healthy choices in a 'consumer society' (p.3).
The NHS improvement plan: putting people at the heart of public services	2004b (DH)	Identified the priorities for the next four years including extending choice and access to services, greater emphasis on prevention and delivering care more quickly. Outlined how 'contestability' would encourage service providers to become more responsive to patient needs and drive improvements in efficiency (p.72). This included the use of punitive measures and allowing PCTs to commission care from private sector organisations.
Creating a patient-led NHS: delivering the NHS improvement plan	2005 (DH)	Pledged that by 2008 there would be free choice of referral to any provider who met the standards and price tariffs of the NHS. Patients would also be free to research their options using the internet and book elective treatment.
Our health, our care, our say: a new direction for community services	2006 (DH)	Argued that in order to keep pace with the expectations, ambitions and opportunities of the population, the NHS would need to become increasingly flexible and responsive to the needs of the individual.

Table 1		
Title of policy document	Year of publication	Principle focus of policy
New Labour: Gordon Brown		
High quality care for all: NHS next stage review final report (Darzi report)	2008 (DH)	Proposed a formal constitution for the NHS and outlined the rights and responsibilities of patients and staff members. It also proposed the creation of over 150 new GP-led health centres to supplement existing services and provide a broader range of services to match the needs of local communities.
The handbook to the NHS constitution for England	2009a (DH)	Set out the rights and responsibilities of patients, staff members and groups providing NHS funded services.
NHS 2010-2015: from good to great. preventative, people-centred, productive	2009b (DH)	Outlined the direction the NHS would take following the collapse of the US sub-prime mortgage industry in 2007-2008 and global recession. Warned that in order to protect frontline spending, savings would have to be made 'in every part of the NHS' (p.3).

Table 1

Title of policy document	Year of publication	Principle focus of policy
Conservative and Liberal Democrat Coalition: David Cameron		
Equity and excellence: liberating the NHS	2010 (DH)	Proposed that responsibility for commissioning services would be devolved to local consortia of GP practices overseen by a new national commissioning board. Promised that choice and competition would be extended with commissioners free to buy services from ‘any willing provider’ (p.17). Pledged that patients would be more involved in decision making: ‘no decision about me without me’ (p.3). Monitor would become an economic regulator to promote competition, regulate prices and safeguard the continuity of services.
Health and social care bill	2011 (HC)	Proposed that all hospitals in England should become Foundation Trusts and that 49% of their work could be in the private sector. It also proposed that GP consortiums should have greater control over the NHS budget in order to commission healthcare on behalf of their patients. It outlined how Healthwatch would investigate complaints and scrutinise the performance of local health providers to make the NHS more accountable to patients.
Health and social care act	2012 (HC)	The act replaced PCTs with 211 Clinical Commissioning Groups (CCGs) that controlled the majority of the NHS budget (about £65 billion) and were able to commission services from an increasingly competitive marketplace. All service providers had to be registered with the Care Quality Commission (CQC) and Monitor. Monitor was also provided with additional responsibilities including a mandate to guard against anti-competitive practices. Healthwatch and Healthwatch England were to operate as local and national ‘consumer champions’ to ‘drive patient and public involvement’ (p.7).
Five year forward view	2014 (NHS England)	Outlined how the NHS needed to change over the next five years and proposed the creation of seven new care models designed to break down traditional boundaries between care providers. These included Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS). Three waves of ‘vanguard’ sites will test five of the models commencing April 2016.

the financial difficulties that have beleaguered the NHS since its inception. Choice was identified as the defining characteristic of the consumer's relationship with healthcare services and was intended to increase responsiveness and flexibility within the NHS and encourage the transformation of healthcare service users from the 'lying down patients of the past' to the 'standing up consumers of the future' (Cayton, 2003). Decades of market orientated policy have encouraged greater-and-greater customer focus and the NHS is now subject to the same consumer drivers that can be identified elsewhere in society. As the Health Secretary, Alan Milburn, remarked in a 2001 speech to the Fabian Society:

"People grow up today in a consumer society. Services - whether they are private or public - succeed or fail according to their ability to respond to modern expectations...People today exercise more choices in their lives than at any other point."

This has resulted in a system in which service users have been encouraged to become more-and-more assertive regarding their expectations of how the NHS should operate and the standard of care they receive. This will be discussed further in the next section in relation to consumerism in healthcare.

2.14 Consuming healthcare

In many ways, the NHS is the perfect consumer vehicle since, year-on-year, scientific advances in medical knowledge and technology drive the development of increasingly sophisticated treatments and interventions for an array of conditions and diseases (Sturgeon, 2014a). There is a high degree of disposal and acquisition in the service as outdated therapies and ways of working are replaced by new, more effective, options. According to Bauman (1992ab) this raises expectation amongst service users and health professionals who regard each medical breakthrough as an occasion for rejoicing and optimism that the fight against the 'causes of death' is slowly being won. However, extending life does not necessarily save the NHS money that can be diverted back into the service to help others in greater need. In the long term, the converse may be true as expenditure increases per

capita as individuals' experience greater longevity. At the same time, the NHS has a responsibility to continue to provide treatment to all that require it throughout the course of their - extending - lifespan. Political policy adviser Nick Seddon (2007) points out:

“By increasing life expectancy, the NHS created increasing numbers of the malignant and degenerative diseases that many had previously avoided by premature death, leading to browbeating about the paradox of a health service that was creating more problems for itself by doing what it was supposed to do” (p.20).

The NHS will be 70 years old in 2018 and is just beginning to see the cost of treating the first generation of NHS 'natives'. By employing consumer choice as a mechanism to drive improvements in health service provision, in a system that is continually chasing advances in medical science and is free at the point of delivery, the end result must be a consumer who can only be satisfied for a short period of time. There will always be another medical breakthrough or advance in the future, which must be developed and provided to the consumer as soon as possible. Most healthcare service users are what Beresford (2009) describes as 'involuntary consumers' (p.206) and their everyday priorities and motivations are likely to alter significantly when faced with unexpected or serious injury/illness. Their motivation will almost certainly be framed in terms of physiological or psychological need and is likely to be negative in most cases. Motivation that has a physiological basis is usually described as 'internal' since it is concerned with instinct, need, drive or emotion (Evans et al, 2009, p.10).

Individuals are compelled to avoid and remove negative stimuli and situations such as pain, illness and discomfort. 'External' motivation, on the other hand, focuses on the attractiveness and appeal of environment factors such as products and services and may eventually become internal motivation in the form of preference following instrumental or vicarious learning (p.11).

In healthcare terms, the above scenario probably relates more to which NHS service provider the 'involuntary consumer' chooses to attend. A number of factors may influence this decision including previous experience, word-of-mouth, temporal considerations, location of provider, physical

environment, quality of care and clinical credibility. In simple terms, therefore, internal motivation may be understood in this context as a 'need' (medical attention) whilst external motivation represents a 'want' (the desirability or appeal of a particular provider where choice is available). Emotional and subjective criteria (e.g. fear, pride or status) may also influence the decision to seek healthcare, or select of particular provider, depending on the severity of the illness or injury.

In summary, prior to the introduction of the NHS in 1948, the quality of healthcare provided was very much determined by individual financial status and geographical location. After 1948, the NHS promised to deliver standardised healthcare to all citizens equally on the basis of medical need rather than their ability to pay. However, health service expenditure was much greater than anticipated as scientific advances enabled the treatment of an increasing number of diseases and life expectancy was extended. In order to continue to meet service user expectation and manage cost, the Conservative Government of Margaret Thatcher introduced a series of measures designed to encourage managed competition through the separation of healthcare purchasing from its provision. This has been embraced by all subsequent UK Governments, and decades of market orientated policies have encouraged a system of healthcare provision that is subject to the same consumer drivers that can be identified elsewhere in society. Whilst this has fostered a greater degree of customer focus - that aims to place the service user at the centre of their care - it has also heightened expectation regarding the type and availability of services available. Having considered the influence of consumerism in healthcare, the following sections (2.15-2.19) will now go on to examine the complexity of choice and how consumers are conceptualised in relation to the choices that they make. It will also consider how consumer choice and voice have been presented as a mechanism for reforming and improving public and healthcare services.

2.15 Choice

Choice is often thought of as an intrinsically worthwhile activity (Le Grand, 2004, 2007; Coulter, 2010, 2011). Oliver and Evans (2005) remark that one of the underlying reasons for this belief is that

choice is closely linked to notion of individual autonomy. Consumers have witnessed a 'choice explosion' in which the range of choice in various markets has grown exponentially (Evans et al, 2009, p.34). According to Gabriel and Lang (2006) what sets modern consumption apart from earlier examples is not merely the growth of spending power across social strata but the experience of choice as a generalised social phenomenon. Bauman (2007) argues that:

"...the history of humanity is represented as a long march towards personal freedom and rationality. Its latest stage, the passage from the society of the producers and soldiers to the society of consumers, is commonly portrayed as a process of gradual...emancipation of individuals from the original conditions of 'no choice' and later 'limited choice'...The individual member of a society of consumers is defined, first and foremost, as homo eligens"
(p.61).

The very act of choosing a particular product or service can confer a sense of power and independence upon the consumer which is increasingly reinforced at a political and cultural level. It suggests the possibility that that the 'problems and dissatisfactions of the present can be remedied by more or different choice in the future' (Clarke et al, 2007, p.6). Harrison (2005) comments that just as global markets are learning how to treat consumers as citizens, it appears that political 'markets' are trying to treat citizens as consumers. Edwards (2000) argues that this sense of consumer power is as illusory as it is real and leads to a dialectic where consumers either make their own destinies or are duped into thinking they are. Typically, consumers are portrayed as either chooser (confident and independent people making decisions that influence their future) or as victim or dupe (somebody who is gullible and easily manipulated by market forces). The idea of the consumer as confident chooser embraces the notion of 'consumer sovereignty' whereby the consumer actively helps to determine the goods and services produced and offered for sale based upon collective endorsement and choice (Dixon, 1992, p.116). In other words, 'good consumers'

have the potential to help others by targeting consumption of particular products or through complaint (Simmons and Powell, 2009).

The notion of the consumer as rational actor, seeking to maximise personal and social outcomes, contrasts sharply with the view of the consumer as dupe or victim of market manipulation. In this conception, the consumer is fooled or seduced by the power of advertising, marketing or selling, into purchasing or 'choosing' a product or service that they neither want or require. This builds upon Marxist and neo-Marxist beliefs that consumption is perpetuated by false needs and linked to the notion that we are all increasingly 'sucked into the world of consumption...where the poor, in particular, come off the worst' (Edwards, 2000, p.12). The consumer is no longer viewed as a strong and independent decision-maker who exerts a high level of influence over his, and societies, fortunes but rather as a passive victim of capitalist exploitation and the temptations of the market. The creation of unlimited needs, wants and desires perpetuates a system in which the consumer appears to exercise freedom of choice but, in reality, has little power or control over their purchasing, environment or situation. Such contrasting views - the consumer as king and the consumer as hapless victim - are equally simplistic. Consumer expectations are continually increasing and evolving and this fosters complexity and complication (Evans et al, 2009) hence positive and negative attributes of consumer behaviour are both interdependent and intricately intertwined. In some circumstances, consumers are free to vote with their feet and, in others, they are manipulated and directed by market forces. It is unsurprising, therefore, that some aspects of consumerism, and indeed the people who try to assert their rights to make choices as healthcare consumers, are regarded by some as unruly or unmanageable.

2.16 The 'unmanageable consumer'

Gabriel and Lang (2006) evaluate the complexity of modern consumer activity and identify a number of typologies to classify the diverse motivations for consumer behaviour and activity. These include the consumer as: chooser, communicator, explorer, identity-seeker, hedonist, victim, rebel, activist

and citizen. Some combinations of these consumer-roles exhibit considerable overlap such as communicator and identity-seeker; whilst others, such as rebel and victim, are more exclusive (Ritzer, 2001, p.64). However, none of these representations satisfactorily epitomises the fragmentation of contemporary consumer activity and Gabriel and Lang (2006) argue that:

“The notion of an average consumer has become a fiction. In a world where everybody claims the consumer for her- or himself, the consumer must now be deemed unmanageable, claimed by many, but controlled by nobody, least of all by consumers themselves” (p.194).

Consumers become ‘unmanageable’ because of their ability to move between different positions - in some circumstances they are rational choosers, but in others they are activists or any of the other possibilities (Greener, 2008). This view of multiple and frequently overlapping motivations adds far greater depth to our conception of consumer behaviour and demonstrates how difficult it is to impose a one-size-fits-all model to consumer activity. The consumer is no longer a person who simply desires, buys and uses a commodity, they now explore, interpret and decode information necessary to inform their decision to buy or reject a product and may experience an emotional reaction, or total indifference, towards the commodity (Gabriel and Lang, 2006).

Healthcare consumption shares some of these characteristics. For example, service users expect ever increasing standards of healthcare and personal longevity as medical knowledge advances and treatments and procedures continue to improve and develop in sophistication. As with consumer culture in general, health expectations are continually increasing, bringing with them complexity and complication (Evans et al, 2009). However, the way in which service users interact and engage with healthcare services is diverse. A scoping review by Victoor et al (2012) investigated why service users choose a particular healthcare provider. The researchers concluded that:

“Patients’ choices are determined by a complex interplay between a variety of patient and provider characteristics. There is no such thing as a typical patient: different patients make

different choices in different situations...It can thus be argued that the choice process is much more complex than is often assumed” (p.13).

Research conducted for the Economic and Social Research Council (ESRC) and Arts and Humanities Research Council (AHRC) project Cultures of Consumption (2007) also found that public-service users were able to see beyond their own needs and expressed a desire to share quality public services with others which further emphasises the subject of choice in healthcare and the decisions that consumers of healthcare have to make when discerning between different options available to them.

2.17 Types of choice

The shift from central Government to governance, from producer to consumer interests, signalled the transformation from standardised service provision to a demand-led approach activated by the intelligent consumer (Storey et al, 2008). According to GP Ethicist Peter Toon (2015) political pressures have led to the NHS ‘being seen in terms of consumerism, not treating patients but fulfilling the desires of consumers for convenience and choice’ (p.219). Although there is hostility to the idea of service users as consumers from a number of quarters, it is not without public and professional support. An Ipsos MORI opinion poll from 2004 found that 80% of respondents agreed that Britain’s public services needed to adopt the private sector’s approach to customer care. Clarke and Eales-Reynolds (2015) also argue that that the drive to introduce a customer care framework in healthcare not only demonstrates a commitment to improving quality but also service user safety. The promotion of neoliberal policies in England (and elsewhere) has provided greater opportunity for service users to participate in decisions about the services and treatment they receive (Owens, 2012). However, it is important to ask the question: how much choice do service users really have? It is generally accepted that using (or consuming) healthcare services is ‘not the same as shopping’ and although service users may ‘want’ to be treated as customers that does not mean they want to shop

around for the best deal or threaten to do so (Leadbetter, 2004; Fotaki et al, 2005; Clarke, 2007; Powell et al, 2009; Mold, 2015).

Le Grande (2005) argues that, in practical terms, the concept of service-user choice comes in a number of forms: choice of provider (where?), choice of professional (who?), choice of service (what?), choice of appointment time (when?) and choice of access channel (how?) (p.201). In the context of health service provision, this broadly translates as the choice to see a doctor, nurse or allied health professional (AHP) for an initial consultation at a GP practice or Emergency Care Centre. Or the choice to see a doctor, nurse or AHP for a booked consultation, procedure or diagnostic test at a primary or secondary care location (e.g. choose and book). Since April 2008, all service users in England requiring a specialist referral have been entitled to a choice of provider and should be able to choose from any hospital listed in a national directory of services, including NHS and independent providers - so-called 'free choice' of provider (García-Lacalle, 2008; Dixon et al, 2010). In 2009, the NHS Constitution made this a right for service users (DH, 2009a). Choice of service itself is frequently limited by the nature of the medical need. Choice of appointment time may be provided or it may be a case of 'waiting your turn'. Finally, choice of access channel may be face-to-face, via the telephone (e.g. NHS 111 or GP consultation), the internet (e.g. NHS Choices or Skype) or possibly in the form of a text message. However, all of these choices are subject to a variety of other factors including local availability of provision, access to (and ability to use) appropriate technology, time issues, financial and demographic considerations (DH, 2015). Not least amongst these is the necessity to hear what individual service users actually want or need. This will now be discussed in the next section.

2.18 Patient voice

Service users have been progressively elevated from passive recipients of healthcare services to drivers of change on behalf of the state (Greener, 2004). As an organisation, however, the NHS (like other public services) has traditionally operated on the basis of established models of professional and social authority. Doctors, nurses and other AHPs exercise autonomous judgement on behalf of

the service user, based upon their professional expertise and knowledge. In addition, a range of Government and technological initiatives, spanning the last three decades, have contributed to a significant reconfiguration in the relationship between service user and professional by encouraging the former to challenge the expertise and authority of the latter. The empowered consumer is viewed as an effective mechanism to counterbalance professional dominance and paternalism and to strengthen the ability of managers to squeeze greater value from the system on their behalf (Coulter, 2011).

The managerial transformation of the NHS has also actively sought to realign professional autonomy with organisational goals, values and missions (Evet, 2003, 2011). Consequently, although healthcare organisations recognise that a degree of professional autonomy is necessary to ensure the effective delivery of services, professional bodies are often perceived as reinforcing 'narrow' professional interests that introduce 'inflexibilities' into the operating system of the organisation (Clarke et al, 2007). Giddens (1994) draws attention to the role of social movements and support-groups in 'democratising' professional knowledge and 'resting power from experts' (p. 121). For example, CHCs were established in 1974 to represent the voice of the consumer within the NHS. Although they were disbanded in 2003, a variety of different bodies have taken-on this role including Patient Forums, Patient Advocate and Liaison Service (PALS) and the Commission for Public and Patient Involvement (Mold, 2015). In 2012, Healthwatch England became the 'national consumer champion' for healthcare with responsibility for ensuring people's views and opinions were communicated to those responsible for commissioning and providing healthcare services (DH, 2012). The NHS Operating Framework 2012-13 (DH, 2011a) states that:

"NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques" (p.17-18).

Consequently, individual healthcare providers often employ a variety of additional methods to access and sample service user experience. These include the short message surveys such as the friends and family test (FFT), National Voices and a wide range of services provided by the independent-sector. According to Dr Pam Carter and Professor Graham Martin (2016) of the University of Leicester Centre for Medicine, the patient and public involvement (PPI) arena is becoming increasingly congested by independent organisations 'claiming to offer patient's views on health and social care, often deploying Web 2.0 enabled services to allow people to...describe their experience of care [and] producing TripAdvisor-style ratings' (p.2). Professor Debra Lupton (2014) remarks that online technologies of the Web 1.0 era, largely provided information from experts with limited opportunities for service users to contribute their insights and experiences. Web 2.0 technologies, on the other hand, encourage the active production and sharing of healthcare data by service users. This type of 'peer-to-peer marketing' is also cost effective and tends to generate a high degree of confidence (Ibid). According to Healthcare Digital Marketer Sarah Brechon (2014) customers are

"...more likely to trust the word of others in their position than a professional advertising campaign and knowing that this public feedback mechanism is available may reassure otherwise hesitant customers into taking a chance on your product or service" (p.42).

Community groups such as Cure the NHS (established in 2007 following the disclosure of poor standards of care at Mid-Staffordshire NHS Foundation Trust) have also done much to encourage public voice at a local and national level. However, although PPI encourages service providers to become more responsive to patients' needs, it does not necessarily guarantee greater efficiency and effectiveness of service provision. In 2005, a Public Administration Select Committee Report *Choice, Voice and Public Services* (HC, 2005) assessed the effectiveness of plans for providing service users with greater choice of services and more say about the way in which they were provided. The report argued that giving service users a 'voice' without allowing them to exit the service and choose

another, limited the effectiveness of that voice (p.15). To put it simply: 'choice gives power to voice' (Le Grand, 2007, p.4). The ability to choose one healthcare provider over another was intended to foster competition based upon quality of service provision rather than price. Yet, for many people, there is little alternative provision available locally, particularly when patients require specialist services that might only be provided by a regional or national centre as discussed below.

2.19 Greater specialisation of services

The need to undertake service reconfiguration - including hospital closures and mergers - to ensure that healthcare services continue to be delivered in an efficient and equitable manner seems inconsistent with a system of governance that encourages consumer choice to drive up standards of care. Both the Government and senior healthcare professionals have argued that specialist services should be provided and hosted by regional centres of excellence. As far back as 1991, the Bristol heart surgery inquiry concluded that paediatric surgery should be concentrated in fewer, larger centres (Kennedy, 2001). In 2010, a group of fourteen medical leaders, led by the chairman of the UK Academy of Medical Royal Colleges, Professor Neil Douglas argued that:

"...specialist clinical services, such as stroke, trauma and heart surgery, should be concentrated in fewer centres...The greater volumes of patients mean doctors are better at spotting problems and treating them quickly. Survival and recovery rates would improve markedly with many lives saved" (Douglas et al, 2010).

These recommendations were based upon clinical effectiveness and not simply the need for financial savings. The following year, a report by The King's Fund argued that A&E, maternity, neonatal and heart surgery services would benefit from being delivered from fewer sites (Palmer, 2011). A joint report by the NHS Confederation, the Academy of Medical Royal Colleges and National Voices also recommended that the health service must do more to emphasise a 'whole system' approach to care which enabled providers to work together to 'deliver the right care in the right place' (NHS Confederation, 2013, p.4, 21). The report stressed that service users and their organisations must

continue to be engaged as co-producers or 'equals' (p.38) in order to critique current provision and redesign it to meet their needs and preferences. It also recognised that despite 'clear evidence' that reconfiguration could lead to better experience and outcomes for service users, some people would remain 'suspicious of changes they perceived to be aimed at cutting services and downgrading the care they received' (p.5). This has proved to be the case and in 2013 there were successful legal challenges to the closure of children's heart surgery services at Leeds General Infirmary and the downgrading of maternity and A&E services at Lewisham Hospital.³ Both campaigns received considerable public support and widespread media coverage throughout the process (BBC News, 2013ab). Despite apparent consensus between policy makers and senior health care professionals regarding the need for service reconfiguration, the public remain strongly attached to local care centres and services.

Consumers are often portrayed as either 'good' consumers (those with the potential to influence the types of products and services offered through collective endorsement and choice) or 'bad' consumers (the victims of market manipulation). Both extremes are equally simplistic and consumers move between positions as their motivations change and evolve in response to differing needs and circumstances. Key to the notion of the 'good' consumer is choice and individual autonomy. The very act of choosing a particular product or service can confer a sense of power and independence upon the consumer. Consequently, choice has increasingly been promoted as a mechanism to reform 'stubborn' public services, such as healthcare, on behalf of the service user. This assumption is based on the expectation that when NHS money follows the choices made by healthcare service users, service providers must compete for custom on the grounds of quality (since price is fixed). This competition, or contestability, is intended to empower healthcare consumers to drive up standards which, in turn, improve services for all. However, for many service users, there is

³ Chase Farm Hospital (Enfield) mounted an unsuccessful legal challenge to save its A&E department and maternity wards. Both were closed by the 9th December 2013.

often little alternative provision available locally and, even where there is, many are unable or unwilling to travel to receive care.

Consequently, providing service users with a voice, without allowing them to exit the service and choose another, limits the effectiveness of that voice. Similarly, the need to undertake service reconfiguration, including hospital mergers and closures, to ensure healthcare service continue to be delivered in an efficient and equitable manner seems inconsistent with a system of governance that encourages consumer choice to drive up standards of care. Having discussed greater specialisation with regard to service provision it is incumbent on me to consider the growing expertise of service users particularly with regard to the management of their own care as part of the self-management agenda. In the following sections therefore, I will explore whether service user participation in the production of healthcare can encourage consumer empowerment and deliver financial savings to the NHS. This will include further discussion of the use of Web 2.0 technology and the evolution of the expert patient. Finally, in section 2.24, I will examine whether choice and competition encourage equity and equality of service provision for all.

2.20 Expert patients and e-medicine

According to Charles Leadbetter (2004), writing for the cross-party political think-tank Demos, service users occupy a stronger position to influence healthcare decisions and outcomes (individually and collectively) when they participate in the production, delivery and consumption of healthcare. Health policy analyst and research scientist, Angela Coulter (2002, 2011) comments that the rights of health consumers have traditionally been smothered by the paternal authority of professional providers and that service user engagement in treatment and health management decisions is not only desirable but improves health outcomes. She writes that service users must be viewed as:

“Partners in the business of healing, players in the promotion of health, managers of healthcare resources, and experts on their own circumstances, needs, preferences and capabilities” (2011, p.1).

She also argues that:

“Paternalism breeds dependency, encourages passivity, and undermines people’s capacity to look after themselves. It may appear benign, comfortable and reassuring, but it is a hazard to health (p.2).

The view that paternalism represents ‘a hazard to health’ for all is perhaps a little overstated and many service users benefit from, and are happy to accept, strong professional recommendation (see chapters 4-7). However, the concept of service user as ‘joint provider’ or ‘co-producer’ of health is thought to reinforce the value of their opinion in relation to that of the healthcare professional and a number of studies have demonstrated that involving service users in their care and treatment decisions can improve health outcomes, boost satisfaction and increase knowledge, understanding and adherence to treatment (Coulter and Ellins, 2006, 2007; DH, 2010, pp.13, 56-7/fn.17, 18). It has also been proposed that the process of shared decision making may contribute to reducing overall cost for the NHS. The Wanless Report (2002) estimated that high levels of individual engagement could deliver savings of up to £30 billion by 2022. However, this model is based upon a ‘fully-engaged’ service user who is able to identify the most effective and appropriate treatment option available (Holmes-Rovner, 2005).

The role of the expert patient was first acknowledged in the White Paper *Saving Lives: Our Healthier Nation* (DH, 1999a) and further developed in *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century* (DH, 2001b). The latter was intended to help service users communicate more effectively with clinicians, engage better with treatment regimens and to develop a pro-active, goal-centred approach to coping with medical conditions. It also reflected the fact that - in line with New Labour’s choice agenda - the public had become more assertive in their relationships with health service providers. This process was assisted and encouraged by the rapid growth in web-based, health-related information (Henwood et al, 2003; Fox et al, 2005; Laing et al, 2009). Eysenbach (2000) predicted in 2000 that information systems designed primarily to assist

physicians and other healthcare professionals would rapidly be adapted to suit the needs of consumers in order to 'equalise relationships between healthcare professionals and lay people' (p.1713). The following year, pharmaceutical director Chris David (2001) remarked that:

"Instead of being passive recipients of judgements and treatments handed out by the medical community, consumers will actively demand a better quality of life, better care, personalized treatment, convenience, choice, and value for money" (p.67).

One aspect of ceasing to be passive recipients of healthcare is the need for service users to have greater information regarding the healthcare opportunities available to them. There is little doubt that the 'white heat' of technology has markedly shifted both expectations and service uptake in this regard as discussed below.

2.21 Transforming choice and expectations through the use of technology

According to Ham and Alberti (2002) the impact of the internet on the relationship between the public and health professionals was 'akin to the impact on the clergy of the translation of the Bible from Latin' (p.840). It is certainly true that the internet has improved access to healthcare information by breaking down many of the barriers caused by time and location. The growing use of hand held devices and wireless communication means that consumers have access to healthcare (and other) information wherever they happen to find themselves - 'clicks verses bricks' (Solomon et al, 2013, p.76-77). The process of 'information ownership' is growing rapidly as mobile technology becomes an increasingly ubiquitous part of everyday life for much of the UK population. It is also something that has been widely supported by successive Governments. However, many commentators have expressed concern regarding the reliability of some web-based sources of information and whether all service users are sufficiently critical and discerning to recognise when information is either inappropriate or inaccurate (Editorial, 2005). In order to address this issue, NHS

Choices was created in 2007 as the official NHS website.⁴ In 2015, it recorded 583 million ‘visits’ to its site - a rise of 80 million on the previous year (NHS Choices, 2016). Sixty-eight percent of those accessing the website did so via mobile or tablet devices and NHS Choices estimate that it also reaches up to 3 million people per month via social media platforms such as Facebook and Twitter (NHS Choices, 2015).

The use of Web 2.0 technology to access healthcare data is set to grow exponentially as the NHS seeks to modernise services further. In 2014, NHS England published *Five Year Forward View* which explains how service users will be empowered ‘to take much more control over their own care and treatment’ by ‘exploiting the current information revolution’ (p.7, 31). It also describes how ‘technology - including smartphones - can be a great leveller’ and explains how it intends to ‘build the capacity of all citizens to access information...and use new technologies’ (p. 32). The same year, the National Information Board (NIB) published *Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens* (NIB, 2014). This framework outlines an unequivocally pro-technology agenda regarding service user engagement with the NHS in the near future. It states that:

“While health and care services have particular, perhaps unique features, they also have much in common with a wide range of consumer-driven service industries that have been transformed in recent decades. Human interaction will always be at the heart of health and care, but that interaction can be better informed, more efficient and better organised if supported by data and technology services” (p.10).

The NIB (2014) also remarks that one of the reasons mobile technology has not been used to its full potential is because ‘professional behaviour tends to change more slowly than consumer behaviour’ (p.10). At the same time, the NIB is careful to stress the importance of public sector involvement in

⁴ Prior to this, NHS Direct added a website (including a symptom-checker feature) to its telephone service at the end of 1999.

the development of new technologies and data enabled services. They propose a national approach to the 'accreditation and kite-marking of apps, devices and digital services will help give users, consumers and care professionals confidence to use them' (p.22). Laing et al (2009) argue that the internet has the potential to destabilise traditional 'consumer certainties' (p.83) regarding the quality of the information available in an unregulated environment. They conclude that the core challenge for service providers and professionals is 'less about responding to paradigm shift and more about responding to increasing diversity of consumption behaviour' (p.83). Shankar et al (2006) note that, confronted by too much choice, consumers may experience 'paralysis' arising from information overload.

The use of information-technology may provide an opportunity to assert power but it can also generate high levels of doubt and uncertainty. This could result in service users making uninformed decisions that have consequences not only for themselves but also for health-service budgets and the wider community. For example, following the publication of the now retracted paper by Wakefield et al (1998) purporting a link between the MMR vaccine and autism there was widespread public confusion regarding the safety of vaccination. Despite professional opinion to the contrary, many parents chose not to vaccinate their children with the triple vaccine with the result that there remains a genuine risk of a large scale measles outbreak in the UK - as demonstrated in Swansea in 2013 (McIntyre and Leask, 2008; Pearce et al, 2008; BBC News, 2013c). Public reluctance to trust medical opinion, encouraged by media comment, resulted in additional health-service expenditure and an insufficient number of pre-school children receiving both doses of the MMR vaccine to achieve herd immunity (Kmietowicz, 2008).

The assumption that all healthcare consumers can be trusted to make informed decisions regarding healthcare options, or indeed wish to do so, is perhaps overly optimistic. Newholm et al (2006) also point out that a recurrent counterpoint to the contention that information-technology empowers consumers, is that service-users are increasingly carrying out research which was formerly

undertaken by service providers. In engaging in what Sociologist Charles Koeber (2011) describes as 'consumptive labour' (p.205), consumers are spending more of their time producing the service itself, raising questions as to whether this constitutes true empowerment. Social Scientist Peter Scourfield (2007a) also refers to the development of what he terms the 'entrepreneurial self' (p.116) whereby the service user increasingly takes on the functions, risks and responsibilities that were formally undertaken by the state. In relation to the introduction of individual budgets for social care he comments:

"One wonders...where this leaves the sections of society who have neither the desire nor the ability to be entrepreneurial and who cannot be self-sufficient, if indeed any one of us can"
(p.119).

Scourfield's observations suggest that, for those that have neither the desire nor the ability to make decisions for themselves, there needs to be shared decision making in the form of a negotiated care contract with healthcare providers. Hence the importance of shared decision making in addition to individual choice and the necessity to listen to the service user's voice when negotiating care and care decisions in such circumstances.

2.22 Shared decision making, the flip-side of choice and voice?

There is a great deal of evidence that service users attach importance to the ability to participate in healthcare decisions. However, they also value the opinion and recommendation of a trusted healthcare professional. A somewhat underpowered qualitative case study by Bourlakis et al (2011) investigated UK hospital supply chain following policy reform providing service users with greater choice of hospital for elective surgery. A total of nine interviews were conducted with hospital managers, each lasting for around 60-90 minutes. The key research objective was to establish what hospital managers believed to be the key factors for service users when making a choice of hospital. Case study was an appropriate methodology since the study aims to understand and explain the effects of policy development (service user choice) within a specific environment. The researchers

reported that all nine managers believed service users would act according to GP recommendation regarding their elective procedure. They concluded that, when making a choice of hospital, patients currently remain dependent upon their GP but may become more influenced by attractive marketing information (p.33). Limitations to this study include the fact that the researchers did not engage with other key groups involved in the hospital supply chain such as clinicians and service users. In addition, the research was restricted to only 3 NHS Hospital Trusts (within 2 UK counties) from the same Strategic Health Authority.

For many people, professional expertise remains highly valued even where tolerance of professional authority (or paternalism) is less certain (Clarke et al, 2007). Doctors in particular have transformed from figures of paternal (and unquestionable) authority to knowledgeable advocates and, in some circumstances, facilitators of care. In popular culture, the uncompromising characters of Sir Lancelot Spratt and Nurse Ratchet seem tyrannical and anachronistic to today's audience. These stereotypes represent the unacceptable face of institutional authority and paternalistic self-confidence.

Neuberger (2015, p.24) remarks that 'doctors, along with other health professionals, are no longer treated as deferentially as they once were, and largely no longer wish to be'. At the same time, however, the polar opposite of this position can be equally intimidating for some service users particularly if they lack the time, motivation, confidence or ability to research healthcare options etc. Healthcare is not a typical market commodity since it is not consumed for its own sake and has positive and negative consequences for those who consume and those who do not (Fotaki et al, 2005).

Consumption of public services is more complex than consumption of private goods and services, therefore, because of the possible tension between equity criteria and individual versus collective elements (Powell et al, 2009). However, successive Governments have argued that increasing individual choice results in greater equity and equality of service provision for all users. This assumption is based upon the expectation that since money follows the choices made by service

users, service providers must compete on grounds of quality rather than price. This competition - or 'contestability' - empowers healthcare consumers to drive-up standards which in turn, improves services for all users (Willcocks, 2008; Gutacker et al, 2015). The introduction of choice and voice was intended to allow consumers to apply pressure on providers to ensure that services are personalised and responsive to their needs whilst new providers entering the market ensure that current providers maintain quality and standards of care (or risk exiting the market). However, the opposite may be true and increased competition may exacerbate health inequalities and fragment healthcare services as more providers enter the market. Palmer (2011) argues that market forces alone are unlikely to deliver desirable service reconfiguration and that:

“Competition and choice in contestable services may inadvertently cause deterioration in the quality of essential services provided by financially challenged trusts...In many cases the most likely outcome will be continued deterioration in both the quality of care and the financial position. The NHS will have no alternative but to continue to fund their deficits or allow them to fail” (p.vii).

According to the 2015-16 third quarter accounts presented by Monitor and the NHS Trust Development Authority, most Hospital Trusts continue to find themselves in severe financial difficulty and, at the end of 2015, just 7 out of 138 Hospital Trusts remained in surplus (Dorsett and O'Mahony, 2016). There have also been a number of high profile failures by private companies to run public sector services. For example, Circle Health became the first independent company to run an NHS Hospital and then subsequently withdrew from the contract following financial pressures and a critical Care Quality Commission (CQC) inspection report (House of Commons Committee of Public Accounts, 2015). In the event that poorly performing trusts are acquired and assimilated by more successful organisations, services will almost certainly be rationalised with specialist services provided in centres of excellence. This may improve efficiency and save money in the long term but

it may also prove unpopular with those travelling further for services previously delivered locally, hence the importance of the question addressed in the following section (Sturgeon, 2014b).

2.23 Does choice encourage equality?

One of the most politically sensitive expressions of inequality and absence of consumer choice is ‘postcode prescribing’ variations in the availability of services and treatments between different geographical locations in the UK (Powell, 1998; Delamothe, 2008). The National Institute of Clinical Excellence (NICE) was established in 1999 in order to remedy this situation by making recommendations to the NHS regarding new and existing medicines, treatments and procedures (DH, 1998).⁵ However, NICE has been criticised on many occasions by service user groups, pharmaceutical companies and the medical profession for not endorsing particular medications and treatment (White, 2004; Drummond and Mason, 2009; Godlee, 2009). At the same time, a recent report by the Centre for Health Economics, University of York, found that the threshold used by NICE when evaluating the cost-effectiveness of new drugs is too high (Claxton et al, 2015). Co-author, Professor Karl Claxton, remarks that ‘increasing pressure to approve new drugs more quickly at prices that are too high will only increase the harm done to NHS patients overall’ (cited by University of York, 2015). For example, they argue that the approval of any new drug that costs the NHS an additional £10 million each year would offer benefits of 333 Quality Adjusted Life Years (QALYs) but would lead to the loss of 773 QALYs for other NHS service users with increased mortality in cancer, circulatory, respiratory or gastro-intestinal diseases etc. This issue is further complicated by the suggestion that not all QALYs are equitable or indeed whether it is feasible to estimate the monetary value of a QALY at all (Whitehead and Ali, 2010; Donaldson et al, 2011).

There are inherent inconsistencies with the assumption that the NHS can provide a personalised and equitable service to all. A system that operates with limited financial means cannot offer everything

⁵ In 2005, NICE joined with the Health Development Agency to become the new National Institute for Health and Clinical Excellence (still abbreviated as NICE).

to everybody and there is a risk that service users will end up in competition with each other over limited resources (Scourfield, 2007b; Glendinning, 2009). Oliver and Evans (2005) remark that extending service user choice produces not only competition between providers, but also between service users competing for resources in a financially restricted system. They argue that:

“It is necessary to accept that the NHS cannot provide everything that each individual patient may want. Although an individual patient may gain greater satisfaction from being offered more choice, the opportunity costs of extending choice to this patient, arising from a reduction in resources available to other patients, may be detrimental to the overall social good” (p.187).

As noted above, it is difficult to ensure that healthcare resources are divided and distributed equally across the whole population and there has been a great deal of debate regarding whether or not choice increases inequality (Clarke et al, 2007; Le Grand, 2007; Thorlby and Turner, 2007).

Competition between service users may bring benefit to one group while simultaneously limiting access and availability to goods and services to others. Oliver and Evans (2005) draw attention to the application of the ethical principal on non-maleficence in these circumstances. That is to say, individual freedom of choice should be curtailed in circumstances where it may pose harm to others or lead to a situation where the strong exploit the weak.

One of the criticisms levelled at the concept of ‘voice’ as a mechanism for ensuring greater responsiveness to individual need is that it favours the middle classes, or those who work within the health service itself, since they are more competent when articulating their needs and preferences. The Public Administration Select Committee Report *Choice, Voice and Public Services* (HC, 2005) recognised the potential for inequity posed by those who were wealthy and articulate and expressed concern that greater choice would simply give ‘the articulate and the prosperous an even better opportunity to take advantage of the best in public services’ (p.24). A further conclusion drawn from Bourlakis et al’s case study (2011) investigating UK hospital supply chain was that:

“There remains an underlying suspicion that more affluent people might travel farther to a hospital for treatment, whilst the elderly and those from deprived areas will go to their local hospital. This could create inequity in terms of real patient choice and has been highlighted by this research and others” (p.420).

Bourlakis et al’s work reminds us of the importance of service users’ ability to access healthcare opportunities and the following section will discuss social and cultural capital in relation to healthcare decision making.

2.24 Social and cultural capital

A mixed methods study by Rosen et al (2007) explored GPs’ views about the introduction of choice at the point of referral. In particular, it focused on what influences GPs’ referral behaviour, the information needed to support choice and the impact of service user characteristics on equity in choice. The study used a combination of telephone interviews and focus groups guided by a topic schedule covering the themes outlined above. Overall, 30 GPs participated in six focus groups held in contrasting rural, urban and suburban locations. The study found that although there was broad support for extending service user choice, GPs identified several constraints that could affect service users’ ability to choose between different providers. For example, most GPs assumed that ‘patients who were better off and better educated would get a better deal from patient choice’ (p.63). One GP also expressed concern that although disadvantaged communities in inner cities were often served by excellent teaching hospitals, choice would attract affluent suburban service users, further disadvantaging those from the deprived areas. Limitations of the study include the fact that one focus group consisted of only two participants. The researchers also point out that participants were all GPs and it is possible that different insights into the implementation of choice would have emerged if other professional groups who support choice had been included (e.g. practice nurses or receptionists). Finally, the study took place during the introduction of service user choice and the views expressed in the focus groups may reflect GPs’ limited experience of using Choose and Book as

well a changing awareness regarding choice among service users and doctors. These findings are supported by a literature review by Propper et al (2006) suggesting that greater choice may also lead to a concentration of sicker individuals in hospitals that signal higher quality. This effect may be exacerbated by the entry of new providers to the market who concentrate on service users who are easier to treat and 'cream-skim' these away from established providers (Propper et al, 2006; Glendinning, 2009; Bourlakis et al, 2011)

It is unavoidable that many research studies investigating service user choice in healthcare take place in large metropolitan centres but one independent research study, conducted in four urban and rural locations outside London between August 2008 and September 2009, articulates the very different experiences of those for whom choice in healthcare is undeniably limited (Dixon et al, (2010). The study, commissioned and funded by the Policy Research Programme of the Department of Health, showed that even when faced with hypothetical choices, older respondents, and particularly those with fewer qualifications, together with those from mixed and non-white backgrounds, were more likely to value choice. This indicates that it is not simply younger and better educated metropolitan service users who value choice although the study does not demonstrate whether service users with lower levels of social and cultural capital were as successful as their metropolitan peers in articulating and obtaining their preferences.

A literature review from 2008 suggests that better educated populations make greater use of information and are more likely to exercise choice in healthcare (Fotaki et al, 2008). That is not to say that those who are less prosperous or educated lack the ability or capacity to make informed choices, as Dixon et al (2010) indicate, rather that there is unequal distribution of the social and cultural capital that enable and empower choice (Bourdieu, 1984). This includes access and control across a wide range of institutional contexts and the ability to make contacts and network. For example, Edwards (2000) draws attention to the paradox of consumer society as an apparently

‘open shop’ to anyone with the material, temporal and spatial access. However, whether an individual possesses these assets is not always under their control or reducible to individual will.

Henry (2005) argues that even where markets are open to consumer empowerment, ‘class position’ impacts on the expectations of empowerment which leads some individuals to ‘self-restrict already limited opportunities’ (p.766-67). In the case of health services, wealth is not significant per se (other than the fact it provides the means to opt-out if necessary) but it may contribute, reflect, or be indicative of other advantageous attributes such as education, confidence and the ability to articulate concerns. This is sometimes referred to as the ‘problem of the middle class’ whereby unequal distribution of social and cultural capital has historically enabled the middle class to benefit disproportionately from public services (Clarke and Newman, 2006). There seems to be some evidence, therefore, to suggest that those who are less educated or prosperous have the desire and ability to make informed choices but that they are more likely to be constrained by other factors. These may be practical considerations such as high demand for local services and access to transport or the fact that they are less able to articulate their needs than those with greater cultural capital. There is a risk then, that service users may find themselves in competition with one another for limited resources and that those most able to articulate their needs and wants will prove the most successful. However, the picture is complicated and an evaluation of the *London Patient Choice Project* found little difference in the uptake choices offered to service user groups in relation to class, education, income or ethnicity (Coulter et al, 2005). However, it did note that when considering where to be treated, practical considerations such as transport arrangements, timing of treatment and convenience for themselves and their relatives ‘tended to weigh more heavily for those in less advantaged groups’ (p.5). They also found that unemployed service users were less likely to exercise choice.

A survey by Frank et al (2011) evaluated service user participation from the perspective of those who received care at emergency departments in Sweden. A consecutive sample of 356 participants

completed questionnaires in 2008. The results revealed that 'mutual care situations' between service users and healthcare professionals required further improvement in order to ensure that the former are satisfied and 'do not have to struggle and fight' to participate in their care (p.733). Interestingly, the researchers concluded that young and well educated service users perceived that they needed to 'fight more' to participate in their care and that they gain less attention for basic needs than older and less well educated service users. They suggested that health professionals need to consider how to encourage different types of service user to participate fully. However, the sample was limited to Swedish-speaking service users and the researchers accepted that the inclusion of non-Swedish speaking participants would have contributed valuable information. The researchers also noted that it was difficult to get service users to complete a postal questionnaires and the response rate was low.

In relation to social and cultural capital, therefore, it could be suggested that one of the reasons healthcare services have failed to respond to service user needs is because of strong professional authority (paternalism) which encourages passivity and undermines service users' ability to care for themselves. A number of studies have demonstrated that involving service users in care and treatment decisions can improve health outcomes, increase knowledge and concordance with treatment. The Wanless Report (2002) also estimates that high levels of service user engagement in their care ('fully engaged') could result in significant financial savings for the NHS. Consequently, service users have increasingly been encouraged to participate in the production and delivery of care as well as its consumption. This process of service user empowerment has been greatly assisted by the growth of Web 2.0 technology which allows individuals to research healthcare options and to rate the services they receive. However, although the use of technology may provide the opportunity to assert power for some, it can also generate high levels of doubt and uncertainty for those less confident with its application.

Finally, in relation social and cultural capital, there is also concern that service users are increasingly expected to carry out research and other 'work' formerly undertaken by healthcare service providers on their behalf. Sociologist Charles Koeber describes this activity as 'consumptive labour' and questions whether it constitutes true empowerment. Another consequence of encouraging service user choice and co-production of care is that it promotes competition between individual service users for resources in a financially restricted system. This may benefit one group of service users whilst simultaneously limiting access and availability for others. Furthermore, where markets are open to consumer empowerment, class position has the potential to impact upon expectations. That is to say, there is concern that those who have become more assertive regarding their expectations may benefit whilst others may 'self-restrict' already limited opportunities. In the final sections of this chapter (2.25-2.29) I will explore whether healthcare service users want greater choice and, if so, what types of choices are they making. I will also investigate whether healthcare marketisation and customer service models of care provision are changing the relationship between service user and providers.

2.25 Do service users really want choice?

There has been much debate as to whether genuine choice is possible in the public services and whether service users really want it (Le Grand, 2004, 2007; Oliver and Evans, 2005; Fotaki et al, 2005, 2008; Boyd, 2007; Clarke et al, 2007; Bojakowski, 2008; Jones and Mays, 2009; Robertson and Dixon, 2009; Simmons, 2009; Coulter, 2010, 2011). The *National Choice Consultation*, undertaken by the DH in 2003, reported that 76% of respondents thought the most important aspect of NHS care was involving service users in decisions about their illness and treatment (DH, 2003; Leatherman and Sutherland, 2007). Half of respondents indicated that this element of NHS care needed improvement (DH, 2003). A survey undertaken by the British Medical Association (BMA) in 2006 also reported that 69% of those interviewed rated 'the choice to have a say in things generally' as 'very important' (BMA, 2006). However, although service users seem to want information about choices of treatment

they do not always want responsibility for choosing their treatment or healthcare provider (Barratt, 2011). The recent report published by the CQC (2016) found that, in 2015, 60% of respondents stated they were 'involved as much as they wanted to be' in decisions about their care and treatment. A retrospective analysis of routinely collect statistics by Gutacker et al (2015) investigated the extent to which service users are more likely to choose hospitals which are expected to achieve larger improvements in service users' health. The researchers analysed service user data from Hospital Episode Statistics for all elective admissions for those aged 18 or over who underwent NHS funded primary hip replacement surgery between April 2010 and March 2013 in NHS or private providers (n = 173,773 treated in 230 providers). The research showed that the effect of quality changes on the providers' ability to attract service users away from local competitors diminished rapidly as distance increased - although healthier service users were more willing to travel to receive care. The research also suggested that some service users may not consider the variation between hospitals sufficiently large to be considered important. The paper concludes that the incentive effect of service users 'voting with their feet' and demanding higher quality is likely to be limited. However, the author's acknowledge that because patients can decline to participate, or providers may fail to administer a questionnaire, there is scope for missing data and selection bias.

Another retrospective quantitative study by Moscelli et al (2016) investigated how service user choice of hospital for elective hip replacement is influenced by distance, quality and waiting times. The researchers also analysed data from Hospital Episode Statistics on all elective admissions for NHS funded elective primary hip replacement surgery between April 2002 and March 2013 in English NHS and privately-operated hospitals for service users aged 18 and over. The key finding from the study was that that distance was the main predictor of hospital choice although noting that, after 2006:

"...we find that patients preferred, on average, providers with lower waiting times, emergency readmission rates, and mortality rates" (Moscelli et al, 2016, p.20).

Fotaki et al (2005) undertook a scoping review to identify and assess the extent and nature of the evidence available on individual service user choice in the NHS. The scoping review process was built around literature review, expert panel workshops and the knowledge of team members. The team reviewed the literature on different theories of choice and consulted key experts to construct their analytical framework. The study found (at the time of publication) that choice of health care was not a high priority for NHS service users. Choice of hospital was more likely to be important to service users where the existing service is very poor or where waiting times are long. However, the authors acknowledged that these findings had to be interpreted against a background of a service which has traditionally offered very little choice. A further literature review by Fotaki et al (2008) examined whether service users wanted to exercise choice of hospital, primary care provider and treatment, and investigated the likely impact of policies designed to increase choice on equity of access. Selected papers focused not only on offering choice to individual service users but also on the impact of choice by service users' representatives such as GPs, and on the impact of introducing choice in education and social services. The authors concluded that although service users want to be more involved in individual decisions about their treatment, there is little evidence that service users want increased choice in healthcare except where local services are poor or have long waiting times. They also found that when service users became ill, they were increasingly likely to want to rely on a trusted health practitioner to choose their treatment or care pathway.

These findings seem to be supported by *The 2006 Inpatients Importance Study* (Boyd, 2007) which also noted that, in comparison with other aspects of care, choice (of hospital, admission date and information pertaining to these decisions) was an issue rated low in importance by all ethnic groups. Dixon et al (2010), on the other hand, found that 75% of respondents from their study said choice of healthcare provider was either 'very important' or 'important' to them, (p.xiii). However, when offered a choice of alternative provider, most patients (69%) chose their local provider, and GPs described their patients as loyal to their local Trust and reluctant to consider travelling further for treatment. Dixon et al (2010) also found that when making a choice about healthcare provider,

service users made little use of published information regarding hospital performance, despite the fact that it offered comparative data (p.xv-xvi). Instead, they relied upon their own experience (41%), the advice of their GP (36%) or that of their friends and family (10%). García-Lacalle (2008) remarks that, in the absence of personal experience with a healthcare provider, recommendation by a friend or relative seems to be the most important factor regarding selection. When, during a BMA survey, members of the public were asked to prioritise where Government NHS funding should be directed, 'cleaner hospitals' came top of a list of 10 options and 'choice of where to have an operation' bottom (BMA, 2005). However, this probably reflects infection control issues highlighted by the media rather than aesthetic preference. The same year, Professor of Public Health Research and Policy, Alison Pollock (HC, 2005), argued that:

"healthcare isn't something we even want to make choices about. What we want, by and large, is to know we will get nothing but the best, and that there are enough well-trained, motivated professionals available near enough to where we live and work to provide it. We want clean, quiet, hospital wards with appropriate privacy and decent food" (p.17).

It seems to be the case that although service users value and appreciate the offer of choice, and the sense of self-determination that it provides, they are likely to choose their local service provider (based upon personal and vicarious experience) particularly when they experience serious illness or injury since it offers convenient access for friends and family. Moreover, as noted above, even when local services are poor, there is considerable opposition to travelling further afield to receive care, indicating that localisation, and local cultures of consumption, based upon individual and family experience, may play an equally important role in determining consumer choice in relation to the care they seek.

2.26 Cultures of consumption

The research project *Creating Citizen-Consumers: Changing Relationships and Identifications* was funded by the Cultures of Consumption research programme, a joint initiative of the ESRC and AHRC,

and ran between April 2003 and May 2005. The project team studied three public services (health, policing and social care) at two urban locations (*Newtown* and *Oldtown*). They distributed 600 questionnaires to service users and front line staff (46% return rate) and conducted 24 interviews with managers, 23 with staff and 10 with service users. All interviews were semi-structured and explored issues from the questionnaire as well as providing further questions regarding relationships with services. The project team also undertook 6 focus groups: one for each service in both locations (Clarke et al, 2007). The key questions posed by the study were:

- How have public services adapted to consumerist ideals and pressures?
- Have the three services adapted in different ways?
- What relationships and identifications matter to the public when they use public services?

Overall, the study found that the majority of public-service users rejected the term ‘consumer’ or ‘customer’. Health service users, for example, made it clear that they perceived themselves as ‘patients’ or ‘service users’ rather than customers or consumers (p.128, 131). When asked ‘who are the people who use your services’, front line staff also used preferred these terms (p.126).

Interviews with senior health service staff identified the on-going struggle to reconceptualise service users in ways that recognised and responded to changing public expectations and acknowledged the need for creating and maintaining legitimacy in the eyes of potentially sceptical users (p.122). The concept of the NHS marketplace was generally viewed with distrust and the project team noted that the relationship between provider and service user was still dominated by clinical models of care, albeit models in which service user experience was accorded high value because of its impact on health outcomes (p.123-4, 133-4). Service users contrasted the personal, on-going relationship that they had with their provider (e.g. GP) with the anonymity experienced by many customers (p.132-3). For example, Newtown health user interview 1 commented:

“I don’t want to be a customer. I want to be a patient...I think that once you become a customer you are lumped with customers in a shop...whereas as a patient you have a personal relationship which is very difficult to break” (p.132).

The research team commented that the term ‘patient’ exemplified the wider political and cultural significance of the NHS as the embodiment of public services and their values in the UK. They also found that service users were ambivalent about the concept of choice. Newtown health user interview 5, for example, remarked that:

“I don’t quite know what choice is about, but if it’s about getting the best treatment, to give you the best chance, I don’t think that should be choice, I think that should be a fait accompli” (p.134).

What is interesting about these (and other) comments is that although health service users were willing to express their needs and challenge providers if necessary, they also valued the ‘publicness’ of the NHS and the ideal of a collective and inclusive service (p.137). Newtown health user interview 3 remarked:

“If I was 100 per cent healthy and not using, consuming the services, I would still feel a relationship to the health service because I pay for it...I do consider that when I cast my vote...I feel it’s more than just a direct consumer [relationship] because you are paying for a national service for everybody’s benefit. Whether you actually need to consume that service or not” (p.138).

The idea that service users do not focus purely on their own needs but also on how the service functions for other users more generally is supported by another Cultures of Consumption project *Choice About Voice: Hearing the Public in Public Services* (Simmons et al, 2007; Simmons, 2009). In summary, the study by Clarke et al found that service users wanted improved health services that met their needs and that provided the best treatment ‘as a right’ (p.134). They also wanted services

to be provided locally and to treat them as individuals. Both staff and managers expressed concerns that changes risked creating health inequalities as service organisations struggled to manage demand efficiently and equitably in the face of the current choice agenda (p.103-19). Although the study used a variety of data collection instruments to ensure rigour, service user interviews were under-represented in the sample as a whole. This is discussed further in chapter 3 since it informed my choice of data collection instruments. Before this, however, it is necessary to consider the severity and urgency of service users' conditions regarding the choices they make since these factors may limit or restrict their options when selecting the most appropriate destination.

2.27 Choosing between urgent care providers

A more recent qualitative study by Hunter et al (2013) explored how service users with long term conditions (chronic obstructive pulmonary disease, asthma, coronary heart disease and diabetes) chose between available healthcare options during a crisis. Service users in north-west England were invited to participate in a questionnaire cohort study and a sub-sample of 50 also took part in semi-structured interviews. The study found that service users described using emergency-care (e.g. A&E and on-call GP services) only in response to perceived urgent need. Choosing between different emergency-care providers was largely determined by previous experience regarding accessibility and perception of technological expertise. The study also identifies two theoretical concepts that help to provide an interpretive framework for the findings: candidacy and recursivity. Candidacy describes the 'work' service users have to undertake to access healthcare and how eligibility to access is 'continuously negotiated in patient-practitioner interactions' (p.339). The second concept, recursivity, describes how future demand for services, and the process of help-seeking itself, is determined by the service user's previous experience. Hunter et al explain that the two concepts

"...highlight that the key determinants of patient choice of healthcare are social and diachronic, with future healthcare use contingent on prior service responses to patients' requests for care, and on previous experiences of the social process of care" (p.339).

They also use the term 'permeability' to conceptualise the barriers and obstacles that service users encounter when trying to access healthcare services. For example, services such as A&E were considered 'highly permeable' since they are open 24-hours a day and required less work from those who accessed them. GP surgeries (with designated systems for urgent access), on the other hand, were considered relatively 'impermeable' because of receptionist 'gate-keepers', mobility problems and lower levels of technological expertise. The authors conclude that:

"In contrast to the 'deficit' model that underlies the view that patients need education to reduce their emergency care use, our findings demonstrate that patients with long term conditions are highly knowledgeable and discriminating in their healthcare choices. They prioritise experiential knowledge when choosing between services" (p.340).

However, the study has several limitations. Firstly, the authors identified that service users may have recounted previous use of emergency care in what they believed to be publicly defensible ways. Secondly, the study was limited to one geographical area which may limit transferability. Finally, most of the participants were White British service users who spoke English as their first language. The method of recruitment is likely to have influenced the recruitment rates of different ethnic groups.

The Patients Association (PA) and The Royal College of Emergency Medicine (RCEM) undertook an open access survey between September 2014 and February 2015 to explore how service users with urgent healthcare needs accessed A&E services. The report found that 52% of service users decided to go to A&E themselves, 39% attended on the advice of someone in another part of the healthcare system, 7% attended on the advice of a friend or relative and 2% could not remember (PA and RCEM, 2015). Service users were also asked if they had tried to access primary care treatment before attending A&E. Almost a quarter (23%) reported that they had contacted their GP surgery to make an appointment before presenting at A&E and, of these 23%, almost half (45%) had been informed that they could be seen by their GP the same day (with an average appointment time of within 3

hours of their telephone call). The PA and RCEM (2015) commented that an ‘inescapable message’ arising from the survey is that many service users are:

“reluctant to accept a wait of as little as 3 hours to see a GP when they perceive their care needs as urgent – even when their symptoms have been present for several days. Many patients attend at the behest and advice of other healthcare providers including those who, it is suggested, could act to reduce A&E attendance. These behaviours emphasise the lack of trusted available alternatives” (p.7-8)

The decision to attend A&E (and by association other emergency care providers) seems to be based, therefore, on service user ‘confidence and convenience’ (p.6). Tingle (2015) remarks that ‘patients can choose to go to A&E in their own time, at a time convenient for them’ (p.644). A recent RCEM report (2015) highlights that 43% of UK A&E departments have a co-located out-of-hours primary care facility and the PA and RCEM study (2015) concludes that ‘co-located services should include the full range of emergency medical services and out-of-hours primary care services that are necessary to meet both emergency and urgent care needs’ (p.8). One of the research questions for this thesis asks why service users choose to attend MIUs rather than an alternate healthcare provider. It will be useful, therefore, to compare the findings from the studies outlined above with the data compiled from case A and B. Another of the research questions for this thesis asks whether service users view themselves as ‘customers’ or ‘consumers’ of healthcare and, if so, is this reflected in their relationship with service providers. These will now be discussed in relation to service user and provider dynamics.

2.28 Service user and provider dynamics

Two empirical studies, and one opinion piece by Professor and Canada Research Chair Wendy Austin, provide insight into how healthcare marketisation and customer service models of care provision may be changing the relationship between service user and providers. The first, a small qualitative study by Johansen (2014), explores the relationship between nurses and service users

when accessing emergency care in the US. A sample of 9 emergency nurses from 2 hospitals in New Jersey participated in focus groups designed to investigate the types of conflict commonly encountered by nurses (when treating service users) and understand how they deal with interpersonal conflict. Johansen argues that competition between US hospitals for service users and their 'healthcare dollars' has changed nurses approach to delivering care and has created 'favourable conditions for conflict as the nurse tries to achieve specific patient satisfaction goals' (p.13). She concludes that nurses experience a 'disconnect' or 'mismatch' between management's priority to achieve high service user satisfaction scores (to increase potential revenue) and nurses' priority to provide high quality care. Nurses felt that service user satisfaction was important but that it was not necessarily an indicator of quality care. However, the study also has a number of limitations. Firstly, it was limited to two emergency departments in New Jersey that provide care to those with health insurance or are able to cover the costs of their treatment. Secondly, the sample was small and may not be representative. Both of these factors limit the transferability of the findings to the UK. Finally, the author remarks that the use of focus groups, rather than individual interviews, may have affected and/or limited the discussion as the result of reflexive behaviour.

A more recent study, involving the secondary analysis of others work, by Glasdam et al (2015) explored service users' participation in decision making when meeting with healthcare professionals in Denmark. The researchers selected two 'exemplary cases' from previous empirical studies. The first case emerged from a study investigating meetings between healthcare professionals, service users and their relatives in order to decide whether service users should receive treatment for cancer (Glasdam, 2003). Twenty-eight interviews were conducted with physicians, nurses, service users and their relatives in an oncology ward in Denmark. The second case used a combination of participant observation and interview (15 participants) to explore meetings between healthcare professionals and service users who had to decide whether to receive treatment for atrial fibrillation in an outpatient clinic. This case was part of an ongoing (but unpublished) study and provides insights regarding uncertainty about choosing the correct treatment. The researchers explained that

healthcare services in Denmark, like many other Western countries, are increasingly influenced by marketisation and neoliberal principles that frame healthcare service users as customers who must choose between different options. Consequently, the decision-making competence, in relation to choice of care and treatment, is seen as belonging to the service user rather than the healthcare professional. The healthcare professional continues to support the service user with their knowledge, preferences and alternative views but the service user must make their own choices and take responsibility for those choices in the present and the future. In this respect, the healthcare professional is free from responsibility once the information is delivered. The researchers conclude that service users do not always want to be a 'customer' or an 'expert' in the healthcare system and some 'want to be a patient, consulting an expert for help and advice as seen in both cases 1 and 2' (p.234).

However, the study has a number of limitations (not identified by the authors). Firstly, it does not explain how or why the 'exemplary cases' were selected or their reasons for choosing the data sets that they created their hypotheses from. There is also no discussion of sample selection in relation to validity or reliability criteria. Finally, the researchers adopt a theoretical framework for data analysis informed by Foucault and his concepts of power, resistance, and governmentality. Although this position fits with the overall aims of their paper, it may stifle alternative interpretations of the data since it is not clear whether the original studies were developed with this secondary analysis in mind.

Finally, Wendy Austin (2011) argues that corporate and commercial values that reframe the provision of nursing care in terms of a customer service model are inherently incommensurable with nursing conceived as a moral practice. Austin writes that few nurses would argue with the idea of empowering service users to make choices about their care but 'conceiving of patients as customers seemingly puts them at a safe distance' and 'refocuses the challenge of really seeing the person before you' (p.163). Although none of these papers are from the UK, and both empirical studies have

clear limitations, it will be interesting to see whether the view expressed above are replicated in the data from case A and B. Before concluding this chapter it is necessary to synthesis each of the above themes in relation to the specific area in which my study took place, namely the use of MIUs by service users who may, or may not, exhibit varying degrees of consumerist behaviour when doing so.

2.29 Consumerism and consumer behaviour in the MIU

It is clear from the literature discussed above that attempts to designate service users as co-producers and consumers of healthcare has had mixed results. For some, it has led to better standards of care and greater satisfaction with healthcare services but this is not the case for all. Clarke et al (2007) remark that these are 'unstable encounters' (p.67) in which the possibilities of getting it wrong have multiplied as both the service users and providers try to manage each other during increasingly uncertain times. Having been promised choice of service provider by successive Governments, many service users, understandably, do not wish to see their local provider closed, downgraded, merged or moved. Although service users want to be more involved in individual decisions about their treatment and care, there is little evidence that they want increased choice of healthcare providers except where local services are poor (Fotaki et al, 2005, 2008; Dixon et al, 2010). Consequently, whilst there seems to be widespread agreement that NHS services must continue to be person-centred and delivered on the basis of individual need, it is important to emphasise the difference between 'personalisation' of care and 'choice' of care. The former supports the creation of services that are individually 'owned by' or 'tailored for' service users but it does not guarantee when and where it is delivered (Bojakowski, 2008; Owens, 2012,). That is not to say that all services should be delivered in large specialist centres and both Palmer (2011) and the NHSC report (2013) support the view that many hospital-based services can be delivered more efficiently and cost effectively in the local community. One example that is already well underway is the transfer of minor injury/illness services, walk-in centres and outpatient care from hospital to non-hospital settings (Palmer, 2011). According to Monitor (2014) the aim is to:

“improve patients’ access to primary care, modernise the NHS to be more responsive to patients’ busy lifestyles, and offer patients more choice” (p.4).

Predictably there is a market analogy and many supermarkets have established ‘local’ stores in order to increase profitability in an increasingly competitive and segmented market. This involves increasing trade from smaller stores, extending opening hours and providing a smaller selection of essential goods (Solomon et al, 2013). Although transferring services from hospital to community settings (or from large general hospital to small community hospital/site) is not for profit, it is intended to be more efficient, save money and represents the same ‘kiosk approach’ adopted by supermarkets. MIU’s, for example, provide a tailored local service, with limited staff and skill-mix (typically nurses and health care assistants) offering extended or 24-hour care for a limited range of complaints. The intention is that the organisation and consumer both benefit from tailored, locally provided services. According to Solomon et al (2013) if a product is introduced which is easier to buy, the ‘fickle’ consumer will not hesitate to do so. This also applies to convenience of location in a healthcare context providing the service is considered to be at least as good as that provided at greater distance. However, there is also a risk that service users will continue to expect the same range of services provided by larger sites/centres unless there is clear information regarding the type of care provided. MIUs were selected as the cases for this study since they serve a large community with multiple and diverse needs and provide a crucial bridge or stepping-stone between primary and secondary care services. Although there is a high degree of homogeneity regarding clinical protocols and professional practice, there is also much diversity in terms of the types of services offered and the culture at each site. Consequently, MIUs offer an opportunity to sample and examine the NHS in microcosm and test some of the theories discussed above.

In conclusion, there has been much debate regarding whether genuine choice is possible in the NHS and whether healthcare service users genuinely want it. The picture is complicated and attempts to conceptualise service users as consumers and co-producers of healthcare have had mixed results.

Clarke et al (2007) found that the concept of the NHS marketplace was generally viewed with distrust and that service users contrasted the personal relationship they experienced with healthcare professionals with the anonymity experienced by many customers. They also found that service users did not necessarily focus on their own needs but valued the 'publicness' of the NHS and how it functioned for others. At the same time, many service users appear to be highly knowledgeable and discriminating when making choices regarding when and where to seek healthcare and welcome the opportunity to attend a preferred healthcare provider on the basis of convenience and trust. Conversely, there is little evidence that service users want increased choice of healthcare except where services are poor and there has been widespread resistance to closures of local services even though they may result in better clinical outcomes.

Overall, it appears that although service users value and appreciate the offer of choice, and the sense of self determination that this provides, they do not always want responsibility for choosing their healthcare provider or treatment. Moreover, increasing specialisation in healthcare, and the need to travel for specialist services, may further limit personal choice in this regard. In order to take these factors out of the equation, I decided to conduct my study in a clinical area which is conceivably, although not always, located in most major population centre so as to detract from some of these geographical and specialist limitations. Most people have accessed an MIU at some point (as a stand-alone centre or as part of an A&E) and, for the most part, they will have done locally. In the following chapters I will demonstrate how my study was conducted in such a way that consumerism and consumerist behaviour could be observed and analysed in a context where service users' typically did not require care provided by specialist regional or national centres.

The following chapters will explore service user choice and behaviour at two MIUs in order to assess whether or not they view themselves as consumers or customers of healthcare and why they hold this view. Whilst some of the studies discussed in this chapter identify convenience and trust as important considerations when service users make decisions about healthcare provision, it is

important to understand why they are making these choices, what factors have contributed to this process and what effect, if any, it is having on expectation of care and service delivery. It will also be interesting to compare the findings from Clarke et al's 2003-2005 study (published 2007) conducted in primary care settings with the findings from this research, a decade later, in order to assess whether service user views have changed or remain broadly the same.

Chapter 3: Methodology

3.1 Introduction

The principle aim of this research is to investigate what drives individual and collective consumer behaviour in healthcare, how this behaviour is expressed, and what advantages/disadvantages it provides for service users and providers. In the preceding chapter we observed that consumer behaviour is complicated and frequently described in seemingly contradictory terms (i.e. good and bad consumers). However, both extremes are equally simplistic and consumers move between positions as their motivations change and evolve in response to differing needs and circumstances. This is represented in the literature and some service users welcome the opportunity to make choices and decisions about their healthcare and appear to be knowledgeable and discriminating when doing so. Conversely, other service users do not want to take responsibility for choosing their healthcare provider or treatment and may lack the skills to research available options etc. This is not surprising per se, but it raises the question whether choice and competition encourage equity and equality of service provision for all. The literature also highlights how conceiving of service users as customers or consumers of healthcare may place them at a 'safe distance' from service providers as they are expected to take greater responsibility for their care/treatment and the risks this may entail (Austin, 2011).

In this chapter I will explain how the research process addresses the research questions and explain why a combination of ethnographic and case study method represents the best fit in this instance (3.2-3.5). This includes discussion of how my interpretation of this tailored approach differs from others researchers. The next sections (3.6-3.8) outline how the two cases were selected and examine practical considerations associated with preparation, access and feasibility. The following sections (3.9-3.17) discuss the data collection instruments with particular emphasis on the challenges associated with the participant observer role. The interview process is also discussed in detail with explanation of how my own experience as an ENP, and the *Creating Citizen Consumers*

study, inspired and influenced the interview questions. The next sections (3.18-3.22) discuss ethical considerations including justice, worthiness, informed consent, anonymity and confidentiality. The penultimate sections (3.23-3.26) explain the criteria used to ensure the trustworthiness and credibility of the study. The final sections (3.27-3.28) discuss how the data was analysed. This includes explanation of how I dealt with a number of specific challenges and explanation of how I developed the typology of consumer behavior in relation to the literature discussed in chapter 2.

3.2 Rationale for undertaking a qualitative study

The research questions posed by this study are inherently qualitative in nature. That is to say, they seek to understand the quality of a number of social variables within an identified social setting. The aim of qualitative inquiry is to develop understanding of social phenomena in natural, rather than experimental, settings and to provide insight into the experiences and views of the participants.

According to Pope and May (1995) qualitative studies are concerned with:

“...answering questions such as 'what is X and how does X vary in different circumstances, and why?' rather than "how many Xs are there?" (p.43).

However, there are a wide range of overlapping approaches to qualitative research including ethnography, case study, phenomenology, grounded theory and action research (Holiday, 2007). A combination of ethnography and case study was considered to represent the most appropriate methodology in this instance for a number of reasons. Firstly, the study is primarily interested in why people (service users) act the way they do when making choices regarding their healthcare. The word ethnography literally means ‘writing about people’ and ethnographic study has its roots planted in the fields of anthropology and sociology (Genzuck, 2003; Ybema et al, 2010). In a broad sense, therefore, ethnography encompasses any study of a group of people for the purpose of describing their socio-cultural activities (Burns, 2000). Fetterman (1998) remarks that ethnography is the:

“Art and science of describing a group or culture and that description may be of a small tribal group in an exotic land or a classroom in middle-class suburbia” (p.1).

Ethnography comprises many methods or tools for gathering data but what distinguishes ethnographic research is its purpose - cultural description (Uzzell and Barnett, 2006). Spradley (1980) defines culture as ‘the acquired knowledge people use to interpret experience and generate behaviour’ (p.6). According to Holliday (2007) when a researcher looks at an unfamiliar social grouping, it can be said to have ‘a culture’ when there is a discernible set of behaviours and understandings connected with group cohesion. In this study, I try to identify patterns of behaviour that explain why service users make/don’t make particular choices and decisions regarding their healthcare. This assists identification of different categories of behaviour and facilitates the creation of typologies that explain and predict individual and collective ways of thinking/acting regarding choice and decision making. Secondly, I hope to understand whether service user choice and decision making is encouraged/supported by service providers (a group with their own culture) and how this may affect the relationship between service users and providers now and in the future. In order to achieve this, it is necessary to interview service providers and to observe their interaction with service users to ensure that what they say is consistent with what they do. The best way to achieve this is through participant observation whereby the researcher becomes part of the service provider team and is able to view events from an insider perspective (see 3.10-12 for further discussion). Ethnography encourages the researcher to engage closely with the subjects as they undertake the activities being investigated in order to scrutinise their views and the circumstances in which the activity takes place (Fetterman, 1998; Silverman, 2010).

3.3 Ethnography and interpretative inquiry

Ethnographic research is an example of interpretative research in which ‘the researcher is involved in a process of interpretation and (re)construction of reality’ (Uzzell and Barnett, 2006, p.3013). The naturalistic or interpretive approach presupposes that all knowledge of reality, including the domain

of human action, is socially constructed by human actors, including the researcher (Walsham, 1993, 2006) whilst Geertz (1973) suggests that:

“What we call our data are really our own constructions of other people’s constructions of what they and their compatriots are up to” (p.9).

Such a perspective suggests that the social world is not objective but involves subjective meanings and experiences that are constructed by participants in social situations (Burgess, 1984) and the interpretive researcher attempts to understand phenomena by accessing the meanings participants assign to them (Orlikowski and Baroudi, 1991). Geertz (1973) argues that culture and behaviour cannot be studied separately because they are inherently intertwined. He writes that by analysing the whole of culture, as well as its constituent parts, it is possible to develop a ‘thick description’ which details the mental processes and reasoning of those being studied (Geertz, 1973, p.5-6). According to Denzin (1989) thick descriptions are ‘deep, dense, detailed accounts... [whilst]...thin descriptions, by contrast, lack detail and simply report facts’ (p.83). To illustrate thick description, Geertz points out that there is a wealth of difference between the ‘thin description’ and ‘thick description’ and argues that the object of ethnography is to decipher and interpret stratified hierarchies of cultural categories (Geertz, 1973). Those reading the research need to be able to formulate a connection to the researcher’s version of reality that resonates with their own, and the best way to achieve this is to write in as much detail as possible at all stages of the research process. This also helps to ensure the credibility, transferability, dependability and confirmability of the data, as well as ensuring that the study has been conducted ethically (see 3.23-26). Consequently, ethnography is a style of research, rather than a single method, and uses a variety of techniques to collect data. According to Morse (2016) good ethnography requires multiple data sets, using different methods, all with adequate samples. She suggests that:

“Each data set is a piece of the puzzle, to be reflected on in light of the others, to indicate the collection of further data to further confirm, or to illuminate, or to disconfirm what the researcher is thinking” (p.875-6).

In attempting to capture the social reality of a group, therefore, the formulation of appropriate research problems, and asking appropriate questions, becomes the most important feature of the research (Burns, 2000).

3.4 Case study research

According to Yin (1994) when ‘how’ and ‘why’ questions are being posed, the preferred strategy of inquiry tends to be case study. Case studies are an appropriate research method when trying to attribute causal relationships and not just seeking to explore or describe a situation. They are also recommended when the research relates to contemporary phenomena, within a real-life context, where the researcher has little control of the behaviours and events being investigated (1993). This fits well with the research aims and objectives for this study which seek to investigate what drives individual and collective healthcare consumer behaviour at two MIUs. Another important consideration when undertaking case study research is the relevance of context to the phenomenon being studied. Consequently, there will always be more variables of interest than data points to be analysed and case study relies upon multiple sources of evidence, with data needing to converge in a triangulating fashion (see 3.18). According to Yin (1993, 1994) case study design must have five components: the research question/s, its propositions, its unit/s of analysis, a determination of how the data are linked to the propositions, and criteria to interpret the findings. The primary and secondary research questions are summarised below:

- Has the introduction of market reforms to the NHS influenced the way in which service users access care and interact with service providers when receiving it?

- Do service users view themselves as 'customers' or 'consumers' of healthcare and, if so, is this reflected in their relationship with service providers?
- Do service users participate/wish to participate in healthcare decision making during clinical consultation/treatment?
- Why do service users choose to attend MIUs rather than an alternate healthcare provider?

Propositions help to identify theoretical issues and themes that inform the construction of the research design. For example, the following proposition presents a theory that there is a causal relationship between healthcare policy and the way in which service users access and use healthcare services in MIUs.

- The case study will show that Government policy (since the 1980s) has actively encouraged consumer behaviour amongst healthcare service users and that this behaviour is becoming the norm

The next statement represents a rival theory that can be used to direct data collection and inform analysis of the data.

- The case study will show that the relationship between service users and providers is dynamic and evolving but that offering service users greater choice may not be sustainable

The number and type of case studies depends upon the purpose of the inquiry which may be exploratory, descriptive, interpretative or explanatory (Zucker, 2009). In this instance, a collective or comparative case study design was selected since it allows the study of a number of cases in order to inquire into a phenomena described above. Multiple case studies include two or more cases within the same study and should be selected in order that they can replicate one another - either exact (direct) replications, or predictably different (systematic) replications. The next consideration is how to define the unit of analysis to be studied and to ensure that the questions of the study are relevant

to the selected unit of analysis. The unit of analysis can vary from an entire organisation to an individual or group of individuals.

However, in order to qualify as a case study, the unit of analysis must have clearly demarcated boundaries (Smith, 1978) and must be an entity within itself which focuses on a bounded system that is either highly representative or extremely atypical (Burns, 2000). It is vitally important, therefore, to differentiate between the setting in which the research will take place, and the case (or unit of analysis) to be studied. Hammersley and Atkinson (2007) propose that a setting is a named context in which phenomena occur that might be studied from a number of angles. A case, on the other hand, represents one or more phenomena which is/are the exclusive object of inquiry or analysis in that setting (Yin, 1994). Any setting will inevitably contain a large number of potential cases and the researcher must ensure that inquiry remains focused on the object of the inquiry if they are to ensure detailed and thorough data collection and that the case study remains appropriately bounded. It might also be necessary to go beyond the confines of the setting to collect information relevant to the case. At the same time, it is common for each case to contain further 'embedded' units of analysis. For example, a school (or schools) might constitute the main case/s, but an embedded unit of analysis might be the students or teachers within the school (Yin, 1993).

In this study, the unit of analysis is consumer behaviour in a healthcare environment. The MIUs represent bounded social systems in which service users have an opportunity to make consumer choices regarding the provision of healthcare and the treatment they receive (see chapters 4-5). The cases contain a number of inter-related locations where relevant social interaction may occur, both within the confines of the setting and outside of it. For example, advice or information given to the service user by a telephone referral system or GP surgery. These are outside the immediate setting but have an impact on the object of inquiry (case) being studied. Other phenomena may also be observed within the confines of the setting but they should not receive attention since they are of

no relevance to the case being investigated. For example, shift patterns or skills-mix in the MIU which, whilst essential to successful operation of the setting, does not impact upon the specific object of inquiry. Embedded units of analysis include service users and service providers from case A and B. With its own unique culture and history, each case is an extremely complex phenomenon, therefore, operating within a number of contexts, backgrounds, reified discourses and behaviours. Stake (1994) comments that the case is singular 'but has subsections, groups, occasions, a concatenation of domains - many so complex that at best they can only be sampled' (p.91).

3.5 Combining case study and ethnographic research methods

Although case study and ethnography share many of the same data collection techniques, and rely on multiple sources of evidence, Yin (1993, 1994) points out that there are key differences between the two approaches. He proposes that case study may be characterised as seeking (a) to define specific questions of study ahead of time, (b) emulate positivism in developing rival hypothesis and collecting external evidence bearing on these questions, and (c) carrying out fieldwork in a targeted and time limited fashion (1993, p.46). This may involve an extended data collection period for each case (typically a year or more) or a one-time data collection phase (typically a shorter number of days). If the latter strategy is selected (as in this study) much of the critical information must be collected through interviews and documents since the investigator/s have less control over whether the relevant events will reliably occur (or not) at the right time and place to observe them (p.35). Yin (1993, 1994) argues that ethnography, on the other hand, encourages fieldwork for a prolonged period of time in a relatively unstructured manner, challenges the positivist position by claiming that evidence cannot be independent of the investigator, and that 'thick' description makes the narrative overly detailed and possibly tedious to read.

Whilst I agree with Yin that case study research offers many advantages when studying contemporary phenomena in a real-life context, and that it provides a valuable framework when 'how' and 'why' questions are being posed, I strongly disagree with the assertion that case study

must emulate a positivist approach and that the evidence it provides represents objective truth. In some circumstances, case study may allow rival hypotheses to be developed etc.. but this should not preclude its application to naturalistic or interpretative research particularly when the researcher has little or no control over the events and behaviours being investigated. Furthermore, case study (and ethnography) encourage the use of direct and participant observation as a data collection instrument. When undertaking this role, it is essential that the researcher acknowledges that their presence in the field may impact upon the setting and the responses/behaviours they observe. They must also identify and manage their own preconceptions and prejudices (see 3.11 for further discussion). Consequently, the very nature of participant observation requires the researcher to maintain an interpretative or naturalistic position. This does not undermine the researcher's commitment to realism but guards against the assumption that knowledge must be based on some absolutely secure foundation (Hammersley and Atkinson, 2007).

I also disagree with Yin that ethnographers spend too long in the field and that 'thick' description renders the narrative overly descriptive and tedious to read. There may come a point where nothing new is being learned from the field and further engagement is unproductive (see 3.23). However, all the time new insights are being provided the researcher should, if possible, continue to collect data. Thick description also allows the reader to formulate a connection to the researcher's version of reality in order to ensure reliability (Silverman, 2010; see also 3.26). Stake, proposes a similar series of necessary steps for completing case study method to Yin but advocates a more naturalistic approach (1994, 1995). According to Stake (1994) case study is characterised by the researcher spending a substantial amount of time in contact with the activities and operations of the case, reflecting and revising meanings of what is going on. This type of immersion in a culture allows the researcher to document observations and experiences, if not in real-time, shortly after the event. The process may appear unsystematic at the outset but the detailed record of observed phenomena produced by the participant observer is an essential component of the thick description of the case. Consequently, this study used an ethnographic approach to data collection (the benefits and

disadvantages of which are discussed further below) combined with the structure, theoretical underpinning and replication logic afforded by comparative case study. Both approaches allow for the inclusion of qualitative and quantitative data and use multiple data collection instruments in a triangulating fashion.

Yin (1994, p.8) observes that case study relies on many of the same techniques as historical investigation but adds two sources of evidence not usually available to the historian: direct observation and systematic interviewing. History remains an important consideration when undertaking any study of social systems since all institutions are essentially transitory and subject to internal and external drivers. Mills (1970, p.168) proposes that if we want to understand the dynamic changes in a contemporary social structure, we must try to discern its longer run developments and ask 'what are the mechanics by which these trends have occurred, by which the structure of this society is changing?' In order to answer that question, he proposes that we must make a statement of at least 'from what' and 'to what' (Mills, 1970, p.168). Document analysis of NHS policies and contemporary consumer attitudes helps to provide insight into why and how service users approach decision making when accessing front line healthcare services. However, without observation and interview any conclusions drawn will be limited, unfocused and speculative at best.

3.6 Selection of case study locations: practical considerations

Hammersley and Atkinson (2007) remark that research 'never starts from scratch; it always relies on common-sense knowledge to one degree or another' (p.50). It is often the case, therefore, that the researcher already has a connection to the social group or setting being investigated (Corrigan, 1979). It is important not to underestimate the significance of pragmatic considerations when selecting an appropriate setting to undertake research and Hammersley and Atkinson (2007) comment that:

'Contacts with personnel promising easy access, the scale of the travel costs likely to be involved, and the availability of documentary information, etc. are often major considerations in narrowing down the selection' (p.30).

Sampson and Thomas (2003) describe how they utilised their previous experience of practical issues to maximise data collection opportunities when selecting potential cases:

In the course of our research we deliberately selected a high proportion of ships with long sea passages and few port calls. This was the result of our finding that seafarers tend to have little free time in port...Our choice of ship was thus driven by our assessment of the optimum conditions for data collection' (p.170).

There is nothing wrong, therefore, with selecting a research site on the basis that it offers the most practical and realistic opportunity to access and retrieve data.

As noted previously, two MIUs were selected as research sites/cases since they operate on a walk-in basis, serve a large community and provide care for a wide range of illnesses and injuries. They offer a unique opportunity to sample and observe planned and spontaneous consumer behaviour in a healthcare environment with minimal risk of causing further distress or inconvenience. Furthermore, my own experience as an Emergency Nurse Practitioner (ENP), 10 years previously, also proved to be of great benefit when trying to secure access to the research settings. Firstly, it provided a degree of professional credibility that helped the researcher to integrate with the teams in case A and B. Secondly, it contributed to the formulation of research questions and theoretical propositions, and provided a degree of insight regarding 'foreshadowed problems' (Delamont, 2002). The acquisition of a licence to operate (honorary contract) was another important consideration since it enables interaction with service users and providers in a manner that would not be possible as an outsider. Other practical considerations that influenced the selection the research settings include the fact that both sites were located within manageable driving distance of the researcher's place of work (no more than 18 miles). This was important since there was a limited amount of time available to

spend in the field and it was sensible to maximise the time spent at the research setting. This provided greater opportunity to undertake data collection and write-up field notes during/following participant observation and interview.

3.7 Gaining entry and building rapport in the study settings

Before data collection could commence at the MIUs in case A and B it was necessary to seek ethical approval from the NHS REC and permission from the Hospital Trust where the research would take place. The application to the NHS REC was made via the Integrated Research Application System in May 2014 and following committee review (June 2014) I was informed that the proposal had been rejected in its current format. The principle objection related to use of participant observation as a data collection instrument and the committee asked for further clarification regarding how this would be implemented in practice. They also requested that all those attending the research sites (when data collection was taking place) received a detailed participant information sheet (PIS) regarding the participant observation process as well as the use of posters alerting them to the fact that research was taking place (see also 3.10, 3.15).

Favourable ethical opinion was eventually provided in August 2014 following a number of specific revisions and clarifications to the PIS document. Management permission/approval was then sought from the host organisation prior to the start of the study. Site specific documentation was submitted and reviewed by their R&D Department and Caldecott Guardian before permission to commence data collection was approved in October 2014. During the interim period between NHS REC and local R&D approval (August - October 2014) it was also necessary to gain agreement to undertake data collection from appropriate individuals in authority (gatekeepers) at both research sites. Initially, an e-mail (and letter) of introduction was sent to the ENP senior manager responsible for both sites to explain the purpose of the research and to ask permission to undertake data collection at what would become case A and B. A meeting was arranged to discuss practicalities and to answer questions regarding service user/provider recruitment, confidentiality and the interview/observation

process. I was able to provide reassurance that the research sites would be respected throughout the data collection process and that there would be no disruption to service user 'journey' (Cresswell, 2009). The senior manager was positive and enthusiastic about the study and kindly agreed to act as Hospital Trust supervisor for the duration of the data collection process (a requirement for R&D approval).

Following this meeting, further e-mails/letters of introduction were sent to the individual unit managers from case A and B to ask their permission to undertake data collection at their place of work (subject to favourable opinion from the Trust R&D committee). Fortunately, by the time they received this correspondence, the senior manager had already had an opportunity to discuss the research project with them and they were also supportive and accommodating from the outset. However, had the senior manager, or either of the unit managers, been reluctant or unwilling to support the study (even with a favourable opinion from the R&D committee) the data collection process, and possibly the choice of sites/cases themselves, would have had to have been reconsidered and revised. Sampson and Thomas (2003) describe a similar situation where agreement from a number of parties was necessary to carry out fieldwork on board ship. They describe how obtaining permission from the ship's owners was only the first step in the process and that the success of the research ultimately depended on securing the support of the Captain. Even with his cooperation, however, they found themselves involved in a constant round of negotiations and further requests for access throughout the research process.

3.8 Feasibility and preparation

Sampson (2004) suggests that a pilot study may prove a useful way to foreshadow research problems such as those identified above. Yin (1994) also comments that pilot studies can be used 'formatively' to develop relevant lines of questioning and help refine data collection instruments. Consequently, once the unit manager from case A had agreed to allow access, I worked a number of shifts as an ENP (September 2014) in order to assess potential problems re: data collection and get

to know the staff/unit before the study commenced in October. Although this did not represent a formal pilot study, it did allow me to familiarise themselves with the organisational culture in case A and to observe the service user 'journey' through the department. Once R&D approval had been confirmed, written invitations to participate in the research were provided to all clinical and non-clinical staff from case A (and latterly case B). The individually addressed envelopes included an invitation letter and two participant information sheets (one explaining the research process and one explaining the interview - appendix 4ab, 5). On receipt of this information, a number of potential participants were keen to ask questions about the research topic and appeared genuinely interested in the project. I provided honest and informed answers to their questions but tried to limit details/specifics that might contribute to bias or influence their behaviour/responses in the future. Some members of staff expressed strong views regarding changes to the NHS from the outset but since many of these opinions were not directly relevant to the research it was convenient to discuss them at the time.

3.9 Data collection approaches

Evidence for case studies may come from six sources: archival records, documents, direct observation, participant observation, interview and physical artefacts (Zucker, 2009). Yin (1994) remarks that when visiting the case study 'site', the researcher creates an opportunity for direct observation. This may be informal observation that takes place at the same time as other data collection techniques (e.g. interview). Alternatively, it may be formal observation and could, for example, relate to the investigation of certain types of behaviour within the case during a particular period of time (Wilkinson, 1995). Participant observation, on the other hand, requires the researcher to embed themselves within the case they are studying. According to Patton (2002) the challenge is to combine participation and observation so as to become capable of understanding the setting as an insider while describing it to and for outsiders. However, this can create tension between emic and etic approaches to data collection. An emic approach involves the study and analysis of the

setting or behaviour from the perspective of the participants being investigated. According to Morse and Field (1996) cultural explanations and patterns are 'inductively discovered within the cultural context' (p.198) rather than analysed from the researcher's perspective or from prior theory. In etic research, on the other hand, the categories for data collection are decided before entering the field (Alexander, 1982). One of the strengths of the etic approach, therefore, is that it allows for comparison across contexts and populations, and the development of more general cross-cultural concepts (Morris et al, 1999). The tension lies in the extremes of the two. A purely emic approach is difficult to achieve since most research is informed, to some degree, by the researcher's idea and background and from previous studies. Similarly, an entirely etic stance risks ignoring emerging themes and concepts which may prove new and innovative. A tailored approach is necessary and desirable, therefore, since each qualitative research design will be slightly different according to the nature of the social setting investigated.

3.10 How observation was operationalised in the study

Data collection took place in a number of concurrent and complimentary stages. The first stage of the data collection process involved participant and direct observation to provide evidence of service user/provider interaction and organisational culture. Hammersley and Atkinson (2007) remark that personal appearance is an important consideration when undertaking overt and covert participant observation. For the most part, I adopted the same uniform as other members of Emergency Nurse Practitioner (ENP) staff in order to strengthen a sense of professional identity, engender trust and reinforce 'insider' status. This seemed to be successful and although I always explained my status (as a member of University staff with a licence to operate as an ENP) to service users, and displayed my University identification badge, no one I approached declined care or treatment from me. Interestingly, during the one shift (case A) I dressed in normal clothes (with my University identification badge visible) I was unable to recruit any interview participants and those I treated seemed more apprehensive regarding my clinical competence.

From an ethical point of view, it was essential that all participants were made aware of the observation process from the outset. Posters were clearly visible in all public spaces at both cases and participant information sheets (PIS) were provided to service users at reception and to service providers with their letter of introduction (appendix 2, 3a, 4ab, 5). At the same time, however, it was beneficial for me to maintain a discrete presence since it allows me to observe and scrutinise attitudes, behaviours, opinions and feelings in context and unhampered by self-conscious behaviour. Yin (1994) suggests that the researcher is able to perceive 'reality' from the viewpoint of someone 'inside' the case study rather than external to it. As discussed above, the researcher must ensure that they continue to maintain the stranger position whilst embedded in the group or organisation being studied. Howe (1953) argues that this is not hypocrisy but rather living a ruse: 'deceiving the society to study it and wooing the society to live in it' (p.60-1). In this case, there is no direct deceit or dishonesty, simply that I was careful to remain low-key and inconspicuous throughout the data collection process in order to minimise the incidence of reflexive behaviour and observer bias. Similarly, I did not record incidents that occurred with service users they had cared for/treated to avoid the risk of observer and other forms of bias (e.g. selection, instruction, confirmation etc.). Consequently, only unsolicited interactions that occurred between (other) service providers and users were eligible and recorded.

Conversations with service providers and users (in the field) were also recorded when appropriate and with their consent. All of these interactions and encounters are anonymous and recorded numerically on a Field Note (FN) date basis (e.g. FN: Nov.15, 2014). No information that could identify the service user/provider is included unless permission has been specifically requested/authorised. One of the disadvantages I encountered as a result of the participant observer role is that clinical activity is very time consuming and limits the opportunity to observe for evidence of social interaction, make sufficiently detailed notes or pose pertinent questions from a number of different perspectives (Yin, 1994). On the other hand, this temporal unpredictability afforded a degree of randomisation to the observation process since it is difficult to predict how long

each service user consultation/ treatment will take until it is underway. Supernumerary status was essential, therefore, since it allowed the researcher to take time to observe, interview and complete field notes when appropriate. Finally, one of the reasons I chose to undertake the participant observer role was that it enabled me to contribute in a practical way to the workload at both MIUs. I was aware that my presence as a researcher could prove intrusive and had the potential to delay treatment etc. for service users in an already demanding and pressurised environment. Consequently, by working as an additional member of the ENP team, I hoped to offset any delays or interruptions that recruitment and interview may provide. In this way, my impact on the research site was kept to a minimum in accordance with the ethical principles discussed below in 3.19. This also helped to strengthen my position in the ENP teams at both sites since I did not interfere or hinder their day-to-day work.

3.11 Preconceptions, prejudices and insider-outsider tensions

As noted in section 3.5, when undertaking the participant observer role, it is essential that the researcher identifies and manages their own preconceptions and prejudices. For example, before data collection commenced, I expected service users and providers to be broadly opposed to the notion of healthcare customers or consumers. This was partially informed by the literature (particularly Clarke et al, 2007) and partially by my own experience as an ENP a decade earlier. However, whilst this proved to be correct for some of the participants, it was certainly not correct for all. Moreover, their responses and behaviours were much more nuanced than I had anticipated and I quickly had to reassess this view. Also, from a professional point of view, I had tended to view service users who attended MIU with non-urgent complaints as 'inappropriate attenders'. However, once I started to understand why many of them were presenting to case A and B for care, rather than an alternative provider, I also had to re-evaluate this view.

Another important consideration when undertaking the participant observer role is to be aware and responsive to the tensions involved in being a 'marginal native' in the research environment in

relation to insider-outsider status (Lave and Wenger, 1991). It is often the case that the researcher already has a close connection to the social group or setting being investigated (Corrigan, 1979). Hammersley and Atkinson (2007) remark that when undertaking research in a familiar setting 'it can be more difficult to suspend preconceptions, whether these derive from social science or from everyday knowledge' (p.81) whilst Cameron et al (1992) comment that researchers cannot help being 'socially located' (p.52) and, as such, they become part of the social landscape they are investigating. It is not always possible, therefore, to totally eliminate personal and ideological influences when undertaking research since it is frequently guided by the researcher's beliefs and feelings about the world and how it should be understood and studied (Denzin and Lincoln, 2005). Consequently, one of the key challenges I faced was the temptation to over-identify with ENP colleagues. This was complicated by the fact that my (former) ENP status had proved very useful regarding access to the research site and had enabled me to integrate into the team much more easily than would have been the case if I had not possessed this professional credibility. It also allowed me to make informed judgements regarding the use of medical terminology that would not have been possible as a non-native. Spradley (1980) points out that it is easy to overlook language differences and lose important clues to cultural meanings. In this instance, therefore, the way in which terminology was applied and explained/not-explained by service providers proved to be an important consideration regarding service user choice and participation in healthcare decisions.

Finally, spending time with the different members of the team from case A and B meant that I started to build a personal as well as a professional relationship with them as friends and colleagues. This presented a further issue regarding conflict since I was aware that it may be necessary to record opinions or behaviours that could present members of the team in an unfavourable or critical way (see 3.18 for further discussion). All of these factors needed to be recognised and guarded against during the data collection and analysis process in order to ensure objectivity and emotional distance. Consequently, whilst insider status allowed me to observe and interpret events from the point of

view of the social actors, it was equally important that I continued to approach the participants from the point of view of an outsider or stranger.

Holliday (2007, p.13) writes that even where the research scenario is familiar 'the researcher must find ways of recovering the stranger position'. However, this can be extremely difficult to achieve and the problem of over-familiarity in qualitative research is well documented (Miller, 1952; Hanson, 1994; Denzin and Lincoln, 2005; Hammersley and Atkinson, 2007). Spradley (1980) argues that it is no coincidence that ethnography has its origins in the study of non-Western cultures since 'the *less* familiar you are with a social situation, the *more* you are able to see the tacit cultural rules at work' (p.61-2). Fortunately, it had been a decade since I had worked as an ENP and much had changed in terms of the organisational set-up since then. As a result, I was forced to view the department from the point of view of a new member of staff as well as recognise that my professional skills were not at the level they had been 10 years previously.

Another factor that helped to maintain my status as 'marginal native' was that ENPs work in a largely autonomous fashion and it was possible to remain self-directed and self-sufficient throughout most the data collection period. This was assisted by my supernumerary status and I was able to break-off as necessary from service user care/treatment to record field notes etc. without negatively impacting on others work. According to Morse et al (2002) 'research is only as good as the investigator' and it is the researcher's 'creativity, sensitivity, flexibility and skill' when using verification strategies that determines the quality of the research (p.10).

3.12 Participant observation and reflexivity

In order to establish the rigour of the research process, the researcher must acknowledge and demonstrate how they have responded to the social setting/s in which the research took place (Holliday, 2007). They must use their knowledge of the environment whilst, at the same time, recognising that it might be erroneous and subjecting it to systematic enquiry (Hammersley and Atkinson, 2007). This is often referred to as reflexivity or the process of reflecting critically on the

self as researcher. Guba and Lincoln (2005) propose that reflexivity forces the researcher not only to come to terms with the choice of research topic and with those with whom they engage, but also with themselves and with the multiple identities that represent 'the fluid self' (p.210) in the research setting. Reinharz (1997) suggests that these different identities fall into three broad categories: research based selves, brought selves, and situationally created selves. The concept of reflexivity acknowledges, therefore, that the motivation and orientation of the researcher will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them (Hammersley and Atkinson, 2007). Consequently, throughout the data collection process, I was aware that I must maintain a reflexive standpoint when observing (and interviewing) participants in order to avoid introducing leading behaviours or projecting my own views and feelings onto the situation. At the same time, I also tried to maintain a questioning and analytical position in order to interpret and understand participant motivation and orientation. This is important since those being observed cannot help but develop an impression of the researcher/observer and use that impression as the basis of their response (Vidich, 1955).

For example, I noted in section 3.10 that during one shift in case A, when I was wearing normal clothes as opposed to a uniform, I was unable to recruit any interview participants and those I treated seemed more apprehensive regarding my clinical competence. This is important to recognise since the subject/s may change or improve aspects of their behaviour in response to awareness of being observed (McCambridge et al, 2014). LeCompt and Goetz (1982) propose that this type of behaviour may be conscious, in order to reveal the subject in the best possible light, or it may be an unconscious distortion performed to provide what they believe the researcher wants to see. This was particularly important when observing and interviewing service providers and one of the reasons I chose to conduct their interviews towards the end of the data collection process was to allow them to get used to my role/presence as a colleague rather than a researcher. I also tried hard to blend into the work environment to minimize the impression that their behavior was being scrutinized (as well as providing benefit to the department as discussed above). Becker (1958, p.654)

suggests that in order to ensure the credibility of informant's actions and statements, therefore, it is necessary to consider:

- Whether the informant has reason to lie or conceal some of what he sees as the truth?
- Whether vanity or expediency lead him to misstate his own role in an event or his attitude toward it?
- Whether he actually had an opportunity to witness the occurrence he describes or is hearsay the source of his knowledge?
- Whether his feelings about the issues or persons under discussion lead him to alter his story in some way?

3.13 Choice of interview technique

Burns (2000) remarks that it is common to complement data from participant observation with information obtained from interview. There are three main types of interview that can be conducted by the qualitative researcher: structured, unstructured and semi-structured. Structured interviews typically involve strict adherence to a particular set of guidelines and each respondent is asked the same questions, in the same order, without any deviation from the protocol (Fontana and Frey, 2005). In some cases, the interviewer is also required to demonstrate consistency of behaviour during the interview and reaction to participant responses is kept to a minimum or avoided entirely. However, in this instance, I considered this approach too constrictive since I wanted to be able to respond to participants' answers, as and when necessary, to explore emerging themes/topics. I also discounted unstructured interviews, whereby the respondent is encouraged to discuss the area of interest in their own words and on their own terms, since they are too open-ended (Bogdan and Biklen, 1992). Although this approach can help to interpret complex behaviour (without imposing *a priori* categorisation which may limit the field of inquiry) I was concerned that I may not be able to move the conversation in the direction of interest within the time provided. This could have resulted

in insufficient data being collected or required extending the data collection period. Consequently, I decided to adopt semi-structured interviews since I felt this approach offered the best chance of answering the research questions at the data collection sites.

Although the questions were prepared in advance and adhered to a schedule, I was able to change the question order, or probe the respondent for additional information, in response to a particular line of questioning. This also enabled me to formulate impromptu questions in order to explore unanticipated and emergent themes I had not considered previously (Smith and Eatough, 2006). This proved to be very useful and interview participants frequently provided insightful and unexpected observations that benefited from further exploration and scrutiny. At the same time, however, I was careful to remember that this approach provides greater opportunity to lead and/or influence the participants and that interviewer bias must be acknowledged and guarded against. It was also important to recognise that participants may experience anxiety regarding the interview process itself, particularly when disclosing sensitive and confidential information about themselves or others. In order to alleviate this concern, I explained that any personal information would be redacted from the interview transcript or designated a generic illness/injury category if appropriate. It was necessary, however, to request some biographical information (e.g. age, occupation etc.) since it may be relevant to the decision making process. However, there was no obligation to answer these questions.

3.14 Service user interviews

Whilst undertaking participant observation in case A and B, I planned to recruit approximately 20 service user interview participants from each site. Silverman (2001) suggests that 15 in-depth interviews are usually sufficient to allow for all the available views, opinions and attitudes of the target group to be collected. Consequently, 20 from each site seemed to represent a realistic target to achieve data saturation. The research and interview questions were, in part, informed by my own experience as an ENP 10 years earlier, and my current position as a nurse educator at a higher

education institution. I had witnessed at first-hand how market-orientated reforms and consumer values had increasingly been introduced to healthcare and higher education and how this had created tensions regarding target-setting and professional education (Sturgeon, 2010ab). However, it was not until I read *Creating Citizen Consumers* that I began to question how this might influence the delivery of care in the future and began to formulate the research and interview questions explored in this study. Consequently, some of the interview questions were adapted from the sample questions provided by the *Creating Citizen Consumers* service user questionnaire (p.159-163). The questionnaire uses a 5 point Likert scale to allow the respondent to express how much they agree or disagree with a particular question or statement. Unfortunately, no details are provided regarding the interview questions although it seems likely they were broadly similar.

One of the key research questions posed by Clarke et al's work is: what relationships and identifications matter to the public when they use public services? Consequently, question 17 in the service user questionnaire asks: which of these words best describes your relationship with social care/health/police (please tick two at most). The options are: consumer, customer, service user, patient, citizen, member of the public and member of the local community. I felt that it was important to revisit this notion of identity in my study, and a similar question/range of options is provided to service users and providers from case A and B (appendix 6, 7, 8). I also adapted questions regarding choice, voice, challenge, personal responsibility and decision making. At the same time, I introduced a number of new questions regarding the role of the internet/technology, comparison between health and other service industries, and site specific criteria including why service users attend MIU rather than other providers.

Although there are similarities between the questions asked in this study and the *Creating Citizen Consumers* project, I wanted to use semi-structured interview to capture service user voice (rather than questionnaire) for a number of reasons. Firstly, it helps to ensure that service users' recollection of the care/treatment/service they have received in case A or B is immediate and fresh

in their memory. Secondly, it allows direct comparison with service provider views (and observed behaviour) regarding the experience and events they describe in situ.

3.15 Sampling and recruitment

Service user interviews took place during the participant observer phase of data collection. A sample of patients was recruited using critical case sampling. This type of purposive sampling is useful in exploratory qualitative research where a small number of cases can be decisive in explaining the phenomenon of interest (Mujere, 2016). It was not practical to employ a sampling technique that required prior knowledge of personal attributes, behaviours, experiences, incidents, qualities etc. because of the high number of potential participants that accessed the service on a largely unpredictable and unplanned basis. It was also important to try to ensure a sample that included a range of service users which is why interviews took place over the duration of the data collection period (October-February in case A and February-May in case B) rather than a narrow period of time. This was necessary because service users attended MIU for different reasons depending on the day of the week and the time of year. For example, the decision to attend for care between November-January was often influenced by conflicting messages regarding winter pressures and customer service (see chapters 4 and 5). Consequently, at convenient points between service user consultation and treatment, I reviewed the department tracking screen to identify whether any service users (waiting to be seen) fitted the inclusion criteria for interview (appendix 9). As mentioned above, service users were alerted to the fact that research was taking place by posters located in the waiting rooms at both cases (appendix 2) and provided with a PIS (appendix 3a) at the reception desk on arrival.

If an appropriate candidate was identified, I introduced myself, explained the purpose of the study and asked whether they would be willing to 'provisionally consent' to be interviewed following consultation/treatment by another ENP. If they agreed, the service user was provided with a copy of the service user interview PIS (appendix 3b) and re-approached once their treatment had been

completed. This ensured that they had an opportunity to read the information provided and consider whether they were still willing to continue with the interview. Many service users declined to continue at this point usually because of time related issues (e.g. they had to get back to work, a relative was waiting to provide a lift, their parking ticket was due to expire etc.). Occasionally, they had simply changed their mind. Those who agreed to be interviewed were taken to a private room where they were asked to read and sign the consent form (appendix 10). I was careful to point out that although I was dressed as a member of staff I was not employed by the Trust and the interview was entirely confidential. Interview participants were encouraged to be as honest and open as possible about the care they had received and about their views regarding healthcare delivery in general. I also reiterated that consent could be withdrawn at any point during or after the interview. Some service users were accompanied by friends or relatives who occasionally contributed answers during the interview and were consented retrospectively if they wanted their views to be included. As a result, some interviews have 2 respondents. The primary participant is identified as service user (SU) followed by a number allocated after the interview (e.g. 01) and the case they attended (e.g. A). When their partner/friend answers a question they are designated male (m) or female (f) to differentiate - e.g. SU01A and SU01A(m). Similarly, service providers are designated SP01A or SP01B depending on which case they were based at.

During the service user interviews, many participants provided information that was not directly relevant to the research aims. Although it was often necessary to redirect or re-orientate the conversation, it was also important not to interrupt the dialogue too early since it could belittle the often personal information shared by the interview participant. Listening and responding to what was being said, even when it was seemingly unrelated to the research questions, helped to build trust which often resulted in rich data later in the interview. I was also surprised by the number of service user interview participants who thanked me for allowing them to express their opinions and discuss issues that they felt were of importance.

3.16 Service provider interviews

A sample of 17 service providers (mostly ENPs) and 1 senior manager were recruited using expert sampling. That is to say, all recruits were invited to participate based upon their healthcare experience and expertise. Service provider interviews were conducted in a less systematic manner than those for the service users since they were constrained by professional and workload issues. In most other respects, however, exactly the same considerations applied. All service providers were invited to participate in the interview process (appendix 4ab, 5) and consented in the same way as service users (appendix 11). Generally speaking, service provider interviews tended to be slightly longer than service users. Interview questions were not disclosed to the participants prior to the event (with the exception of the senior manager) since a number of questions referred to whether choice and participation in the decision making process were offered during service user consultation. This could lead to deliberate or unintentional changes in their behaviour/responses if they felt they were being judged on this issue. Although this entailed withholding information, it was a necessary step to ensure the overall success the research (Denscombe, 2002; Barrett, 2006). It was also not considered to represent a source of risk or harm to the participants since they were cognizant of the main aims of the study and debriefing took place at each case once data collection was complete (Kimmel, 1988).

None of the participants elected to withdraw from the study. The only member of staff to view the service user and provider questions before data collection commenced was the senior manager since she was also Hospital Trust supervisor for the project and was interviewed - with her consent - using an amended (undisclosed) set of questions. This final interview took place after data collection had been completed at both cases in order to address some of the emerging themes that had been identified during the research. Seven ENPs, one technician, one receptionist and one GP were interviewed in case A. Five ENPs, one staff-nurse and one GP were interviewed in case B. In order to protect the identities of service users and providers from cases A and B, all interviews and

observations have been anonymised. Any information that could identify the participants (including medical/surgical complaints) has been removed from the data.

All interviews were digitally recorded and then transcribed for later analysis. The transcripts were sent by post, or as an e-mail attachment, to service user participants for member checking (see 3.25). When sent by post, a pre-paid envelope was supplied to enable the participant to respond without charge. Service provider member checking took place at the end of the data collection process (May 2015) rather than following transcription of each interview. This was a deliberate consideration to reduce the likelihood that they would discuss or show their answers/opinions to colleagues before they had been interviewed. None of the participants withdrew consent or contested the interview content and a small number of service users expressed gratitude for the opportunity to express their opinion. Two service user interview participants (SU16A and SU08B) provided incorrect e-mail addresses and their interviews were withdrawn from the study since they could not be contacted for member checking in accordance with the terms of REC approval. Data has been stored on a secure, password-protected University computer in accordance with University research ethics regulations.

3.17 Artefacts, environment and documentary evidence

Another important source of data for comparative analysis is that obtained from material artefacts and observed physical evidence. A piece of equipment, a significant object, an item of clothing or the physical environment in which social interaction takes place may all contribute to the researchers understanding of events. Hammersley and Atkinson (2007, p.136) remark that the material decoration and furnishing of a house are 'not simply backdrops to the everyday performance of identity and biography...they are deeply implicated in the joint construction of a household'. In the same way, therefore, the physical appearance and design of an institutional environment - such as a hospital - not only impart meaning to those who interact with it, they also effect and influence the social phenomena that occur within its confines. The ethnographic researcher needs to pay close

attention, therefore, to both the physicality of the environment in which the study is taking place and the material artefacts that occupy this space. For example, Delamont (2002) points out that in an ethnographic study of the classroom, it is usual to observe the clothing of the participants, the décor of the room, the arrangement of furniture and fittings, the materials used for the lesson and so on, before any interaction begins. Artefacts may form a valuable component of the overall case, therefore, and it is important to recognise how material objects and the physical environment are used by social actors. As Hammersley and Atkinson (2007) put it:

“People do not act in a vacuum. Not only do they do things with words, but also they do things with things” (p.137).

The physical environment of case A and B is discussed in chapter 4 and 5 respectively. The final source of evidence for case studies is that obtained from historical and contemporary documents and archival records. It has already been noted that document analysis may provide insight into dynamic changes within contemporary social structures - such as the NHS - by helping to explain and elucidate the mechanics by which these trends and developments have occurred. The sources of documentary evidence that may be scrutinised by the researcher include private records and correspondence, institutional reports, media sources, visual documents, and Government papers and policy documents (Jupp, 1996; MacDonald and Tipton, 1996).

Other sources of documentary evidence from case A and B include friends and family test (FFT) responses from the period spent at each case and e-mails from the senior manager to staff. From April 2013, every NHS hospital has been required to ask service users accessing emergency care (and other clinical services) whether they would recommend the care and treatment they received to friends and family (NHS England, 2014b). Consequently, service users from case A and B are contacted by text message or interactive voice message (to landlines) following their visit. This is known as the NHS FFT and service users are asked to rate the service they received using a

numerical scale (1-6). The first question they are asked is whether they would recommend the service to friends and family if they required similar care. The following options are provided:

- 1 = Extremely likely,
- 2 = Likely
- 3 = Neither likely nor unlikely
- 4 = Unlikely
- 5 = Extremely unlikely

The second question is only sent if the first has been answered and asks the recipient to text/provide their own feedback regarding the service they have received. This type of qualitative comment is typically concise and provides a degree of context regarding question one. The Hospital Trust collates the FFT responses and sends the information (as a pdf document) to the senior manager for each clinical area on a weekly basis (originally monthly). The information is then disseminated to the relevant staff to inform practice and guide improvements in service delivery. The reports also form the basis of 'you say-we do' action and are displayed (in an appropriate format) in waiting rooms and other public areas. The FFT service is free of charge and service users may decline to respond and opt-out of future FFT surveys. I received the collated FFT data whilst I was a member of the team in case A and B respectively. Consequently, the FFT data that has been analysed is consistent with the participant observation phase of data collection between October 2014 and May 2015. The data is both quantitative and qualitative and provides an important source of information regarding satisfaction and dissatisfaction with service delivery.

There were 7 weeks where no FFT data was provided (reason unknown) but the total responses from both cases number in excess of 1500 (appendix 12). However, the total number of FFT responses for case A are much higher than case B (1394 compared to 189). This reflects the fact that case A is much larger than case B and is open 24-hours. It may also be indicative of the fact that data collection in case B took place over a slightly shorter period of time as I became more experienced in my role as researcher. According to Yin (1994) the most important use of document analysis for case

study is to corroborate and augment evidence from other sources. It is often easy to overlook importance of written evidence, however, and Rees (1981) remarks that:

“Both medicine and medical sociology have to a large extent neglected the record. Indeed, so rarely is it mentioned that one could be forgiven for thinking that that medicine is a purely oral discipline” (p.55).

There are also a number of problems associated with the use of documents as evidence including access difficulties, selectivity bias if document retrieval is incomplete and (unrecognised) reporting bias if the researcher is not careful (Yin, 1994).

3.18 Ethical considerations

Researchers must make every effort to ensure that the four ethical principles of autonomy, beneficence, non-maleficence and justice are observed and closely adhered to at all times (Beauchamp and Childress, 2009). The principle of respect for autonomy requires the disclosure of information that will allow research participants to make an informed and voluntary decision regarding their decision to participate in the study. Moreover, according to Beauchamp (2007) true respect requires more than mere non-interference in another’s personal affairs hence:

“It includes, at least in some contexts, building up and maintaining others’ capacities for autonomous choice while helping to allay fears and other conditions that destroy or disrupt their autonomous actions” (p.4).

Adams (2004) remarks that it is no coincidence that Beauchamp and Childress place respect for autonomy first, when listing the principles which should guide ethical decision-making since:

“They are highlighting the widespread view that most users of healthcare services today regard respect for autonomy in general, and informed consent to treatment in particular, as the cornerstones of ethics” (p.2).

The second principle, beneficence, refers to action that is done for the benefit of others and the third, non-maleficence, to action that does no harm. Sieber (1992) proposes that ethical choices should maximise 'good outcomes for science, humanity and the individual research participants while avoiding or minimizing unnecessary harm, risk or wrong' (p.18). However, this presents a potential conflict for researchers who fulfil multiple roles (e.g. during the participant observation role) and McDonald et al (2008) suggest that this type of situation merits a sort of 'trust-wariness' (p.41) from participants. The position of the participant observer as 'marginal native' is both beneficial and detrimental in roughly equal measure since it engenders a sense of trust but also necessitates a degree of deception (Freilich, 1970). Wilkinson (1995) comments that this is particularly significant in relation to the possibility of role conflict brought about by the personal demands made on the researcher by their dual character. Ethically, all subjects must consent to the observation process, but managing personal and professional relationships when embedded in a social setting, can lead the researcher to become deceptive regarding how they truly feel/think about those being studied (Dallos, 2006). This can lead to the observer becoming socially marginalised in order to avoid committing personal allegiance to certain sections of the group or disclosing personal information that might jeopardise their research.

Finally, it is difficult to quantify beneficence and non-maleficence in relation to acceptable risk or clearly define what benefits may serve the larger cause (Aluwihare-Samaranayake, 2012).

Consequently, the application of these two principles can be challenging since it is difficult to accurately predict all good and bad consequences (Macklin, 2003). At the same time, there are ways that the researcher can maximize benefit to participants and society and minimize risk. For example, when considering research design, the researcher should consider whether there are other ways to obtain the same information with less risk etc.

3.19 Justice

Justice is often associated with the concepts of fairness and equality. In healthcare ethics, Gillon (1994) subdivides obligations of justice into three categories: fair distribution of resources (distributive justice), respect for people's rights (rights based justice) and respect for morally acceptable laws (legal justice). Sieber (1992) also identifies the importance of reciprocal justice in social research and comments that those who bear the risks of research should also be the ones who benefit from it. Spradley (1980) too argues that every ethnographer has a responsibility to weigh carefully what might represent a 'fair return' (p.24) to informants while Miles and Huberman (1994) suggest that benefits for subjects may include being listened to, gaining personal insight, improving personal practice, or the strengthening of a programme or policy they are involved with. It may also be appropriate for the ethnographer to offer expertise or support in exchange for the time and insights provided by the participant/s (Hammersley and Atkinson, 2007).

In section 3.10 I noted that one of the reasons I chose to undertake the participant observer role was that it enabled me to contribute in a practical way to the workload at both MIUs. I was aware that my presence as a researcher could prove intrusive and had the potential to delay treatment etc. for service users in an already demanding and pressurised environment. Consequently, by working as an additional member of the ENP team, I hoped to offset any delays or interruptions that recruitment and interview may provide. Similarly, during service user interviews, participants were often grateful for the opportunity to express their opinions and discuss issues that they felt were of importance. Finally, direct payment is not recommended since it can foster inappropriate expectations, reinforce artificial attachments and shape the participants' responses throughout the study. Fetterman (1998) cautions that although 'reciprocity in some form is essential during fieldwork and, in some cases, after the study is complete...it should not become an obtrusive, contaminating, or unethical activity' (p.143).

3.20 Worthiness

The final ethical consideration to be discussed is the value or 'worthiness' of the project. According to Miles and Huberman (1994) the following questions should always be considered:

- Is the study worth doing?
- Will it contribute in some significant way to a domain broader than my funding, my publication opportunities or career?
- What makes the research of value and interest?

Sethy (2012) points out that a research-worthy problem should relate to a known gap in the relevant body of knowledge and attempt to expand upon previous research or evaluate existing knowledge by examining it in a different context. Career advancement alone is not sufficient justification to expose research participants to potential harm, embarrassment or realisations they had not solicited given that, in the majority of cases, research is:

"A process of asking people to take part in, or undergo, procedures that they have not actively sought out or requested, and that are not intended solely or even primarily for their direct benefit, although in some cases participants may indirectly benefit from the process"

(Guillemin and Gillam, 2004, p.271).

Spradley (1980) therefore, proposes that research should not only be of benefit to those investigated, but, in some circumstances, the informants as well, given that 'the needs of informants should have equal weight with scientific interest in setting ethnographic priorities' (p.18).

3.21 Informed consent

One of the principle reasons for selecting an ethnographic approach is to study people in naturally occurring settings whilst undertaking ordinary or everyday activities. However, all research participants must understand the purpose, aims, possible risks and method of such research, and

must consent to participate without coercion (Burns, 2000). However, there are also numerous studies where subjects were totally unaware that they were being investigated and this has generated debate regarding whether or not the end justifies the means in such studies (Homan, 1991; Burgess, 1984). Punch (1994) observes:

“In much fieldwork there seems to be no way around the predicament that informed consent - divulging one’s identity and research purpose to all and sundry - will kill many a project stone dead” (p.90).

Consequently, the issue of informed consent is raised most acutely by covert participant observation (PO) though it also arises in other forms of ethnographic research. Hammersley and Atkinson (2007) suggest, for example, that:

“It is not uncommon for participants quickly to forget this once they come to know the ethnographer as a person. Indeed, ethnographers seek to facilitate this by actively building rapport, in an attempt to minimize reactivity” (p.210).

The researcher can achieve this by getting to know the participants before the data collection process. This provides an opportunity to gain trust and establish a relationship beyond the researchers 'professional' role' (de Munck and Sobo, 1998). Typically, rapport is built over time and continues during the course of the research. However, when interactions with participants are transitory and short-lived, rapport-building involves active listening, showing respect and empathy, and demonstrating commitment to the well-being of the individual (Kawulich, 2005). Data collection methods, such as interview, may also pose potential problems. Before the interview commences the researcher should explain the purpose of the interview, what will be asked, how responses will be treated and what risks and benefits are involved. This is because:

“The process of being taken through a directed, reflective process affects the person being interviewed and leaves them knowing things about themselves that they didn’t know - or at least were not fully aware of - before the interview” (Patton, 2002, p.405).

According to Kellehear (1996) interviews represent ‘an unnatural social situation, introduced by a researcher, for the purpose of polite interrogation’ (p.98). In real life situations, it is difficult to predict how people will respond and most ethnographers accept the principle of informed consent. However, there is considerable disagreement about what this requires in particular cases, and when, if ever, it can be legitimately set aside (Hammersley and Atkinson, 2007). Miles and Huberman (1994) point out that ethical choices always involve ‘trade-offs, balances and compromises among competing goods and threatening bads’ (p.290) since, in some cases, it is not possible to tell research participants everything about the study as that knowledge may alter certain aspects of their behaviour (Barrett, 2006). In field research, therefore, there may be occasions when some information is withheld ‘not with a view to harming others, but merely to gain authentic data in a situation’ (Burgess, 1984, p.201).

3.22 Anonymity, confidentiality and privacy

Codes of ethics insist on safeguards to protect participants’ identities and those of the research location (Christians, 2005). Research participants have a right to expect, therefore, that the information they provide will be treated both confidentially and, if published, will not be identifiable as theirs (Barrett, 2006). However, as Sieber (1992) points out, there are important differences and distinctions between the terms: anonymity, confidentiality and privacy. For example, anonymity provides a degree of privacy and concealment, but it does not guarantee that harm will not occur since it is difficult to predict how they will react to research reports in advance (Piper and Simons, 2005).

The principle of confidentiality, on the other hand, involves a clear understanding between researcher and participant concerning the use of the data provided (Burns, 2000). This allows

subjects to talk openly without fear of disclosure, and also to refuse permission to publish material if they believe it to be harmful in any way (Piper and Simons, 2005). Privacy refers to the condition of being protected from unwanted access by others, both in terms of giving and receiving information (Homan, 1991). According to Sieber (1992) issues of privacy are frequently subtle and not fully understood by the researcher, surfacing only when more information is disclosed than originally intended or anticipated, or following an unexpected reluctance to continue. However, just because a researcher has access to information, this does not mean that it should always be used and there are occasions when data is 'permanently lost from view' (Burgess, 1988). Reiss (1979) remarks that 'the single most likely source of harm in social science inquiry' is 'the disclosure of private knowledge' considered damaging to those involved in the study (p.73). Becker (1964) is more pragmatic, but also comments that researchers should refrain from publishing anything that will cause embarrassment or distress to respondents if it is not central to the research, or if its importance does not outweigh such consequences.

3.23 Ensuring trustworthiness and credibility in case study/ethnographic research

Interpretative or naturalistic research seeks to understand human action from the point of view of the participant in their natural habitat or setting (Alvermann and Mollozzi, 2010). It presupposes that knowledge of reality is socially constructed by human actors and that 'the researcher is involved in a process of interpretation and (re)construction of reality' (Uzzell and Barnett, 2006, p.3013).

Positivist or scientific research, on the other hand, depends on quantifiable observation that leads to statistical analysis and the role of the researcher is less participatory. Both paradigms provide advantages and disadvantages depending on the type of phenomenon being investigated and it is essential to evaluate the research methods employed to ensure the rigour, relevance and utility of the research process and results. However, there is a great deal of debate regarding whether the positivist criteria of validity and reliability can be applied in a meaningful way to naturalistic research. Some propose that validity and reliability should be viewed as appropriate concepts for

attaining rigour etc. in qualitative investigation and argue that qualitative researchers should reclaim responsibility for these verification strategies (Silverman, 2001; Morse et al, 2002; Porter, 2007).

Others prefer to employ alternative criteria devised by Lincoln and Guba (1985) since they (may) offer a better fit with the ontological and epistemological assumptions of naturalistic enquiry (Shenton, 2004; Loh, 2013).

Lincoln and Guba (1985) identify four criteria that must be addressed by the researcher to ensure the 'trustworthiness' of qualitative investigation:

- Credibility (rather than internal validity)
- Transferability (rather than external validity/generalisability)
- Dependability (rather than reliability)
- Confirmability (rather than objectivity)

Each criteria utilises a number of techniques to 'guide the field activities and to impose checks to be certain that proposed procedures are in fact being followed' (p.330). The first criteria, credibility, is used in preference to the concept of internal validity or the extent to which the study measures or tests what it intends to. Techniques for enhancing credibility during data collection include 'prolonged engagement' and 'persistent observation' in the field (p.301-5). This ensures that the researcher is able to gain an understanding of the organisation or setting they are studying and to establish a trusting relationship between themselves and the participants. However, although the researcher must stay in the field long enough to share certain aspects of it with the participants, they must also be mindful of the point where nothing new is being learned - the point of diminishing analytic returns or saturation (Delamont, 2002).

3.24 Triangulation

Another key technique for establishing credibility is triangulation of different methods. The term itself is derived from land surveying and refers to the use of several locational markers to pinpoint a

single position or spot. By analogy, therefore, triangulation in the social sciences attempts to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one view point (Burns, 2000). Denzin (1978) identifies 4 basic types of triangulation: data triangulation (the use of a variety of data sources in a study); investigator triangulation (the use of several different researchers); theory triangulation (the use of multiple perspectives to interpret a single set of data), and methodological triangulation (the use of multiple methods to study a single problem). This study combines different types of purposive sampling, qualitative methods and data collection instruments. The latter include participant and direct observation, semi-structured interview with service users and providers, and analysis of written documents found within and relating to the case environment (Woodside and Wilson, 2003).

The material surroundings at each case were also scrutinised to provide evidence of how the physical environment influences the social actors (see chapter 4). Individually, these sources of evidence provide some insight into how and why service users and providers act when making decisions about their own/others healthcare but any conclusions drawn are limited and unfocused. It is essential, therefore, that the different strands are scrutinised collectively and collaboratively in order to understand the complexity of human behaviour when accessing/providing healthcare services. The use of a variety of data collection methods allows one source of information to be tested against another in order to strip away alternative explanations and to guard against potential bias (Fetterman, 1998). According to Webb et al (1966):

“The most fertile search for validity comes from a combined series of different measures, each with its own idiosyncratic weaknesses, each pointed to a single hypothesis. When a hypothesis can survive the confrontation of a series of complementary methods of testing, it contains a degree of validity unattainable by one tested within the more constricted framework of a single method” (p.174).

However, it is important to recognise that the methods that are triangulated may themselves exhibit bias and sources of invalidity (Maxwell, 2005).

3.25 Member checking, negative case analysis and peer review

Further techniques to ensure credibility include member checking, negative case analysis, and peer review/scrutiny. Lincoln and Guba (1985) remark that the most crucial technique for establishing credibility in a qualitative research study is member checking. This consists of asking participants to review and confirm the authenticity and accuracy of the data collected. This may be 'on the spot' during the data collection process or following its completion. Cresswell and Miller (2000) comment that participants may be asked to review raw data (e.g. interview transcripts or observational records) to confirm that their words or actions conform to what has been recorded/transcribed and match their intentions. As noted in section 3.16, all interview participants were provided with a transcript for member checking and those that could not be contacted were withdrawn from the study in accordance with the terms of REC approval.

A 'negative case' is one in which the participants' experience or viewpoint appears to contradict the main body of evidence or the patterns of explanation that are emerging from the data. When a negative case can be explained or accounted for it strengthens the general explanation for the 'typical' case (Wallendorf and Belk, 1989). This will be discussed further in chapter 7 in relation to the typologies. Opportunities for scrutiny of the study by colleagues or peers should also be welcomed throughout the research process, as should feedback provided following conference presentations or the submission/publication of an article (Shenton, 2004). During this study I published 3 peer-reviewed articles from chapter 2 (Sturgeon, 2013, 2014ab) and reviewed regular feedback and scrutiny from my supervisory team. This new perspective challenged assumptions, offered fresh insights and ensured I continued to approach the study with detachment and perspective.

3.26 Transferability, dependability and confirmability in case study/ethnographic research

In positivist research, external validity refers to the possibility of expanding any claims of causality from the group or sample being studied to the population that the group represents (Lewin, 2005). That is to say, it addresses the ability to generalise the study to other people and situations. This presents a problem for ethnography since studies conducted to examine a particular phenomenon in a unique setting offer a poor basis for generalisability to the wider population. Schofield (1993, p.221) suggests that for qualitative researchers, generalisability is best thought of as a matter of the 'fit' between the situation studied and others to which one might be interested in applying the concepts and conclusions of that study.

Lincoln and Guba (1985) propose that instead of using the quantitative concept of generalisability, qualitative researchers could replace it with 'transferability' - where findings within one context can be applied to another if there is sufficient knowledge of the contexts in question. It is also important to provide sufficient 'thick description' of the phenomenon under investigation to allow readers to achieve a thorough understanding that will enable them to 'compare the instances of the phenomenon described in the research report with those that they have seen emerge in their situations' (Shenton, 2004, p.70).

In positivist research, reliability refers to a measurement that repeatedly and consistently provides the same result (Somekh and Lewin, 2005). The most common technique for establishing reliability is replication or whether the same experimental design leads to the same results on a number of separate occasions (Davis and Bremner, 2006). Qualitative research, however, emphasizes the uniqueness of the human situation and Holliday (2007) proposes that every qualitative research design will be different since decisions about research instruments are made in gradual response to the nature of the social setting being investigated as its nature is revealed. The key to qualitative research, therefore, is to learn from the subjects rather than control them (Wainwright, 1997; Krefting, 1999). Consequently, Lincoln and Guba (1985) replace reliability with 'dependability' which,

they argue, is closely linked to credibility criteria (e.g. demonstration of the latter goes some way to ensure the former).

According to Shenton (2004) in order to address the dependability issue, the processes within the study should be reported in detail in order to allow future researchers to repeat the work, if not necessarily achieve the same results. Yin (1993) comments that the prerequisite for allowing another investigator to repeat an earlier case study is careful documentation of the process and procedure they followed and advocates the development of a chain of evidence including field notes, interview transcripts, archival documents, tabular materials and other records in retrievable form. This database has been collated using the computer software NVivo 10 (see 3.27). Holliday (2007) remarks:

“...qualitative research has to show its workings every single time. This concept of showing one’s workings’ reminds me of doing maths problems at school. One was never allowed just to give the right answer, which was not considered valid unless the steps taken to get it were very clearly and properly laid out” (p.8).

The final criteria proposed by Lincoln and Guba (1985) for establishing trustworthiness in qualitative research is confirmability. In positivist research this equates to researcher objectivity which, as noted above, is difficult to achieve when undertaking ethnographic/case study research particularly when employing participant observation as a data collection instrument. One way to limit the influence of bias and preconceptions is to exercise a high degree of reflexivity and to triangulate multiple data sources, methods and theoretical schemes. It is also useful, if possible, to ask key informants to review material from the draft case study report during the composition stage (Yin, 1994).

3.27 Analysis

In order to arrive at explanations of social situations and processes, it is necessary for me to systematically reduce the complexity of the information generated in the qualitative data collection phase (Gläser and Laudel, 2013). Ethnography and case study both rely on multiple sources of evidence with data needing to converge in a triangulating fashion. Consequently, the different data sets from each of my cases were coded and analysed for recurrent or discrete themes. Thematic analysis is a form of pattern recognition within the data, where emerging themes become the categories for analysis (Fereday and Muir-Cochrane, 2006). Once distinct patterns were identified, the remaining data were linked to, and integrated with, these broader themes (Gläser and Laudel, 2013). The first stage of thematic analysis is to immerse yourself in the data (Silverman, 2010). In my case, I was already very familiar with the data since I was the sole researcher for the study.

I also transcribed approximately a quarter of the interviews and checked the remaining transcripts for accuracy. I also transcribed the field notes from my field journal (onto a word document) and carefully examined the FFT comments noting down initial ideas. The next stage involved generating preliminary codes across the data set. This can be extremely time-consuming for two reasons. Firstly, it is sensible to code for as many themes as possible since it is difficult to predict what might be relevant or important as the analysis progresses. Secondly, in this instance, data collection produced numerous data items (e.g. service user/provider/manager interviews, field notes, document analysis etc.) all of which require careful scrutiny. I chose to use software programme NVivo 10 for the analysis since it allowed me to code individual extracts of data into a number of different but overlapping themes. This not only saved me time but gradually built into a database that allowed me to revisit the data when necessary in a systematic and efficient manner (see 3.26, 3.28). The next stage of thematic analysis involved collating the codes into potential themes or patterns. A theme captures something important about the data in relation to the research question and represents some level of patterned meaning within the data set (Braun and Clarke, 2006).

Themes can be identified by using either an inductive or a deductive approach (Silverman, 2010; see also 3.9). For the most part, my approach was deductive since it was shaped and driven by the research questions derived from my theoretical interest in the area (see 3.14). However, some of the emerging themes (e.g. primary care) were broadly inductive since, although they were consistent with the overall aims of the research, they were unanticipated and required me to reconsider and re-evaluate my initial assessment. The next stage of thematic analysis is to review the themes in relation to the coded extracts and the data set as a whole. This allows the themes to be named and defined as part of the ongoing analysis. Six key themes were identified: choice, convenience, customer service, participation, shared decision making and challenge. Sub-themes within these topics included: primary care, practice nurse care, second opinion, managing expectation, role confusion and complaint. The key themes were identified since they were the most prevalent across the data set. That is to say, they were repeatedly articulated by different interview participants and occurred frequently and consistently in the other data items. The final stage of thematic analysis involves selecting notable and convincing extracts (presented in chapters 4 and 5) and relating the analysis back to the research questions.

Relatively early within the analytical process I began to notice patterns within the data suggesting that there may be at least five potential typologies regarding healthcare consumer activity/behaviour. These were noted to occur at both cases so, during the cross-case comparison, I actively searched for evidence that tested my early hypothesis that people's consumerist choices and behaviours might be amenable to some form of behavioural classification. Cross-case analysis can support the construction of theories by identifying sub-classes of a major phenomenon (George and Bennett, 2005). These can be organised into typologies based upon common characteristics and traits. Although typologies share a specified combination of factors, these are not necessarily causal, mutually exclusive or exhaustive (Khan and VanWynsberghe, 2008). Ryan (2012) also points out that comparisons across cases may not be solely created by the original researcher, but also by those readers and researchers who subsequently use the published work for their own ends that might

include further research. In this instance, I was interested to learn whether there were any traits or differences between service user's motivations and responses when accessing healthcare services in case A and B and undertook a secondary analysis of the service user and provider interview transcripts, and the participant observation data, to identify common features that might explain their outlook and behaviour. The typologies help to explain service user consumer behaviour when accessing healthcare at both cases and have been applied to the service user interview participants (see chapters 6 and 7 for further discussion). Once the categories had been identified and the typologies compiled, the data was re-evaluated and reconsidered to confirm that these constructs account for all instances of the phenomenon involved (Shenton, 2004). This was assisted by the cross-case analysis where both cases were compared and tested against one another including my developing theories and hypothesis regarding the existence of such typologies (Yin 1994; Khan and VanWynsberghe, 2008).

3.28 Challenges encountered during the course of the study

Many of the challenges associated with this research project have already been discussed in the preceding sections. For example: gaining entry and building rapport (section 3.7), feasibility regarding time and location (section 3.8), preconceptions and tensions regarding the participant observer role (section 3.11-3.12), sampling and recruitment issues (section 3.15), ethical issues regarding bias and informed consent (section 3.21), and trustworthiness and credibility of the data when employing qualitative methods (section 3.23-3.26). However, there are a number of specific challenges in relation to analysis and how the data is presented that have not been discussed.

Firstly, thematic analysis is not a purely linear process whereby the researcher simply moves from one phase to the next. Instead, it is necessary to move back and forth through the data during the different stages discussed above. The quantity and variety of data collected in this study makes this difficult. Although computer software NVivo helps to organise the data sets etc., analysis relies upon

my ability to remember where particular codes, themes etc. are located. This is why it was essential to 'know' the data from the outset and have the time available to undertake this activity.

The second challenge is how to present the data since it provides multiple perspectives, often of the same issues and behaviours, which could be confusing to the reader. It is important to provide rich thematic description of the data sets for the reader to get a sense of the predominant and important themes. However, it is also important that the data is to-the-point, well-structured and easy to interpret. In order to address this issue, the data has been organised to broadly reflect the service user 'journey' through case A and B (from the point of view of service user, service provider and researcher as participant observer). Consequently, data from service user interviews is presented first since it represents evidence recorded immediately after the event. It commences with explanation of why service users choose to attend for care and concludes with discussion of challenge and complaint (see section 4.1, 5.1). Service provider views of the same issues are presented next since they also represent evidence that is broadly contemporary to the issues/behaviours described. This is followed by discussion of the FFT data which represents service user views after the event (retrospective analysis) and consists of short, unstructured comment. The evidence from the participant observer phase of data collection is presented last since it represents my interpretation of events as both insider and outsider, and is collated from across the data collection period.

Chapter 4: Data from case A

4.1 Introduction

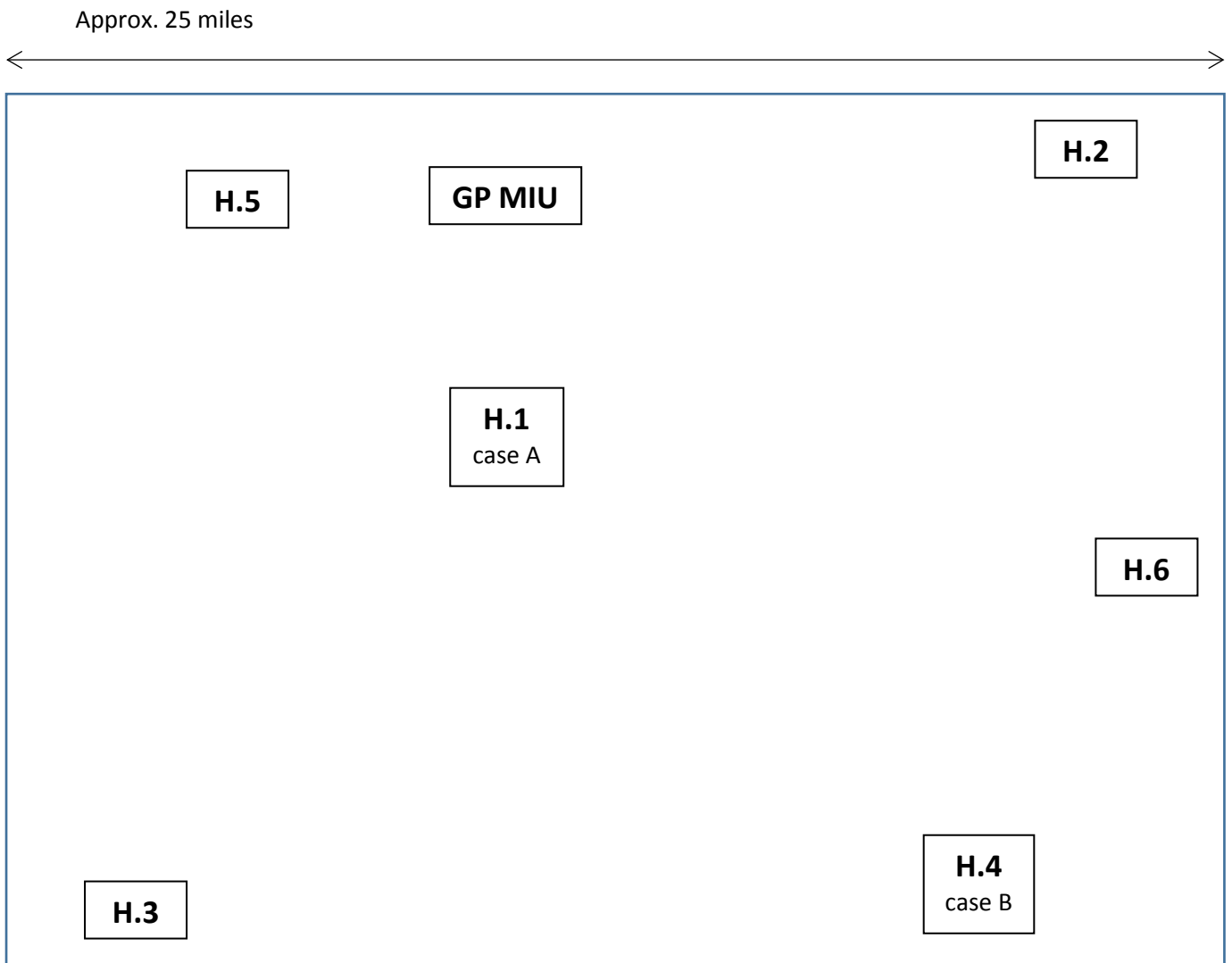
In this chapter I will present the context for case A in terms of its relationship to the wider and local community that it serves (4.2-4.6). This includes discussion of the physical environment and how it relates to the activity that occurs there. The next sections (4.7-4.8) provide demographic information from the service user and provider interviews. In the case of the former, this provides a degree of context regarding the different types of people who attend case A and how they view themselves when accessing healthcare. It also identifies the distance they have travelled from home/site of their injury and how many times they have attended case A in the past. This data is valuable since it informs the decision making process and cross-case analysis. The following sections (4.9-4.36) are arranged to broadly reflect the service user 'journey' through case A from the point of view of the service user, service provider and researcher as participant observer. For example, sections 4.9-4.15 provide evidence from service user interviews regarding the decision making process to attend the MIU. They also explore service user views regarding the physical environment in the MIU, customer service, shared decision making, self-management, changing expectations regarding service provision and, finally, complaint and challenge. The next sections (4.16-4.23) explore the same issues but from the point of view of service providers. That is to say, why they believe service users attend the MIU etc. The penultimate sections (4.24-4.32) provide discussion of the quantitative and qualitative evidence from the friends and family test (FFT) survey conducted once service users have been discharged home (i.e. retrospective observation). The final sections (4.33-4.36) examine and evaluate the evidence collected during the participant observation phase of data collection. This is examined last since it represents my interpretation of events as both insider and outsider. In summary, evidence from 6 data sets is discussed and evaluated in the following order: environment, demographics/designation, service user interview, service provider interview, FFT responses, and participant observation.

4.2 Overview of local service provision and case A town

The MIU in case A forms part of a general hospital referred to as Hospital 1. This constitutes one of the 5 hospitals that make up an English Hospitals University NHS Foundation Trust⁶ serving a total population of about 759,000 people. Hospital 1 is situated between the two larger hospitals (Hospitals 2 and 3) and must transfer those who require specialist or A&E provision (Fig.1). Hospital 4 (hosting case B) is a small community hospital situated 18 miles from Hospital 1 and 22 miles from the nearest A&E (at Hospital 2). Hospital 5 is a small cottage hospital situated about ten miles from Hospital 1. It provides MIU services with no x-ray facilities between 08.00 and 20.00 each day. In addition to the Hospital Trust, the local area is also served by a number of Clinical Commissioning Groups that provide cottage hospital and MIU services. These include Hospital 6 (located about 20 miles from case A and 9 miles from case B) and a large GP practice (located about 7 miles from case A and 30 miles from case B) that both provide MIU services (with x-ray facilities) between 08.00-20.00 each day. According to the 2011 UK census, the town in which the MIU is situated has a district population of 151,200 (covering an area of 308.8 km²) and an urban population of 54,880 (covering an area of 12.8 km²). The English Indices of Multiple Deprivation (IMD) ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). These small areas are known as Lower Super Output Areas (LSOAs). The town in which case A is situated does not have any LSOAs ranked within the top 10% most deprived in England (Department for Communities and Local Government, 2015). However, 3 urban and 5 district LSOAs are ranked within the top 20% most deprived in England (Ibid). Case A town also has a significantly higher number of 20-24 year olds than the national average reflecting a large student population (approximately 31,000 students studying at three universities).

⁶ Referred to as Hospital Trust in text.

Figure 1: Hospital distribution for Hospital Trust (H.1-5) and Clinical Commissioning Group (H.6 and GP MIU)



Hospitals University NHS Foundation Trust

- Hospital 1 Large general hospital with MIU (**case A**) and Emergency Care Centre
- Hospital 2 Large general hospital with A&E department and X-ray
- Hospital 3 Large general hospital with A&E department and X-ray
- Hospital 4 Community hospital with MIU (**case B**) and X-ray
- Hospital 5 Small community hospital with MIU

Clinical Commissioning Group

- Hospital 6 Small community hospital with MIU and X-ray
- GP MIU Large GP practice with MIU and X-ray

4.3 The care context in Hospital 1

Hospital 1 is a general hospital with almost 300 beds (as of March 2014) providing a range of elective and emergency services including an Emergency Care Centre (ECC) and 24-hour nurse-led MIU (case A). ECC and case A are situated directly next to one another and share a common corridor nominally separated by a set of double doors. Historically, the two units formed a single clinical area as part of an A&E department before it was downgraded to ECC/MIU in January 2005. Because of this historic and physical connection, the two clinical areas maintain a high level of cooperation. At the same time, there are also tensions between case A and ECC regarding the most appropriate use of clinical support staff and who takes responsibility for providing care when service users require assessment/treatment from both units (FN: Jan.31, 2015). ECC provides care for adult service users with acute medical illness (including thrombolysis and cardio-pulmonary resuscitation) and those who require surgery for urological and vascular problems. Adults (and children) who require other types of surgical intervention, or emergency care/investigation following trauma, must access/be transferred to Hospitals 2 or 3. The Hospital Trust website clearly identifies that there are no A&E services provided at Hospital 1 but a prominent road sign (situated at a roundabout not far from Hospital 1) still provides direction to 'A&E department'.

Hospital 1 hosts an out-of-hours GP service after 6 pm which is by appointment only (service users must phone in advance). It takes place in fracture clinic (directly adjacent to case A) and has its own waiting room and reception desk. In addition to this service, a separate GP collective (GPC) provides a walk-in service between the hours of 11.00-21.00 Monday-Friday and 08.00-20.00 at weekends. A single GP is based in an office located within the waiting room in case A. The service was originally piloted in August 2009 to cater for the large number of service users presenting at ECC with primary-care complaints and is funded by the Hospital Trust. Service users can be referred to the GP by staff from ECC or case A providing they do not require emergency care. Service users can also self-refer

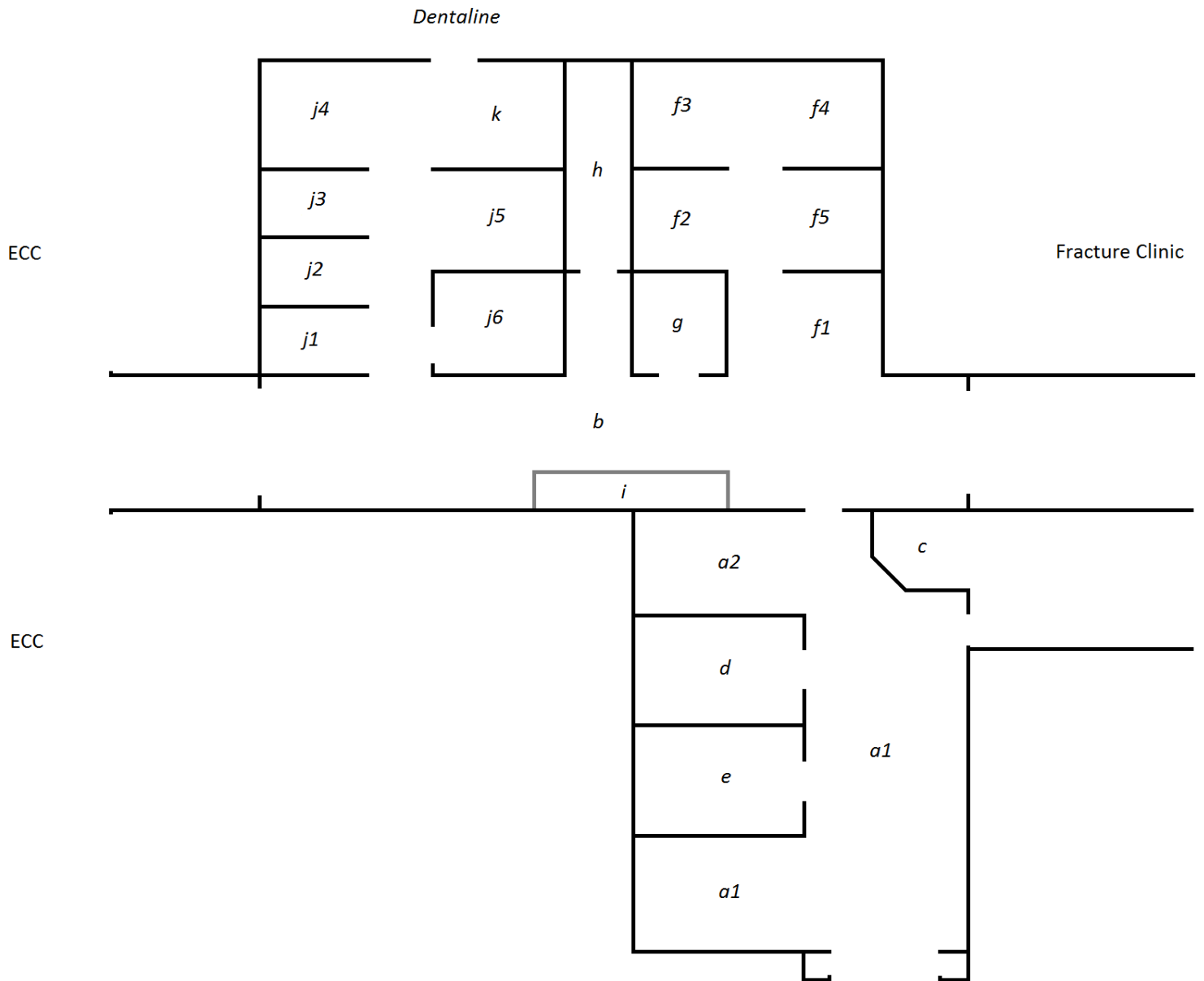
(via case A/ECC reception) on a first-come-first-served basis if they are unable to make an appointment with their own GP.

4.4 The care context in the MIU (case A)

Case A provides a 24-hour, nurse-led MIU service, 7 days a week, 365 days a year. At the time data collection took place (October 2014 - February 2015) it was staffed by 14 ENPs (full and part time) and 7 technicians (full and part time). Most of the ENPs had worked in case A (or ECC) for many years and the senior manager commented how lucky they were to have such 'low turnover of staff'. The MIU in case A delivers treatment for adults and children with minor injury and minor illness of a non-serious or life-threatening nature. It is situated between the ECC and fracture clinic at Hospital 1 (Fig.2). Case A and ECC share a common waiting room (*a1*) and corridor (*b*) separated by a pair of double doors. The waiting room is accessed from the car park via two sets of automatic doors. It has seating for 25 people with a small children's play area (*a2*) opposite the reception desk (*c*). Next to the children's play area there is a small consultation room used by the GPC (*d*) and an office (*e*) used by the on-call mental health team when required. Previously, this room housed the MIU triage nurse before the service was withdrawn in 2011. The waiting room walls are lightly decorated with health promotion posters and there is a small wrack containing health advice leaflets.

The reception desk/area is situated at the back of the waiting room, on the right hand side, between two doors. The facing door (to the left of reception) leads to the shared corridor (*b*) and main clinical areas for case A. The right hand door provides key-coded access to the reception area (*c*). Typically, a single receptionist sits behind a transparent screen at the reception desk/computer. The role of receptionist is to greet service users as they arrive, ascertain the nature of their complaint and book them in (i.e. enter the service users' details on the computer and generate an attendance record) for case A, ECC or GPC as appropriate. They also provide directions for Hospital 1 service users, book outpatient appointments (OPAs) and locate clinical notes/previous admissions etc. if required/requested. For the most part, service users are seen in chronological order by the ENPs since formal

Figure 2: Case A



triage is no longer provided at the MIU. Service users are called from the waiting room by an ENP/technician and seated in one of the clinical consultation areas to await assessment etc. However, service users may receive urgent medical attention/assessment if reception staff and ENPs agree that they should not wait. In this way, reception staff often undertake informal triage and draw attention to service users who may be at risk.

4.5 Paediatric consultation area and main corridor

The paediatric consultation area (*f*) is separate from the adult area and is situated directly across the corridor from the waiting room door. It consists of 4 cubicles (*f.1-4*) each with a trolley or couch, and a further small play area (*f.5*) for young children. There is a single sink and a clinical and non-clinical waste bin. The ENP office (*g*) is situated next to the paediatric area. It is small and seats a maximum of 3 staff. It can be locked but is typically left open since it is usually occupied by a member of staff completing notes/documentation. At the far end of the office, there is a desk that spans the width of the room (approx. 1.5 m) with a computer and assortment of ring/box files. The left, right and facing walls of the office are covered with notices, messages and written reminders. Next to the ENP office, a short sub-corridor leads to a small store room (*h*) that houses a selection of clinical texts and policy folders. A large wrack has been mounted on the other side of the sub-corridor which contains a selection of medical advice cards provided to service users as appropriate. Opposite the ENP office and advice card wrack is a long desk (*i*) with a series of drawers and cupboards mounted above and below. The desk supports two computers, two printers, a telephone, a digital x-ray viewing monitor and a series of files containing paperwork and stationary. This provides a shared work-space for ENPs/technicians to 'track' service users' progress on the computer as they are seen, treated, discharged or referred to another service/agency. The drawers and cupboards below the desk contain a miscellaneous selection of clinical and non-clinical equipment and apparatus. The 6 metal cupboards mounted above the desk are locked at all times and contain medication that can be provided as required. Stock is audited daily by a pharmacy technician.

4.6 Adult consultation area (cubicles)

The adult clinical area (*j*) is situated on the right hand side of the corridor between the advice card wrack and the double doors that separate case A from ECC. It comprises 6 cubicles (*j.1-6*) and a storage area (*k*). The storage area also accommodates a small sink and clinical and non-clinical waste bins. The first 3 cubicles (*j1-3*) are small and have seating for 2 people only. Cubicles *j4* and *j5* are larger and contain a trolley as well as seating. The final cubicle (*j.6*) is designated the ear, nose & throat (ENT) and eye room since it contains a number of specialist items including a slit lamp and back-lit Snellen chart for testing visual acuity. Between cubicle *j4* and the storage area, a locked door leads to a small consultation room used by the emergency dental service in the evenings. Service users must make an appointment to see the dentist by phone and pay for the consultation unless they hold an exemption certificate. They are escorted from the fracture clinic waiting room by a dental nurse on a first-come-first-served basis. Case A also shares some facilities and resources with ECC. For example, some drugs (e.g. vaccinations) are kept in the refrigerator in ECC's resuscitation room and the two units share a large store room located at some distance from both. Finally, the senior manager's office is located at the ECC end of corridor *e*.

In summary, case A provides a 24-hour, nurse-led MIU service, 7 days a week, 365 days a year. At the time data collection took place (October 2014 - February 2015) it was staffed by 14 ENPs and 7 technicians (full and part time). A separate GP collective also provides a walk-in service between the hours of 11.00-21.00 Monday-Friday and 08.00-20.00 at weekends. This is funded by the Hospital Trust. The physical environment at the MIU reflects the fact that it had previously been part of a larger A&E department before this was downgraded in 2005 and divided into an ECC and MIU. Because of this historic and physical connection, the two clinical areas maintain a high level of cooperation. At the same time, there are also tensions between case A and ECC regarding the most appropriate use of clinical support staff and who takes responsibility for providing care when service users require assessment/treatment from both units. The town in which case A is situated has a

district population of 151,200 and an urban population of 54,880. It has a large student population and no LSOAs ranked within the top 10% most deprived in England which made a useful counterfoil to the location in which case B was situated. I will now discuss this in terms of local demographics in the town.

4.7 Demographics

In total, 21 service users and 10 service providers were interviewed in compiling case A. An additional service user interview (SU16A) has not been included/analysed since they could not be contacted for member checking. The age range for service users and providers in case A is outlined in Tables 2 and 3. With the exception of SU21A and SP06A all interview participants were of white ethnicity and British nationality. Fifteen interviews (71.42%) were conducted with female service users and 6 with male (28.57%). On two occasions (SU03A, SU06A) the interview participant's partner also contributed answers. When this occurred, they were consented (retrospectively) and designated (m) or (f) on the interview transcript/data to differentiate them from the principle interview participant. Six service provider interview participants (60%) were female and 4 were male (40%). Most service users at the MIU (61.89%) had attended on at least 1 occasion in the past (Table 4). For 8 service users it was their first visit and one reported attending on over 21 occasions (SU05A). In total, 52.37% of service users travelled less than 5 miles to attend the MIU. Of these, 6 (28.57%) travelled less than 2 miles from their home or the site of their accident (Table 5). No service users travelled more than 15 miles to receive care and more than 85.7% travelled no more than 10 miles. Fifty-two percent of service user interview participants lived or worked within 5 miles of the MIU. The highest educational qualification ranged from none to Masters level (Table 6). All service providers possessed an appropriate professional qualification with the exception of SP02A and SP03A where it was not required. Service user interview participant occupation was varied with a relatively high proportion of retired service users (38.09%) and students (19.04%). Only one service user interviewed was unemployed (Table 7).

4.8 How service users described themselves

Service users and providers were asked to identify which word (presented in alphabetical order) best described them when accessing or receiving healthcare. The words were as follows:

- Citizen
- Client
- Consumer
- Customer
- Member of the Public
- Patient
- Service User
- Other

Many interview participants felt that the terms were too prescriptive and did not fully represent their identity or role when accessing healthcare. Consequently, they often combined the terms in order to reflect the multifaceted nature of this activity. Table 8 summarises the variety of combinations selected by service users in case A. It is interesting to note that the term 'patient' was individually selected by ten participants (47.61%) and by a further eight (42.84%) combined with another term/terms. Two participants selected the term 'customer' and one 'did not know'. Sixty percent of service providers also favoured the term 'patient' when accessing healthcare for themselves (Table 9). Two considered themselves 'service users' and two 'member of the public' or 'member of the public and service user'. When they were asked to select which term/s best described OTHER people accessing healthcare at the MIU, their answers were the same (overall) as their perception of themselves (Table 10).

In summary, the information presented in these sections helps to provide a degree of context regarding the types of people presenting for care at the MIU in case A. Most interview participants were female (15/21) but there was an appropriate variety of people regarding age, education and employment status overall. It is interesting to note that 4/21 were students, which reflects the fact case A has large student population. Just over half of service user travelled less than 5 miles to attend case A. However, this information is most useful when compared to case B where it helps to

Table 2: Service user age (case A)

	18-25	26-35	36-45	46-55	56-65	66-75	76+
	4	3	1	4	2	6	1
(= 100%)	19.04%	14.28	4.76%	19.04%	9.25%	28.57%	4.76%

Table 3: Service provider age (case A)

	18-25	26-35	36-45	46-55	56-65	66-75	76+
		2	2	3	2	1	
(= 100%)	-	20%	20%	30%	20%	10%	-

Table 4: Number of previous attendances (case A)

	None	1-5	6-10	11-15	16-20	21+
	8	9	3			1
(= 100%)	38.09%	42.85%	14.28%	-	-	4.76%

Table 5: Distance in miles from home/location of accident to case A

	<2	2-5	6-10	11-15
	6	5	7	3
(= 100%)	28.57%	23.80%	33.33%	14.28%

Table 6: Service user highest educational qualification (case A)

	None	C&G NVQ	GCE GCSE	A level	Cert.HE Dip.HE	Degree	Masters
	5		6	4	2	1	3
(= 100%)	23.80%	-	28.57%	19.04%	9.52%	4.76%	14.28%

Table 7: Service users' self-description of their occupation/status (case A)

	Business & Management	Customer Service	Driving	Health & Social Care	Manual	Mother	Retired	Student	Teaching	Unemployed
	1	1	1	1	1	1	8	4	2	1
(= 100%)	4.76%	4.76%	4.76%	4.76%	4.76%	4.76%	38.09%	19.04%	9.52%	4.76%

Table 8: How service users viewed themselves when accessing healthcare (case A)

	Customer	Patient	Patient + Member of Public	Patient + Service User	Patient + Member of Public + Consumer	Patient + Member of Public + Service User	Don't know
	2	10	4	1	1	2	1
(= 100%)	9.53%	47.61%	19.04%	4.76%	4.76%	9.52%	4.76%

Table 9: How service providers viewed themselves when accessing healthcare in case A (and elsewhere)

Member of Public	Member of Public + Service User	Patient	Service User
1	1	6	2
(= 100%)	10%	60%	20%

Table 10: How service providers viewed OTHERS who access healthcare in case A

Member of Public	Member of Public + Service User	Patient	Service User
1	1	6	2
(= 100%)	10%	60%	20%

explain key similarities and differences (see chapter 6). The data presented in these sections also provides insight regarding how service users and providers view themselves when accessing healthcare. This is adapted from the *Creating Citizen Consumers* study (3.14) and establishes a starting point for assessing consumer thinking and behaviour in both groups. It is interesting to note that a number of service user interview participants felt that the terms provided were too prescriptive and chose to combine them. However, most (10/21) selected 'patient' as their preferred designation compared to 8 who selected 'patient' combined with another term (e.g. 'member of the public'). Only two service users selected 'customer' and one 'did not know'. Most service provider interview participants (6/10) considered 'patient' to be the most appropriate designation for service users when accessing care. The value of this data is diminished by the low numbers but it serves to inform the qualitative data and the typologies regarding whether demographic factors (e.g. age) influence service users' attitudes when making decision regarding their healthcare.

4.9 Reasons service users chose to attend case A

The following sections (4.9-4.15) provide discussion of the evidence collected during the service user interviews. A number of service user interview participants explained why case A was their first choice of care provider. Convenience, waiting-time and previous experience of good service all figured highly. For example, when asked why they attended case A rather than their GP surgery, SU05A replied:

"Because this is where I came last time and last time they sorted it out straight away...It takes two weeks to get a doctor's appointment and when this happens I can't really wait that long. I need it fixed quickly. It affects my work. I'm supposed to be working on Monday"
(32-year-old male, undertaker).

SU14 described how speed and quality of service had informed their decision to return:

"I arrived the first time with no appointment. I think there were probably two or three people beforehand. I waited, I don't know, ten minutes and then I was seen. I was treated with the utmost courtesy and given all of the information, given pills...I re-attended, same thing, turned up. There were a few people waiting but then very quickly seen...For me, it's great. It doesn't get any better than this" (60-year-old male, retired stock manager).

Similarly, SU17A remarked of their previous attendance:

"Well it was just so smooth. I came in and booked in at reception. And then I didn't wait long and then the nurse called me in and she didn't just...go off...she saw me straight away. She explained everything thoroughly, what she thought it was and, as I say, sent me for x-ray. It was all just nice and easy and quick. Not rushed. I didn't feel rushed at all...I didn't feel like I was wasting their time. They reassured on that. So it was good" (53-year-old female, unemployed)

A number of service users also explained why they valued local services. For example, SU11A expressed disappointment that they had been unable to receive treatment at the MIU in case A and were expected to travel to the nearest A&E:

"The time was good, the people were nice. So I haven't anything bad to say about that. It was just I couldn't have an x-ray which I kind of needed. And they were like 'we really can't help. You might want to go somewhere else' and knowing I'm a student and [Hospital 2] is a long way away from here. How can I get there? I said 'I can't really get there' and they are like...'we really can't help you with that'. It just disappoints me that quite a few A&E's have closed...I think local services are important...I don't understand how you can have, like here in [case A town] for example, you've got proper A&E's so far away, like proper ones. I just don't understand why that is" (20-year-old female, student).

4.10 Service user views regarding customer service and environment

Service users often compared their experience of NHS healthcare service delivery with other non-NHS providers. For example, SU09A compared the service they had received at Specsavers with a subsequent appointment with a local NHS provider:

“They were good because I hadn’t made an appointment and they slotted me in. I saw...an optometrist...[and]...she said ‘right, I’m going to ring the hospital now. You are going straight to [Hospital 2] and they will check you out. Unfortunately it looks like you might have [ophthalmic condition requiring surgery]...But when I got to [Hospital 2] it was a bit distant. It’s quite a serious thing and I didn’t feel confident in the consultant...They didn’t involve me. They were doing things, pulling around and they didn’t involve me...He didn’t give that friendliness you would expect from someone looking after you. When I left he said ‘take one of these papers, you can read that’ and he sort of dismissed it as ‘you’re lucky this time, it could happen again’. I came out feeling quite bad” (70-year-old male, retired engineer)

SU11A also compared their experience of the NHS with visiting an optician:

“I just want to go in, see a doctor and just have everything done nice and easily. I don’t know how to explain it. Just clearly, for example, when you go and see the optician you have a slot, you see your doctor [optometrist] they tell you what’s wrong with you, treat it, easy. I kind of want the NHS to be like this. I know it is similar when you see a GP but I feel it is like ‘oh we will refer you to this place and do this’ and it’s kind of I’m not really sure. It’s a bit muddled I think” (20-year-old female, student).

SU13A explained how they expected the same level of customer service from the NHS as any other service provider (healthcare or otherwise) but also felt there were important differences which influenced this expectation:

“I suppose when I look at the NHS I get quite frustrated with it sometimes. But only because I kind of think ‘we do pay for this, and we’ve paid for it all of our lives and potentially the service could be better’...but I think it’s different, say in a hotel [where] you are paying quite a lot of money for service. I know you are still paying the NHS but it’s kind of a different type of payment if that makes sense. When I go and buy my coffee at Starbucks, I am quite specific about the way I drink coffee...if someone doesn’t make my coffee the way I like it, it will be given back...And yet I wouldn’t do that with the NHS but I’m still paying for it...I think the problem is, and I don’t know if everybody thinks like this, but when I think about the NHS and something doesn’t work quite how I would expect it to work in terms of say an alternative company or organisation is because we are all so aware of the NHS is and how it can be underfunded” (39-year-old female, administrator).

Despite the fact that most service users in case A described themselves as patients (individually or in association with other characteristics) rather than customers of healthcare, they all valued high standards of customer service from clinical and non-clinical staff. Many of them also felt that there were clear similarities between healthcare provision and other service industries. For example, when asked if they could identify any parallels between the two, SU08A replied:

“Yes I think there is. I think they are people skills no matter what industry you’re in. I think anybody that approaches you with a smile on their face or looking cheerful...So if you’re approaching it with the right understanding. We’re customers at the end of the day. I’m old fashioned so I tend to think of myself as a patient rather than a customer but I expect a twenty-year-old might say customer” (54-year-old female, lecturer).

Similarly, SU13A outlined what they thought constituted good customer service when describing a recent in-patient stay at Hospital 3 based upon their own experience of delivering customer service:

“...there was one nurse who I remember. She was doing a night shift and my god she was a grumpy cow. I don’t think she said one word to me. You know, you just think ‘please smile, I

know it's night time but please smile' [laughs]. I never got angry about it but you just think 'goodness gracious'...I get that, everybody has bad days, I have bad days, but at the same time you kind of think 'I couldn't act like that to people', I'd be pulled up on it. When I work in the office I kind of expect the same, even if it's just politeness or a response, you expect that back" (39-year-old female, administrator).

SU11A described themselves as a 'patient, member of the public and consumer' when accessing healthcare and described how they valued the opportunity to assess and rate the care they received in exactly the same way as any other hospitality service:

"I can see there are similarities, at the end of the day, everybody pays tax...to help fund the NHS. So they are essentially paying for a service so, if it's bad...you'd want to be able to review it I think...You can Google reviews for restaurants. I'm not saying do that for a hospital but I feel that's got more impact and authority to help change the NHS because it's about reputation...I go in and expect a certain service. I expect to be listened to. I expect the treatment that I went in for and I expect it to be carried out well. So yeah, essentially, I guess I am a customer" (20-year-old female, student).

Similarly, although SU18A stated that they did not view themselves as a customer of healthcare they continued to articulate a customer (or consumer) view of service provision:

"As a customer no, I'd say as a patient. If you need an x-ray or something then you need to say so. The option is there if you need it. When you tell someone they can't have something that's when you get a problem. That's the only reason why people start making a fuss about anything is when they are told they can't do or have anything...Most people, I would say, don't like being told no. So you have to sort of work your way around that the best you can" (52-year-old female, van driver).

When asked if they could identify any parallels between healthcare and other service industries, SU10A also drew attention to the impact of the physical environment:

“Yes, there should be...a huge interaction between the two. People feel better. Their environment is so - I am a great believer in environment. The room you sit in. What’s around you will affect you big time. And having good food. Having clean surroundings naturally. And hospitality that word itself is being hospitable and while you are here for medicinal reasons you’re in a hospital. I’m not talking go to an extreme but simple hospitality in terms of politeness” (63-year-old female, teacher).

Similarly, SU11A explained how the surrounding environment influenced their expectation of the quality of care:

“Like in hospitals that are very well funded I feel like I am getting a better service because they have got more modern technology, all high tech...This one feels like it’s kind of old. I feel like it’s a bit dated. So I feel the service will be average here...I’m probably getting the same treatment but I just feel that I am being looked after more...When the hospital looks nice, cleaner, more modern I feel they can give me the best treatment possible even if it is the same plan of action that another hospital could provide” (20-year-old female, student).

4.11 Customers of healthcare?

Some service users strongly identified with the idea that healthcare should be more customer-focused. For example, SU14A saw little difference between the type of customer etiquette observed in a supermarket and that expected in an MIU. For them, shopping and healthcare both involved rules and socialised modes of consumer behaviour:

“I would tend to use customer because that’s what I’ve probably used in my life at work...It just seems appropriate. All the way through my life dealing with the public and in my different jobs that I’ve had we’ve always spoken about the customer. You know, I’m the

customer today or you're the customer...It's a bit like when you go shopping at the end of the week for your groceries, you don't just go bowling in there and say 'I want that, that, and that and that' and jump the queue and things like that. Everything has a system so you have to stick to that system" (60-year-old male, retired stock manager).

Similarly, SU04A commented:

"Yes, I am coming here for a service in effect. You are the NHS, the National Health Service, you are a service and if you are not providing that service then I am going to pipe up and say that I'm not happy...When you go into a restaurant...to order food and your food is cold, you say something about it. I come here for healthcare and if I do not think my health has been taken care of then I'm going to complain. It's exactly the same" (22-year-old female, student).

SU04A was disappointed that the environment and staff in case A/Hospital 1 were not more customer orientated:

"Poor direction to the x-ray department, that wasn't satisfactory. It wasn't signposted, we couldn't find it. And nobody seems that happy to be here, I know it's a hospital but nobody seems that chirpy. I'm quite chirpy myself and I was trying to have a little joke with the nurse but she wasn't having any of it to be honest. But she has probably had a long shift so you can't really complain...If every was really happy and friendly to be here I would be like 'this is a nice place'".

Although SU04A recognised why the ENP in case A may not have been as positive as they expected, they go on express further disappointment at their demeanour during the consultation:

"She was just really nonchalant about everything and it...didn't seem like she wanted to spend a lot of time with us. She was a bit like 'yo, whatever' really. She didn't express any emotion, not 'I'm sorry that you fell over' or whatever, she was just like 'right, let's have a

look, get it up, have a look, bye'. She was in and out really, which was quite good because I don't want to be here for ages. She didn't seem that caring but maybe that's what she's like as a person I don't know. She seemed really bored actually if I have to say...It was if she has seen this a million times and she couldn't be bothered".

SU04A was aware the ENP may have worked a long shift and may also have seen the presenting condition on many previous occasions (which is desirable) but also expected the nurse to appear more interested in them as a person (not just their injury). When asked whether they respected the nurse's professional opinion SU04A replied:

"I don't respect them because they are not doing their job properly. They should be caring and interested. To be honest, like I said before, it was like she had seen it a thousand times before and she didn't really care either way...When she goes home tonight she not going to sit and think 'oh, that girl I saw today, I wonder what happened to her'. She not going to care, she doesn't care, it's just her job".

Although SU04A received the correct diagnosis and treatment for their injury they still felt that the nurse had not performed their job properly since they had not demonstrated sufficient care or interest in them. In contrast to the views expressed above, some service users also drew attention to important differences between healthcare and other service industries. For example, SU19A described how they thought customer service in healthcare differed from hotel services:

"There is more superficiality in the hotel arrangement and you [health professionals] get very much more involved and the more you can help people in the situation like that, they get better much more quickly and have great faith in you. And they have the feeling of wellbeing which you wouldn't have if you went to a hotel. I mean politeness yes, you want that at a hotel but no...I don't think they [health professionals] need to be customer focused. They need to actually have the empathy" (73-year-old female, retired nurse).

However, SU19A's opinion may have been influenced by her nursing background prior to retirement. Finally, SU14A drew attention to the tension between individual service provision and prioritisation of need by a healthcare professional. Whilst they accepted that others service users' needs may require priority care they expressed concern that others may not view it in this way:

"I think there are certain members of the public who see the health service just as their own little service, which it is to some extent. But they'll walk in and expect to be seen in the next five minutes. All their whims and wants taken care off. But, if you like, it is a bit like we were used to queuing, now we are not used to queuing. Nobody wants to queue anymore, nobody wants to wait. Nobody sees that there are other people there and you might have a splinter in there and the other guys just broken his leg. No, because I was here first. And it's just you have to take everything as it comes. If somebody's in more need they should go first. Just because he booked in first doesn't give you the right, so yeah. For me, I think there are a certain amount who just see that the health service is there, they pay into it and they want to get their chunk before someone else because they've got to get to a McDonalds" (60-year-old male, retired stock manager).

Clearly, therefore, whilst most patients did acknowledge that they were in some sense customers of healthcare this was not their first and most obvious choice when choosing to describe themselves for the most part as patients. Notwithstanding this, they did not appear to regard a patient as being a passive role and almost all of them actively sought to be involved in decisions regarding their care as I will now describe.

4.12 Service user views regarding shared decision making

Almost all service users stated that they wanted to be involved in the decision making process. However, there was considerable difference of opinion regarding the level of participation considered necessary or desirable. SU02A discussed their frustration when they are not offered an

opportunity to participate in care decisions and highlighted how participation and ownership can be of benefit to the service user and provider:

“Very often we are not given options of treatment, we are told ‘you need this’ and that’s it. And actually I always think there is more than one way to do something. So I think to have those options in the first instance and maybe explanation as to why a particular person is favouring a particular treatment needs to be done more than it is...I think it will lead to a better service for the general public but I also think it will lead to a better service for NHS staff because when people are worried and confused and not sure what to do they start to panic and their behaviour comes out in different ways” (50-year-old male, support worker).

SU11A described how they have had to assert themselves in the past in order to feel involved and informed. They also demonstrate insight regarding the limitations of their own knowledge and workload pressures for healthcare professionals:

“Sometimes I feel that I am easily dismissed and it’s not until I list exactly what’s wrong with me and I’m quite forceful about it...but I like to feel that they are listening to me and not just dismissing it as nothing. It’s better to be safe than sorry. I know it’s probably expensive. It takes time, they’ve got lots of other patients to see but just discounting it from the beginning is what upsets me...I would like an influence. I would like to say what I want them to do. Obviously I’m not the doctor so I don’t know what should happen but I’ve got a vague idea. And I’d like them to think about it” (20-year-old female, student).

SU14A also thought that service users needed to achieve a balance when interacting with healthcare professionals regarding co-production of care:

“Some people like to climb on a high horse and just go ‘no this should be done, that should be done, this should be done’. You have to take the happy medium and, at the end of the day, they have points of view they can put forward but you have to work within the system. You

can't just say carte blanche 'yes, we'll take everything you say and make it happen' because you're the experts you know, you're the people that have to deal with twenty people turning up at once and stuff like that" (60-year-old male, retired stock manager).

A number of service users also discussed the concept of control and ownership during the consultation and treatment process. For example, SU22A described their experience of having a long term medical condition:

"I've got a long standing medical condition but not this [indicates reason for attendance at MIU]. And I guess the people that I've appreciated speaking to most are those where it feels like I'm the decision maker...in order to feel in control of it rather than I've got [medical condition]...So being enabled to feel like you have a decision in how you are going to manage is really important...minor injuries may be a little bit different because I guess there are less major decisions to be made...But I think, on the whole, and for long standing conditions especially, having people being as informed as possible and being given all the options is really important, really important" (29-year-old female, theatre company director).

SU08A described how service users should take responsibility for co-production of care if they want be informed:

"About fifteen years ago I had a [condition requiring surgery] and I have to say that the surgeons were absolutely excellent at explaining things but that's because I asked questions I think. I don't know whether they would necessarily sit down and draw the same sort of diagrams to explain things if somebody hadn't asked" (54-year-old female, lecturer).

SU02A explained how shared decision making had been facilitated by a change in the relationship between service users and providers:

"I grew up in an age when you were frightened of doctors. Doctors didn't converse with you they told you what was happening. This is changing, their attitudes towards patients are

changing and that's much better because if you feel part of the process, and you feel that you have a say, you equally feel that you are being listened to" (50-year-old male, support worker).

Similarly, SU09A described how their experience and interaction with healthcare professionals had changed from the early 1990's:

"Do you remember the Patient's Charter? Right. Suddenly it changed. I was just, if I could use that word, a pleb. When you went to hospital and you had perhaps a serious injury or something like that and you got to see the consultant you were looked down on. There was no shaking of hands, no introduction. It was a bit like the headmaster. You've done something wrong, you've come here. You're wasting my time you know. That sort of thing. And when we had the Patient's Charter is suddenly changed. When I went in, a consultant and his assistant they'd stand up, they'd shake hands, introduce themselves and explain what their job was, the injury that they're look at today with me. And I've also been with consultants where they've said to me 'you've got these injuries, what do you want, what's your target?'...And I said 'my target, I'd like to be able to do the back stroke'. So OK they made that my target...that participation, it gives you confidence in the consultant" (70-year-old male, retired engineer).

Conversely, some service users did not want participate in the decision making process, particularly when it involved diagnosis and treatment options. For example, SU21A remarked:

"I'd want them [health professional] to say 'you've got this or that' and then, you know, just give me the tablets or if not the just treat me there and then and then I'd go home. I wouldn't mind them having a chat but, you know, I'd rather it was quick and go home sort of thing" (20-year-old male, student).

When asked if they expected health professionals to ask their opinion regarding care decisions

SU12A answered:

“Well I don’t know because you get to a situation sometimes where a doctor will say ‘what do you want me to do?’ and I feel like saying ‘I’ve come to you. You’re the doctor’. But this is how they are. I think doctors along with a lot of other medical people are very frightened of litigation aren’t they these days? They are afraid of getting things wrong perhaps. But to my mind...you go for a consultation and that’s what you expect isn’t it” (71-year-old female, retired cook).

Similarly, SU13A felt that participation in clinical decision making was unnecessary:

“To me, being asked my opinion depends on the scenario. If she [GP] was asking my opinion on how I thought [child] was, as his mother I could answer that. But if it came down to his medical condition I can’t have an opinion on that, I’m not medically trained and I wouldn’t presume to have an opinion...So I am more than happy to defer to the person who has more knowledge than me” (39-year-old female, administrator).

At the same time, SU13A valued the information and consideration they received whilst receiving care:

“All the time it was a two-way road of information for me. ‘What do you think? Would that be alright with you? Are you happy doing this?’ sort of thing...you felt more involved. And actually it makes it more of a nice environment you know. The fact that you are not just sitting there, someone off the street as it were...From the time you book in, you are someone who matters”.

For these service users, understanding the decision making process seems more important than active participation and contribution. They welcome the information provided by the healthcare professional but were content to be directed regarding care and treatment options. Finally, SU08A

speculated that some service users may become confused if provided with information they did not understand:

“I can see that for some people it could lead to more problems. Because if you are giving information to people and they are not understanding the information you are giving them it could become more confusing. So, for me, it works very well but I think that’s a judgement call you [ENP] have to make with the patient you are dealing with” (54-year-old female, lecturer).

4.13 The impact of the internet on information-seeking behaviours

The impact of the internet (and Web 2.0 enabled services) on the relationship between healthcare professionals and service users cannot be underestimated. Thirteen service users in case A (61.9%) confirmed that they regularly researched their health using the internet. Eight service users (38.1%) stated that did not use the internet to research their health, or tried to avoid doing so, since they felt that it increased anxiety. The majority of those who did not research their health (5/8) were aged between 60 and 86 with an average age of 70. The three service users who were not in this age bracket were aged: 20, 30 and 39. Those who used the internet, often researched health related issues before seeking medical advice (to check attendance was necessary) and afterwards (to check that the information provided was accurate/inform management). For example, SU07A described how they used the internet to decide whether they required medical attention and where the most appropriate destination was:

“Sometimes I check before and think 'oh maybe I should go to the GP or the hospital and get help for it' just to see if it's actually, if you have any symptoms you can kind of match it and think actually that could be serious and I should probably get it checked out...when I came here, to the minor injuries, I looked up what it could be and thought 'well there's no point going to A&E I can go to the minor injuries because they deal with things like fractures and

lesser injuries'. At the A&E I'd be waiting a lot longer because they have serious injuries there" (18-year-old female, student).

A number of service users commented that although they did not use the internet to self-diagnose they found it useful to check or supplement information provided by health professionals.

For example, SU12A remarked:

"Recently, having more problems with my own health, you get confused with different scans, MRIs, things like that. And you think "well what is the difference?" (71-year-old female, retired cook).

Some service users described how they consulted the internet during their time in case A and SU08A explained:

"If I have a condition then I would do a bit of background research to understand what the condition is...In fact, I sat at x-ray today looking up 'broken bone' [laughs] is that bad? Whilst I was waiting in x-ray, because I was there so long, I looked up broken bones in your arm and saw the different treatments. But that's my mind" (54-year-old female, lecturer).

SU02A commented that they would like to see technology used more frequently and effectively to facilitate healthcare:

"I don't think it has been used to its full potential. I would like to see it used a lot more. I definitely would like to see it being used for consultation because that would have saved me a thirty mile round trip. I may still have needed to go for x-ray but that could have been done by appointment which would have saved the waiting time etc. I think from that perspective it could be used a hell of a lot more than it is" (50-year-old male, support worker).

Almost all service users in case A demonstrated insight regarding the potential limitations of the information that could be accessed online. This included the accuracy of the information presented, the reliability of the website hosting the information and their own/others ability to interpret

potentially complex information in a meaningful way. For example, SU10A commented on the importance of accessing reliable information:

“I remember texting my [relative] when we’d discovered what was wrong and saying ‘look if you want to read up about it just go the [Hospital] website. Do not go onto any of the other links. Mumsnet and all these awful things that were on there because it is terrifying. Stick with the one there which offers a lot of good solid advice and it’s far more optimistic and so on than anything else’. I think you’ve got to go onto the right place, that’s the thing. You might not be finding the right information in the right places but I think sometimes it is the old saying ‘a little knowledge is a dangerous thing’. It can be but at the same time, having some knowledge as I’ve found, helps you to maybe just probe a bit more and possibly just feel a little bit more assertive” (63-year-old, female teacher).

SU11A described how they frequently use the internet to research their health but they also recognise that it can cause anxiety at times:

“It probably makes me more anxious because there will be something niggling that’s been going on for a while and then I think ‘maybe I should get this checked out for my piece of mind’. Then I Google it and I feel a lot worse. But then, on the other hand, it can be quite useful if you are worried about something. Having an idea of what it is it makes you feel a little better rather than the fear of the unknown” (20-year-old female, student).

Finally, SU09A described how researching their health had proved both beneficial and unbeneficial depending on the nature and complexity of the complaint:

“It can make you more worried, yes, there is that fear. But sometimes when you’ve left the consultant and you think ‘I know what he’s telling me but I need to know more to be happier. I need to know more’ and I’ve gone in and then you see other opinions or contradictions. It could be dangerous looking at things like that. It’s a bit un-nerving...On this occasion, with

[describes medical condition] *it just confused me because I can't see it properly...It's too complex...Whereas, when I looked up with the Specsavers thing. I went online and looked up and got everything I could. And I had such a good understanding of it...I learnt so much about that condition. And I copied everything and put it in a file. I fully understand that"* (70-year-old male retired, engineer).

The majority wanted information given to them with regard to their healthcare situation which is encouraging given that information is one of the pre-requisites for self-management, another of the key drivers in healthcare policy at the current time as discussed below.

4.14 Self-management

Service users in case A were generally prepared to manage minor medical issues at home but valued professional advice regarding anything they considered more serious. For example, SU02A explained why they thought self-management was important but also described that there was a limit to how much responsibility people should take:

"I always say 'you could die of a misprint', too much research. It's OK if it's the right information but there is a lot of information that isn't correct out there so that's always a difficult one to call really...I think what we should be doing is educating about our own health and promoting good health at a much younger age. Because then that becomes engrained and people are more likely to continue that through adulthood and so, therefore, their need for use of these services may be much less. From the perspective of gaining information about conditions and things like that it should be left to the professionals who have studied for goodness knows how many years. You know, to offer a diagnosis" (50-year-old male, support worker).

SU09A described how they have always tried to self-manage their medical complaints:

“I’ve always been a self-manager. It started off with having a [medical condition] and injuries when I was younger as an apprentice. And you tend to think of rest, lying here and the doctor would say ‘a week off’ and things like that. And then as you get older you take more responsibility. You need to be at work 120% of the time. I can’t be off sick and you start to self-manage. So I got myself a book on [medical condition]. Do this, this and this...And I’ve managed my [medical condition] without having time off sick. And so as you got more and more responsibility you self-manage” (70-year-old male, retired engineer)

SU14A described how they tried to avoid taking medication if possible:

“Sometimes, if you’re not careful, you’ll just sit there and go ‘I’ll take these pills...Sometimes you can do without the pills just by doing exercise, swimming, stuff like that, which will do the job just as well, rather than sitting around, you know, a gentle walk whatever” (60-year-old male, retired stock manager).

SU20A believed that people should take responsibility for their health but they also felt that health professionals should reinforce that message (forcefully if necessary) rather than defer responsibility to the individual on the basis that it is their right to choose:

“I think personally doctors should be more straight-forward when it comes to things like that...It would help if doctors said ‘stop or else you are going to die’, be more blunt about it. Frighten people perhaps into looking after their health. I think there is a sort of general ‘it’s up to you. It’s your human rights. You are entitled to do it’. There are ethics aren’t there. There are all sorts of ethics involved in what you say to patients as well. I wouldn’t make a very good nurse or doctor. I wouldn’t because I think I would be too straight-forward with them” (67-year-old female, retired IT engineer).

4.15 Willingness to question and challenge healthcare professionals

Two-thirds of service users in case A (66.6%) stated that they were prepared to challenge professional opinion if they thought that it was incorrect or inappropriate. However, many service users also explained that they were uncomfortable doing so or lacked confidence. There was also considerable difference of opinion amongst service users regarding which age group was most/least able to communicate confidently and efficiently with health professionals. SU02A described how they felt confident to challenge medical opinion if necessary but also how this had not always been the case:

“I feel confident now but I wouldn’t have been a few years ago. Because of the field I work in and the job I do I am used to challenging authority, that’s part and parcel of my role...I grew up in an era where you didn’t challenge medical authority and it isn’t like that now. Although I would say that, on the whole, that’s probably a better thing” (50-year-old male, support worker).

SU02A went on to explain what they saw as the difference between the way his generation communicate with health professionals and the way the younger generation communicate:

“If I wanted to challenge something I feel that I would be able to challenge it in a professional and calm manner. I think that the younger generation - I sound really old now - the younger generation...don’t seem to have that respect and don’t seem to have that ability. Their way of challenging is generally-speaking quite aggressive...It’s lack of respect and lack of authority. For whatever reasons, right or wrong, authority has been taken away from everyone...I think it comes down to the fact that people are frightened to exert authority”.

SU09A also described how they had become more confident as they had got older:

“I would probably be on the weak side but yeah I’m not frightened [to challenge]. As you get older you get more rebellious and, as you’ve seen, old people start to argue about

everything. So I think it is an age thing rather than a natural ability...as a young man, no, the confidence isn't there" (70-year-old male, retired engineer).

Conversely, SU12A described how they had lost confidence communicating with health professionals as they got older:

"It's the sort of feeling that doctors know what they are doing and you sort of; it's my sort of generation. I think the younger ones question it far more. I mean obviously now I think I do to a certain extent but perhaps I haven't. I definitely have not always been like that...I suppose it's like an insecurity thing isn't it" (71-year-old female, retired cook).

A number of younger service users (≤ 30) believed that they were more likely to challenge medical opinion than the older generation partly because they were more confident and partly because they had a different relationship or outlook towards healthcare professionals. For example, SU04A explained how they were not prepared to accept medical opinion if they disagreed or felt they had not received the service they were entitled to:

"I want them to do something about whatever the problem is. If I wasn't satisfied I would say something but there are people that will just take whatever. If I was given treatment and didn't think it was satisfactory I would say something. I'd say 'well I want to be treated by somebody else' and make sure action was taken. I don't think a lot of people have the audacity to do that" (22-year-old female, student).

When asked whether they thought their age influenced the way they viewed healthcare professionals, SU04A replied:

"Probably, yes, probably. Some old lady is not going to worry; she'll be like 'thank you doctor'. I think they've got a lot more respect for the medical profession than young people have...They are more respectful generally. Older people have a lot more respect for other people".

When asked if they felt confident to challenge medical opinion, SU11A replied:

"I think I'm just that sort of person. I like to have my own way a little bit. And I know if you don't ask you don't get. So that's one of my key things. I also know that, to an extent, they'll listen to me. Well I feel like that anyway which is why I'm happy to ask. But I know other people are going to leave it and say 'well, they are the doctor. I don't really want to question them'. But, as I said, if you don't ask you don't get. And they are not going to be mean to you for asking...I have asked for second opinions quite a few times. Sometimes you have to because they don't listen to you in the first place" (20-year-old female, student).

However, not all younger service users felt confident challenging professional opinion. When asked if they thought age made you more or less likely to challenge medical opinion, SU07A answered:

"I don't think so, I think it depends on the person. I don't think all young people are more likely to challenge. There are some that are quite quiet anyway and more likely to go along with it. But I suppose people who are more educated, in the sense that they understand basic medicine, could express themselves better to doctors. That would be a lot easier" (18-year-old female, student).

They also commented:

"It's an authority thing I think. Doctors and nurses are the ones that look after you, the higher authority, they treat you to make you better. It's difficult because obviously the medical experts understand what they are supposed to be doing. And so you could challenge them but you wouldn't know what the right course of treatment would be because you're not an expert...I respect them, I think they are very important. I think they have the most important jobs" (18-year-old female, student).

SU21A also explained that they were reluctant to challenge professional opinion partly out of deference to their knowledge and partly because they didn't want to take responsibility for the decision making process:

“Well I don't know because they're experts for most things. So I'd rather take their advice and if it goes wrong then it's not me, it would be their fault kind of thing. Yes, because it's like a student teaching a student kind of thing. If a teacher tells you something and you go and do it and if it's wrong then it's the person who taught you the thing that's wrong, if you know what I mean?” (20-year-old male, student).

There is no strong evidence from case A that age, gender and/or educational background contribute to more/less confident or assertive communication by service users when interacting with health professionals (see also below). Interestingly, SU14A expressed concern that service users of all ages were becoming more demanding and that this may encourage a more assertive approach amongst people who were previously less demanding:

“I would like to say that all the older generation are happy and look at it the same way I do but I think it's going slowly [the other way] because they are just finding that they have to shout so that they can get themselves in. I'll probably get to that stage sooner or later” (60-year-old male, retired stock manager).

In summary, a number of service user interviews indicated that convenience, waiting time and previous experience of good service were the principle reasons they chose to attend case A as their first choice of care provider. They also compared their experience of NHS healthcare service delivery with non-NHS providers and related how the private sector often provided better customer service. Consequently, despite the fact that most service users in case A described themselves as patients (individually or in association with other characteristics), rather than customers of healthcare, they all valued high standards of customer service from clinical and non-clinical staff. Many of them also felt that there were clear similarities between healthcare provision and other service industries and

some service users strongly identified with the idea that healthcare should be more customer focused. Almost all service users in case A stated that they wanted to be more involved in the decision making process. However, there was considerable difference of opinion regarding the level of participation considered necessary or desirable. Some welcomed the opportunity to take greater responsibility for co-production of care whilst others felt that direct participation was broadly unnecessary. These service users appreciated the information provided by healthcare professionals but were content to be directed regarding treatment options etc. One service user commented that people should take responsibility for their health but that healthcare professionals should provide strong advice rather than defer responsibility to the individual on the basis of their right to choose. Over half of service users in case A (13/21) reported that they regularly used the internet to research their health or check information they had received. Almost all recognised the potential limitations of information accessed online regarding accuracy and their own/others ability to interpret and understand it. Finally, 66.6% of service users in case A (14/21) stated that they were prepared to challenge professional opinion if they thought that it was incorrect or inappropriate. However, many service users also explained that they were uncomfortable doing so or lacked confidence. There was also considerable disagreement regarding which type of people were most/least likely to communicate confidently and effectively with service providers, whose views will also now be considered.

4.16 Service provider views regarding the reasons service users choose to attend case A

The following sections (4.16-4.23) provide discussion of the evidence collected during the service provider interviews. Service provider interview participants in case A also identified waiting time, convenience and quality of care as the principle reasons that service users attended to receive care. For example, SP05A noted how convenient opening-hours encouraged service users to use case A in a flexible fashion:

“They learn that they are seen quicker. They don’t have to make an appointment, they just turn up when it suits them, within the opening hours at [case B], but here - anytime. Like this morning [ENP] saw a child with a finger injury, sorry no injury, just a bit of [condition explained]...I think dad probably thought it would be quiet and that they’d be seen straight away and they were” (case A manager and ENP with 12 years’ experience).

Similarly, SP01A commented on the accessibility or permeability of the service:

“...they come here to us because it’s easy access. You just turn-up and you know someone will see you...With a GP it’s more complicated, as in you have to phone first to get an appointment that may not be convenient for you. It may take a bit longer to get through on the phone. They may not get in to see the doctor they want to. There are more steps I suppose, whereas here you just walk through the door...because we are open 24-hours. If there’s something that’s been bothering them at home...or maybe they have struggled through the day at work, or they couldn’t or didn’t try to get a GP appointment and we’re open so they come here” (ENP with 6 years’ experience).

SP08A and SP10A also commented:

“Quite often we will get a family of four or five turn-up all with different problems. They...use it [case A] as their sort of check-in-centre or just for a check-up basically. And obviously we are very nice so they think ‘they are very nice, they are very helpful’. Even if we say to them ‘you need to register with a GP’ or ‘you need to do this’. Or ‘you should go to this person with this problem’ or whatever information you give them” (ENP with 1 years’ experience).

“I have seen a shift towards a much more consumerist ideology promoted by the Government...for example, 18-34 [year olds] will tend to come to A&E and emergency care rather than trying to get a negotiated GP appointment. I think they see healthcare as...a consumer item. So they shop, they come here” (ENP with 11 years’ experience).

SP05A drew attention to how some service users accessed/used the service very much on their terms and not in accordance with professional advice or clinical protocol:

“He left without his fracture clinic appointment...I haven’t had an opportunity to check his radial nerve, I haven’t checked his axillary nerve but he’s gone...I will send him a fracture clinic appointment by post but I don’t expect he’ll go. I hadn’t finished and I hadn’t indicated in any way that he should go...I often find with young men, what’s the point of giving them a sling. I’ve watched them hundreds of times walk across the car park, take it off and throw it in the bin so now I say to them ‘if I give you a sling for your arm are you going to wear it? Be honest with me’. If they say no then I don’t bother giving them one because it’s just a waste of public money” (case A manager and ENP with 12 years’ experience).

Another issue that influenced attendance regarding ‘permeability’ was difficulty making an appointment to see a GP or practice nurse. SP05A also noted:

“...they have such problems getting appointments with GP’s that a lot of people have learned to come to minor injuries...rather than go back to their own GP because they don’t always see their own GP”.

4.17 Service provider perspectives regarding primary care

All service providers in case A stated that they felt an increasing number of service users were attending MIU because they were unable to access primary care services. For example, SP04A commented:

“The main reason [for attending case A with a primary care complaint] seems to be the inability to get an appointment...You will get a few who will come in and say ‘I just wanted a second opinion, because I was getting nowhere with my own GP surgery so I wanted to see if somebody else had a different opinion on what is happening” (GP with 5 years’ experience working for GPC).

SP05A also remarked:

“...they have often had such problems getting appointments with GPs that a lot of people have learned to come to minor injuries and learned that there is a GP here. It is only a few but they have learned that and will keep coming back rather than go to their own GP because they don't always see their own GP do they nowadays” (case A manager and ENP with 12 years' experience).

Similarly, SP06A commented:

“Obviously not everybody can get an appointment with their GP and they need to see somebody, where do you send them? We [ENPs] see them up to eleven o'clock but from eleven o'clock the injuries begin to pile-up so luckily the [GPC] GP takes the load off us” (ENP with 2 years' experience).

SP09A described how word-of-mouth encouraged local people to self-refer to the GP in case A (previously they had accepted referrals from nursing/medical staff at ECC and ENPs):

“A lot of people when they book-in with the receptionist say ‘I've come up here to see the GP’. So they think it is another GP walk-in service but technically it isn't. The word has got around that there is a GP up in minor injuries. We know that. We've heard people saying it” (ENP with 9 years' experience).

SP10A also drew attention to fact that although the GPC service has generated additional work in one sense, it was also meeting a need that would persist even if the service was withdrawn:

“...it is meeting a need and it has generated further people coming to them [GP]. But that is a societal need...for a GP. The issue is that the hours are fairly restricted. If it wasn't there we'd have a nightmare...They'll come here and think ‘well where's the service?’ They bring their sick children, they bring everything” (ENP with 11 years' experience).

Service providers in case A acknowledged that they would continue to see large numbers of service users with primary care complaints regardless of whether the GPC service persisted or was withdrawn. Many of them expressed a wish to work more closely with GPs to increase their knowledge, skills and confidence when faced with primary care complaints. SP10A commented:

“...if perhaps we had a 24-hour GP service where we could all work together, learning off each other becoming a working centre. Up-skill the nurse practitioners such as myself to deal with more minor illnesses and other illnesses but we’d have to have the staff for it”.

SP04A also commented that primary and secondary care needed a more integrated approach:

“I think most places in England need to have GPs working in acute services. For quite a long time now it has been a massive divide between GPs going something in the community and hospitals doing things completely differently. And I think a lot of duplication of work is going on because of that...It works pretty well. You have a consultant on the floor there [ECC]. So you don’t have to admit every patient to ECC that you want an opinion on, you can actually have a chat with them and see if there is a different way to go about things rather than admitting the patient. Most patients don’t actually want to be admitted” (GP with 5 years’ experience working for GPC).

4.18 Service provider views of customer satisfaction

Service providers in case A were conscious of the customer service element of their role and reported how they tried to ensure service users felt welcome and valued. However, there was a general lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context. When asked whether they thought the customer service element of their role was important, SP08A replied:

“I think it is massively, massively important, hugely important...It doesn’t cost anything to be nice and polite and listen to what they have to say” (ENP with 1 years’ experience).

At the same time, SP06A commented on how difficult it can be to maintain an outwardly welcoming countenance at all times:

“...some days you are very happy, some days you are probably a little bit down but you have to have to a smile on your face because you can conquer the world with a smile [laughs]. And I try to keep it on but it is so stressful at times, the work, you can't always have a smile” (ENP with 2 years' experience).

SP07A also commented on the potential contradiction of projecting a positive image when working in a healthcare context.

“...you don't want to be on show, you don't want to have a false smile. You want to have an interaction with people that is meaningful and real and not artificial in that way. I think the expectation is that if you are smiling and appear happy then everything is fine. You don't expect a nurse to look miserable, looking tired, looking stressed, looking overworked. You want someone who looks presentable and looks like the TV version of a nurse” (ENP with 7 years' experience).

SP10A also discussed the image or persona they felt they had to project at work:

“I sometimes think I'm working for Travel Lodge. We have all of these posters up and we have all of these things about this happy smiley hospital with happy smiley staff who are ready to meet your every need and it's very much like a hotel kind of approach” (ENP with 11 years' experience).

Despite this, SP07A offered some insight into how customer service modes of behaviours may be beneficial to service users and how attitudes have changed and continue to evolve:

“I don't know if we are aware that we do it and it might be a way of trying to allay anxieties about being in a hospital setting. This is just another...service that you need but it happens to be healthcare so don't be alarmed...I'm not sure if it is a positive thing or not really. I think it

probably is. I think if you use it to your advantage then I think it probably is but I think the concern is that everything will fuse and merge and become muddled and healthcare will just become another commodity...I suppose we are looking at it with early 21st century eyes. Maybe in fifty years' time people won't look at it in quite the same way" (ENP with 7 years' experience).

SPO8A also highlighted how a positive customer service approach can benefit the service user and provider:

"I try and build a little bit of a rapport with them. Because you haven't got long so you can't really get off on the wrong foot. And it's the first impressions really so if you come across well to people, it makes your job ten times easier...[so]...I suppose it does have a better outcome for both people from that point of view" (ENP with 1 years' experience).

All service providers in case A were aware that they represented their local employer and the NHS as a whole. SP07A remarked:

"The NHS is this big brand, this big logo that everyone has got an opinion on and has experience of... So yeah, you feel responsible, you feel responsible for maintaining a good NHS and a good experience" (ENP with 7 years' experience).

SPO8A also commented:

"Because we are front line staff so we are the first port of call for a lot of people. So, as I said, first impressions are massively important. This might be the first time they have ever visited a hospital...or someone coming who's had a bad experience in the past...so in a way you are just trying to rectify that for them and make them feel better about the service" (ENP with 1 years' experience).

Finally, SP09A drew attention to local reputation:

“We are providing this service for the public and they have an expectation that they are going to get a good service. It’s also a reflection on the reputation of this unit” (ENP with 9 years’ experience).

4.19 Service provider views regarding shared decision making and accountability

All service providers in case A expressed clear support for shared decision making and co-production of care with service users. For example, SP09A remarked:

“They’ve come here with a problem, a condition, an injury and it’s nice if it’s a two-way consultation, not just what the nurse specialist says. They should be involved in decision making” (ENP with 9 years’ experience).

SP07A commented on the benefits of shared decision making regarding outcome:

“I think the more collaborative you are with people the better outcomes there are, you know, both short term and long-term post-discharge because they feel involved” (ENP with 7 years’ experience).

SP04A explained how shared decision making and facilitation of care formed part of their GP training:

*“Part of the core training is to get them involved in their care anyway, so any decisions made, at the end of or during [the consultation] is always with the patient participating in that decision making rather than us telling them what is needed...Yes, if we felt that there was going to be serious risks to their health and/or they weren’t able to understand what we were telling them then that is a different matter. But otherwise, in most cases, it is their decision at the end of the day. You give them the information and they decide what to do.
(GP with 5 years’ experience working for GPC)*

SP04A also points out how guidelines can help to encourage informed decision making, discourage inappropriate choices and correct misconceptions:

“Everything that we practice now is evidence based. You name it...there are guidelines...I say ‘can we go through this’ so at times I have pulled up websites and said ‘is that what you have gone through and is that why you are convinced that this is what is wrong with you? Shall we look up the guidelines and see if these symptoms fit, are you agreeable to this diagnosis based upon this evidence’?”

SP10A made a similar point:

“...we might have some verbal sparring and some discussion and say ‘let’s look at the internet together’ or ‘let’s look at this book’ or ‘let’s talk through what you’ve done’. People really go away feeling more satisfied because they’ve had the conversation” (ENP with 11 years’ experience).

In some instances, service users choose to ignore clinical guidelines and service providers can only offer advice. SP05A remarked:

“For example, my protocol says every dog bite must be treated with antibiotics but you might get a patient who doesn’t want to take antibiotics...I can say ‘my protocol says that you should take them but take them with you and watch [the wound], if it looks like it’s becoming infected start taking them quick’. Some people do and some people don’t” (case A manager and ENP with 12 years’ experience).

At other times, it is more difficult for service providers to assess whether service users want to be actively involved in the decision making process or whether it is appropriate at that time. For example, when asked if they encouraged service users to makes decisions about their healthcare, SP10A replied:

“Only if I detect that they want that as part of the partnership that I’m trying to develop. Some people, if you give them too many options, choices, believe that you don’t know what you’re doing. What they’re articulating is that they’re not used to the idea of choice and

therefore they want to be directed. So it is about reading the patient and it's about saying, at the end of the day, we need a partnership but it depends...whether there is an attitude from the patient. Some attitudes range from the positive to the not positive and therefore I have to read the patient and decide on whether or not it is somebody who would engage in the idea of choice." (ENP with 11 years' experience).

4.20 Service provider views regarding 'Google diagnoses' by service users

Service providers in case A confirmed that, in their experience, service users were increasingly researching their health using the internet before they attended for consultation. In some cases, this was beneficial since it led to greater understanding and a better managed outcome. In other cases, however, it resulted in misunderstanding and confusion which could negatively impact on partnership working between service user and provider. For example, SP01A remarked:

"Maybe if they've got a headache they might have Googled it and come up with fifteen different options...then you have to try and convince them that they haven't got fourteen of those things...I think sometimes it puts them into a panic or more of an anxiety, rather than getting an understanding of something...[Others] present very differently. They are very good with their history" (ENP with 6 years' experience).

Similarly, SP06A commented:

"They say 'I've seen it on the internet and it says I could have this or that'. They are more worried about what they have read than taking good advice...They come to you and they tell you complex things which you have to explain to them which makes our work more difficult in a way" (ENP with 2 years' experience).

SP07A also outlined how internet research can influence expectation:

"There is more knowledge available and people don't come to hospital now with no knowledge...They have researched a little bit about their condition, about what they

expect...and that affects what they think the outcome should be. So if you aren't adhering to that expectation and things deviate from that, in their interpretation they could see that as having failed their expectation" (ENP with 7 years' experience).

Similarly, SP08A explained:

"I call it Google diagnosing...they've read up what the treatment is and what drugs they should be on and that is what they expect. Most people you can have a chat with and explain why you are not doing something that they are expecting...[but]...they have to convince themselves to believe me rather than Google which is sometimes tricky" (ENP with 1 years' experience).

SP07A drew attention to the positive and negative connotations of disagreement and challenge:

"There are times when you feel you being challenged and that you have to explain and expand on what you're saying and that can be quite intimidating. But I think you learn to cope with that, I think you learn to manage it...there's always an opportunity to ask someone else's opinion, to get someone else involved and then you're not alone in that decision. But yeah, challenge is uncomfortable" (ENP with 7 years' experience).

4.21 Services on demand

Service providers in case A explained how some service users employed strategies that were intended to gain advantage for themselves when accessing treatment or investigations. For example, SP04A commented that:

"Some [service users] come in because the investigations are taking too long. The GP has organised everything but it is not happening quick enough, so by coming to hospital [MIU] I can get it done easier, quicker, on the spot...There are a few who will not tell you that their GP has actually organised it and will then try to make the symptoms worse than they actually

are. You then have no other option than to get them sorted on the spot” (GP with 5 years’ experience working for GPC).

SP02A also remarked that some service users:

“...come here [MIU] because they think it’s quicker i.e. you know, rather than got to the GP if they need to have a referral to see an orthopaedic surgeon, if they have a knee issue or something like that. I’m sure they think it is quicker...which I suppose in comparison it is really” (35-year-old female, receptionist).

Although service providers in case A identified that it was only a small minority of service users that made inappropriate demands for services and/or treatment, they also felt that it was becoming more commonplace. For example, SP10A commented on the gradual change they have observed in some service users’ attitudes towards staff and expectations of service provision.

“...they do come in and, in some cases, demand to have investigations. ‘I want an ultrasound, I want a CT, I want this, I want that’. And it’s not like ‘could you see if it is possible or is it relevant’. It’s like ‘I want this and I want that’...It’s not seen...as a partnership with people, which is what I see the NHS as it should be, it becomes a service provider-service user relationship” (ENP with 11 years’ experience).

SP10A also noted that consumer attitudes and behaviour that are acceptable (and encouraged) in other transactional situations seem to be becoming more common in a healthcare context.

“...if you’ve got a choice of fifteen different providers for your internet there is a tendency to get quite argumentative and assertive with the provider because you are saying ‘I’ve got choice, I can go elsewhere’. And I can understand it...I wouldn’t want them to skip into deference but, on the other hand, it goes too much the other way sometimes. What people do, in my view, is use the communication strategies that they use elsewhere...the same type of assertive behaviour that they’ll use in Curry’s or in KFC or when they go to Travel Lodge”.

Whilst most service users in case A seemed to value the treatment and advice they received, there also seemed to be an expectation - from some - that follow-up services should be provided outside of working hours. The senior manager explained the practical difficulties of accommodating requests to return for outpatient and clinic appointments at particular times:

“They expect to be able to do their day’s work and then come to MIU at their convenience. They pick up on certain things in the media and the television as well. Mr Cameron now obviously wants seven days a week, 24-hour health care available. They’ve heard that headline...You have to say ‘we try but...if we bring you back to clinic [at 19.30] and I need a physio they haven’t gone 24-hours yet’. So it is not always that simple” (senior manager with 19 years’ experience as an ENP).

SP04A drew attention to the consequences of offering new and better forms of treatment and expressed frustration that service providers are not always able to provide the care that people need because of financial restraints.

“Attitudes have changed...people are hearing of better outcomes, newer technologies and everything else. So they are demanding these treatments and being a developed country I think it is our job to be able to offer those services...What is the point of saying ‘we have a super healthcare system but, hold on a second, I’m not going to give you that because of money problems’...How are you going to say to a patient ‘I have a life-saving medication but you can’t have it?’” (GP with 5 years’ experience working for GPC).

Most service providers in case A commented that they regularly felt under pressure to provide investigations that were unnecessary or not clinically indicated. The most common example was pressure from service users and/or their families to x-ray when clinical examination indicated that there was no reason to. SP05A explained how they sometimes gave in to pressure because of fear of complaint:

“I can tell they’re not going to be happy until they have got an x-ray. I could put a bet on the fact that it isn’t broken but you still do it and I suppose that must be from the pressure and the fear that there will be a complaint...The therapeutic x-ray...It’s not a good approach to work from but we all do it” (case A manager and ENP with 12 years’ experience).

Even when service providers defend their professional position, some service users insist upon a second opinion. SP06A recounted:

“I said to the mother that I’m not prepared to x-ray because I don’t want to expose her [daughter] to radiation unnecessarily. But she said ‘no, I want a second opinion’ and I said ‘fair enough’. I felt pressurised but I’m going to stick to my guns because I didn’t think there was any clinical indication for an x-ray” (ENP with 2 years’ experience).

SP04A also remarked:

“There are a lot of patients who will come in and ask ‘I’ve had a headache for two days and I want an MRI scan. I think I’ve got a brain tumour’...You would still say ‘let’s try so-and-so medications’ and try to reassure them but if they still kept coming back...OK, let’s get a specialist opinion or a second opinion. You could use another GP for a second opinion, not necessarily a specialist but yes I think if you wanted a good outcome...you would still have to reassure them otherwise they are never going to feel better” (GP with 5 years’ experience working for GPC).

4.22 Managing changing expectations about service provision

According to service providers in case A, the most common reason for misunderstanding and disappointment regarding the availability of service provision seems to be the fact that the MIU is located within a larger hospital environment (Hospital 1). Consequently, many service users assume that they will be able to access the same services and speciality care as that provided at Hospitals 2 and 3. SP01A commented that:

“It’s quite frustrating because patients come in expecting because we are a hospital every service is available here. And when we try to explain that actually the orthopaedic service is at other sites...ENT is over at [Hospital 3]. All those different services, it’s almost as if ‘why have I got to go there?’” (ENP with 6 years’ experience).

SP07A also identified the common misconception that hospitals are able to provide care in all circumstances:

“I think historically people are used to coming to hospitals...People have always associated illness, ill health with coming to hospital. I think they are not aware of all the different provisions...as we are, because we are healthcare workers. So they default back to a hospital quite often. And because hospitals cannot say ‘no’...it is almost a learned behaviour in that respect” (ENP with 7 years’ experience).

Another common reason for service user dissatisfaction and complaint seems to be expectation regarding waiting time. When asked what attracts service users to the MIU, SP06A identified expectation of swift service:

“...lately, there have been loads of people coming here who have said that the service is quicker here, they’ve had good service and are happy with the service” (ENP with 2 years’ experience).

SP10A commented that some service users demonstrate a self-interested approach to waiting time:

“People are...much more assertive and much more sort of ‘I want to be seen, I want this’ when they walk in and see fifteen people there that have obviously been there for two or three hours and they think ‘I’ve got to get the attention of these people” (ENP with 11 years’ experience).

Despite this observation, service providers at both cases agreed that it was only a small number of service users that exhibited unrealistic or unreasonable expectations regarding waiting time. For example, SP05A commented:

“...it’s only a small minority. Most people are friendly...and even if they have to wait, fine, providing they can see the department is busy. The odd one will be aggressive, ‘I want this done, I’m not meant to wait this long, I should be getting a scan now’ but...it’s not the majority” (case A manager and ENP with 12 years’ experience).

SP07A also remarked:

“Some people’s expectations are generally reasonable and some people’s aren’t. But again I think that’s life. Some people’s expectations of any situation are reasonable or unreasonable. You know, you will see every type of person in here as you will in everyday situations. So yeah, I don’t think it’s disproportionate to anywhere else but it is frustrating at times” (ENP with 7 years’ experience).

When asked to identify characteristics exhibited by those with the highest expectations, SP09A suggested that age might be a factor:

“I do find that the majority of younger people tend to be quite impatient. The older people...seem more appreciative...and not quite so worried about the wait” (ENP with 9 years’ experience).

When asked to explain why this might be the case they replied:

“I think it is the pace of life they are living, the majority are quite impatient. They need to be doing things an hour ago”.

Similarly, SP10A identified a contrast in perceived level of gratitude between different generational groups.

“The older generation tend to be much more ‘I’m sorry to bother you...I know it’s relatively minor but I want this to be seen’...Or ‘I’ve been listening about A&E and shouldn’t be coming up but I thought I’d better. Sorry to waste your time’. The younger people think ‘Nah, I’m a student, I’m young and I can everything fixed 24/7 on my computer... I just want it fixed now’. So they just turn up and...expect somebody else to fix it, or ‘well everything else in my life runs like this so why shouldn’t healthcare?’” (ENP with 11 years’ experience).

SP05A, on the other hand, remarked that both the very young (including students) and the elderly were relatively acquiescent. In the case of the former, SP05A believed this was because of lack of experience and confidence regarding self-management. They also felt that ‘30 to 50-year-old middle class people’ were the most confident and likely to articulate their needs during consultation:

“...I would say it’s probably 30 to 50-year-old middle class people who are pretty good at that. The elderly want you to tell them what to do and the teenagers are a still a little bit, want to do what mum tells them. The students, for example, we get hundreds every year, Freshers come here, first time they’ve injured themselves, first time they’ve got a cold, they’ve got nobody there to look after them” (case A manager and ENP with 12 years’ experience).

Service providers also identified personality, education and experience as possible factors that might influence service users’ behaviour when negotiating care and treatment with health professionals.

For example, SP07A commented:

“I think it depends on personality. Some people are quite proactive in how they approach all areas of their life and they will bring that with them into this healthcare setting. And I think, you know, if they are people that have had a particular type of education or occupation then they will be more likely to ask questions, more likely to...ask quite direct questions about their care. It depends on them as a person, their background, their previous experience of

healthcare a lot of the time. So yeah, it is variable but I think it is still becoming more common place to question” (ENP with 7 years’ experience).

4.23 Dissatisfaction and service user complaints

The right to complain about poor standards of care and/or refusal of treatment is an essential quality control mechanism for the NHS and other service industries. Service providers in case A (and B) were aware of the importance of the complaints procedure and the senior manager identified complaint as one of the two factors that contributed to high standards of care:

“Firstly, it’s their own pride. I hardly have a changeover in staff so it becomes their unit. So it’s their self-pride. This is my unit, this is the care I give. And the other one is led by complaints...They don’t want the complaints because complaints are so time consuming and such a negative thing” (57-year-old female, senior manager).

At the same time, SP07A explained how fear of complaint can lead to a more defensive position when interacting with service users:

“Yeah, [I have become] a bit more guarded, reluctantly...I suppose it’s just a self-protection mechanism isn’t it, if you feel that’s happening or there’s a potential for that to happen. If you are aware of it then it is going to affect your conversations with people and your interactions with people” (ENP with 7 years’ experience).

SP04A also remarked:

“It has become defensive...because your career could be on the line so who wouldn’t be defensive nowadays” (GP with 5 years’ experience working for GPC)

SP07A drew attention to how the use of mobile technology to record consultations (often without asking permission) was also contributing to a shift in service user-provider relationships:

“That can develop a kind of guardedness between you and the person that you are talking to because it’s a form of dishonesty in a way isn’t it. Because it depends on what that person is going to do with the information but...it takes away the trust between you and the individual...Material is posted out there everywhere and images put up...It’s all in a state of flux I think at the moment. Things are changing” (ENP with 7 years’ experience).

The potential for service users to upload images and/or dialogue to social media as a form of unofficial and unregulated ‘complaint’ has the potential to undermine participation and cooperation between service users and providers. SP03A also commented how the threat of complaint can be used as a lever to influence clinical decision-making:

“...if they don’t get what they want they kick up a stink and they’re going to report people and they’re going to go to the papers. Some people are very manipulative and if you don’t give them what they want, well then the whole lot of you are going to be reported” (technician with 4 years’ experience).

The senior manager commented on the types of complaint she most frequently received:

“Our complaints are very varied. Very few of the complaints are for bad treatment...[Some are for] misdiagnosis or someone did something wrong. They are the least of the complaints...they’re awful because you are in the wrong. All you can do is apologise...and do something to put it right. A lot of my complaints are about expectation; loads of them are about not being offered a cup of coffee or a cup of tea” (senior manager with 19 years’ experience as an ENP).

The latter type of ‘expectation’ complaint seemed to be a source of particular frustration for service providers from case A and SP05A remarked:

“...a patient complained that...he didn’t get anything to eat or drink and he was, you know, really furious about it. But he did get diagnosed, he did get his antibiotics and he did go

home better than he came in. The fact that he didn't get a drink is not ideal but his wife was with him so she could have walked to the shop and bought him a drink" (case A manager and ENP with 12 years' experience).

In summary, like the service user interview participants, service providers identified waiting time, convenience and quality of care as the principle reasons service users attended to receive care in case A. They also noted how 24-hour opening encouraged service users to attend in a flexible fashion. All service providers stated that they felt an increasing number of service users were attending case A because they were unable to access primary care services elsewhere. Whilst they drew attention to how this created additional work, they also felt that primary and secondary care service would benefit from greater integration. Service providers were conscious of the customer service element of their role and reported how they tried to ensure service users felt welcome and valued. However, there was a general lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context.

All service providers expressed clear support for shared decision making and co-production of care on the basis that it had the potential to improve outcome. However, one service provider explained that, in their opinion, not all service users were used to the idea of choice and prefer to be directed. At the same time, service providers agreed that service users were increasingly researching their health/healthcare management using the internet. In some cases, this was beneficial since it led to greater understanding and a better managed outcome. In other cases, it resulted in misunderstanding and could negatively impact on partnership working if service providers presented an alternative view to the internet.

Service providers also explained how some service users employed strategies that were intended to gain advantage for themselves when accessing investigations or treatments. Although they identified that it was only a small minority of service users that made inappropriate demands, they felt it was becoming more common. There was broad consensus that older service users tended to

be more grateful regarding service provision but opinion differed regarding which group was most demanding. They identified personality, education and experience as possible factors that might influence service users' behaviour when negotiating care/treatment with healthcare professionals. According to service providers, the most common reason for service user disappointment in case A is misunderstanding regarding the availability of services and treatments. Similarly, they noted that consumer attitudes and behaviour that is acceptable (and encouraged) elsewhere seems to be increasing in a healthcare context. As a result, they often felt under pressure to provide treatments and investigations that were unnecessary/not clinically indicated because of the fear of complaint. One of the service providers explained how this can lead to a more defensive position during consultation.

4.24 Friends and family test (FFT) data: service user perspectives

The following sections (4.24-4.32) provide discussion of the quantitative and qualitative evidence from the FFT survey conducted once service users have been discharged from case A (see 3.17). Category 1 or 'extremely likely' to recommend the service represents the most common response to the FFT survey and accounts for 65.85% of respondents from case A. Category 2, or 'likely' to recommend, accounts for 20.37% of the responses from case A. However, these values are much more meaningful when considered alongside the qualitative feedback provided by question two and a number of themes can be identified in the comments from case A. The most common indicator of service user satisfaction in case A seems to be the attitude of the service providers when interacting with service users or what might be termed 'positive affective behaviours' (167 responses - appendix 13). The words 'friendly', 'helpful' and 'polite' are frequently used collectively to describe this experience. For example:

“everyone was very friendly and helpful and seemed that they couldn’t do enough, and although they were very busy...she [ENP] wasn’t stressed still very smiley and professional”
(10/2014).⁷

“receptionist very patient and helpful. nurse that we saw was friendly and helpful”
(10/2014).

“service with a smile” (11/2014).

It is interesting to note that smiling and welcoming behaviour seem to be valued by some service users. Traditional healthcare attributes and qualities such as professionalism, caring/compassion and respect/dignity are cited less frequently in the FFT than positive affective behaviours. In the responses ranked 1 and 2 in case A. Professionalism was cited on 39 occasions, caring, compassion, kindness on 30 occasions; with respect and dignity cited on three occasions. That is not to say these qualities are not valued by service users but they are frequently mentioned alongside ‘friendliness’ and other positive attributes. For example:

“the whole process was very efficient and the staff polite, friendly, courteous and professional, best experience of a minor injury unit so far” (10/2014).

Finally, one service user commented that staff were ‘wonderful’ despite the fact they were under pressure:

“wonderful staff who were under pressure from patients who were pushing boundaries at times” (10/2014).

⁷ Grammar, punctuation, spelling and syntax in all text message and e-mail quotations is reproduced as originally written.

4.25 Positive responses to waiting times in the MIU

The second most frequent indicator of service user satisfaction in FFT data in case A is time or speed of service provision (163 responses). Typical comments read:

“the process was very quick and the follow up appointment was arranged for days, not weeks” (10/2014).

“i was in and out within 10 minutes! I never thought that was possible in a hospital” (11/2014).

“overall my experience at the unit was fast and i experienced good customer service” (11/2014).

However, speed of service was not always a priority for those rating the service as 1 and 2. Some service users still rated the care they received highly, despite the fact that they had to wait. For example:

“although the wait was over 2 hours we received excellent treatment whilst there” (11/2014).

“there was a long wait and no information given regarding waiting times...however, the service of the nurse/doctor and radiographer was brilliant” (10/2014).

“waiting time was long but very friendly staff” (01/2015).

Most respondents' expectation of the time that they would have to wait for treatment seems to be realistic and pragmatic. For example:

“we waited about 60-75 mins but didnt feel that was unreasonable for a drop in service” (01/2015).

The sense that waiting for treatment is expected and anticipated is also evidenced - in part at least - by the surprise expressed in some of the comments above regarding the speed with which they have

been seen/treated/discharged. Other comments provide comparison between case A and the time it takes to be seen etc. by other local service providers. For example:

"[Case A] is the nearest place to go that i know of, other than the doctors surgery, and that could involve a long wait because of appointments" (01/2015).

Although speed of service provision is undoubtedly a strong indicator of service user satisfaction it also seems that some service users are accustomed to waiting for care and are prepared to tolerate the inconvenience providing staff demonstrate a high level of customer service and treatment is appropriate. On the other hand, waiting time appears to be the principle reason why some service users rated the service 2/'likely' to recommend, as opposed to 1/'extremely likely' to recommend.

For example:

"the nurses are very kind and thoughtful, but it is considerably time-consuming to wait for treatment" (11/2014).

"the service was very good and all the staff were very nice although due to the busyness the waiting time was quite long" (11/2014).

4.26 Efficiency and communication

Another term or theme that frequently appears in the question two comments (ranked 1 and 2) is efficiency (57 responses). However, it is not always clear from the feedback how the service or staff member has demonstrated efficiency and, like many of the themes, the term is often applied in conjunction with other indicators of satisfaction. For example:

"efficient and friendly service, also went out of their way to look for a follow up appointment which was a convenient time and day for me. (unfortunately they couldnt find one)" (10/2014).

"the service was fast efficient and very helpful. the staff were all friendly" (10/2014).

“staff were very efficient and despite it being very busy, the wait was reasonable” (11/2014).

Speed of service provision seems to be a factor in crediting efficiency but other considerations such as providing information/explanation and working under pressure also seem to contribute.

Listening/explaining/communicating also form a discrete theme in case A (22 responses) and examples of good practice include:

“very happy with the service. good information and patient friendly staff... left in high spirits even though it was about 2am thanks” (01/2015).

“well organised explained every procedure in simple terms so they could be understood” (01/2015)

Unsurprisingly, poor communication is often cited as one of the reasons the FFT score was not higher. For example:

“no information given regarding waiting times which left me feeling very uncomfortable as i was experiencing a large amount of pain with no idea of how long id be there for. however, the service of the nurse/doctor & radiographer was brilliant” (10/2014).

“i thought that i was seen to really quickly, all staff were helpful and dealt with me and cared really well. however i would say it would have been nice to be kept in the loop a bit...it would have been nice to have been kept informed” (02/2015).

4.27 Locality and environment

Other positive themes that don't figure as highly as those mentioned above but are worthy of note include locality/convenience (9 responses) and environment (6 responses). Examples of the former include:

“wonderful attitude and care from all staff. and journey time of only 15 mins to get to you” (01/2015)

“its clean and tidy and its local to me which made it easier and less painful to get to as id injured my foot” (11/2014).

“its local and convenient should be an a&e given the number of people who reside near” (11/2014).

It is perhaps surprising that locality and ease of access do not figure more highly regarding service user satisfaction. This might be because these considerations are taken for granted or because service user are travelling some distance to receive care. Cleanliness and comfort are only mentioned on 6 occasions in a positive context in case A. This may be because most service users did not consider the standard particularly high or worthy of note. Examples of positive comments include:

“didnt have to wait long to be seen. Hospital was clean and tidy. score 10/10 from me” (10/2014).

“my time spent with you was most comfortable clean environment and wonderful friendly staff” (10/2014).

A number of those who ranked the service as 1 and 2 also commented unfavourably about the environment. For example:

“extremely likely to recommend. efficient and friendly. shame about general state of hospital” (01/2015).

“well treated by all, very kind professional staff and quickly seen to, but the nearest toilet I was sent to was dirty” (10/2014).

“good, friendly, quick service. Environment is rather depressing but to be expected hence a score of 2” (11/2014).

The latter comment implies that the respondent expected the environment to be 'depressing' but it is not clear whether they are commenting on the physical environment or the ambience/atmosphere created as other service users wait to be seen.

4.28 'Got what I wanted'

Another minor theme identified in the category 1 and 2 responses can be broadly grouped as service user or customer expectation (4 responses). Some of the responses rated 1 and 2 indicate that service users had a clear expectation of the type of care/treatment they would/should receive before they accessed the service. For example:

"speedy service and got what I wanted" (12/2014).

However, it is difficult to draw clear conclusions from this short statement since the outcome is not well defined. All service users expect to receive appropriate care/treatment from an NHS health professional and another service user comments:

"i got the outcome i wanted - a diagnosis and treatment i trusted" (11/2014).

This response confirms that the service user received what they wanted but also that their expectation was reasonable and appropriate. Other service users rated the service 2 (as opposed to 1) because they did not receive what they expected. For example:

"waiting time too long and wasn't given an xray" (02/2015).

"i feel i should have had an x ray but due to budget cuts it was no offered" (10/2014).

It is likely that the x-ray was not provided because the ENP considered there was no clinical need.

However, the fact that the respondent attributes this to 'budget cuts' may indicate that this was not explained or understood at the time.

4.29 'Neither likely nor unlikely' to recommend service

The category 3 comments account for 4.23% of the total responses from case A. In keeping with the category descriptor ('neither likely nor unlikely' to recommend) they are frequently ambivalent and equivocal. For example:

"i found the care that i received to be fairly good. however, upon first entering the hospital i felt i was met with a degree of hostility which made me feel somewhat uncomfortable and as though my injury wasnt taken seriously" (11/2014).

"the waiting time was crazy and the building was cold but the nurse who treated me was lovey though" (11/2014).

In addition to complaints about time and environment (highlighted in the second comment and elsewhere) other sources of dissatisfaction include poor communication and issues regarding expectation. For example:

"it is evident that staff do not communicate also do not state what their profession is which causes confusion" (11/2014).

"did not feel my issue was taken seriously" (10/2014).

"i was hoping for more action rather than being referred back to my gp to arrange a chest xray. however, my antibiotics were changed for the better" (11/2014).

"fine nurse but couldnt get my ear syringed" (11/2014).

Failure to provide ear syringing and chest x-ray are familiar complaints that arise from service user misunderstanding of the type of service offered by case A (and B). However, part of the reason for this misunderstanding is that the line between primary and secondary care is poorly differentiated at both cases. Both provide nurse led minor injury/illness management in a similar fashion to A&E (many of the ENPs have worked at both) as well as GP provision. Ear syringing is a service offered by

practice nurses (who have received appropriate training) at GP surgeries or clinics. Chest x-rays, on the other hand, are not indicated for rib injuries since they do not alter management unless the injury is the result of significant trauma, in which case the service user should attend an A&E department. Whilst this is well understood by health professionals, it is not readily apparent to service users and it is easy to understand how and why these 'grey-areas' of responsibility lead to confusion and disappointment for service users and frustration for service providers.

4.30 'Unlikely' and 'extremely unlikely' to recommend service

The total percentage of respondents who were 'unlikely' (4) or 'extremely unlikely' (5) to recommend the service at the MIU in case A is 7%. Overall, this is a relatively small group compared to category 1 and 2 responses (87.3%) but it is important to try to understand the reasons why the service provided was considered to be unsatisfactory. Two themes strongly contribute to service user dissatisfaction. The first relates to failure to meet service user expectation (12 responses). For example:

"was told i needed to hav ultra sound by my doctor if my symptoms changed but was not allowed to have one" (01/2015).

"I have [medical complaint] but the doctor said its very normal and didnt give me any treatment" (10/2014).

"staff good but had to get to [Hospital 3] to complete treatment for [injury]. no consultant at [case A]. told to take taxi to [Hospital 3]. arrived 11pm with notes. over 1hr wait to be seen. treatment then given for [injury]. hope delay has not affected recovery. taxis £80" (10/2014).

"i came in with extremely sore foot...thought i might get a x-ray etc" (10/2014).

"there were no doctors on duty so i had to see a nurse who clearly knew nothing about my injury. i tried explaining things but he...didnt do any tests to find out if it was serious...in

future, where possible i will go to another hospital where at least i will be treated appropriately” (10/2014).

“i was not taken seriously at the minor injuries unit...even when i told them i was referred to them from my physiotherapist whom suggested i get another x-ray (i had one before 4 weeks prior) as she believed it was broken. i was denied an x-ray” (11/2014).

“was on the brink of not being able to walk, so i asked if i could borrow a crutch as it would help, i was told no! this was yesterday and today i am still unable to walk! very unimpressed” (12/2014).

A number of complex and interconnected issues contribute to service user dissatisfaction expressed above. The first has already been highlighted in the preceding section and relates to misunderstanding of the services offered by MIUs and the professional competence of its staff. For example, the first comment refers to disappointment that the unit did not provide an ultra sound scan (USS). However, ENPs at both cases are unable to refer service users for USS and would have to advise them to return to their GP for the referral to be made (or - if urgent - refer them to another health professional to receive further assessment). Similarly, comment two expresses dissatisfaction that the MIU does not provide the same services as Hospital 3 and outlines the financial cost of the journey for the service user. Comment three also complains that there were no doctors on duty and that they were not provided with appropriate tests. Although further information/context would be useful, the GP service in case A is not 24-hour and at least twelve hours of each day is staffed by ENPs only. There is an out-of-hours GP service hosted by Hospital 1 but it is not affiliated to case A and service users must book an appointment by telephone. It is not clear what advice - if any - the service user received regarding their presenting complaint but it does seem clear, from their own comments, that they required alternative provision.

4.31 Discourtesy

The second source of service user dissatisfaction in case A is rude and discourteous behaviour (10 responses). For example:

“my treatment was fine but staff at reception were v abrupt when my daughter asked advice” (10/2014).

“when i arrived i felt the nurse was rather rude” (10.2014).

“staff (nurse) very rude and patronising not happy with service received” (10/2014).

“rude and unhelpful staff” (10/2014).

As with many of the comments cited above, it is difficult to draw clear conclusions from these short statements since context is lacking. However, it is clear that service users felt they had not been treated with sufficient courtesy and respect from staff in case A. It was noted earlier in the chapter that positive affective behaviours such as politeness and helpfulness were highly valued by service users. It is unsurprising, therefore, that the perceived lack of these qualities results in service user dissatisfaction and ‘unlikeliness’ to recommend the service.

In summary, a total of 1394 FFT responses were analysed for the period between October 1st 2014 - February 23rd 2015 in case A. Most responses were either ‘extremely likely’ (918) or ‘likely’ (284) to recommend the service to friends or family. Forty service users responded that they were ‘unlikely’ to recommend the service and 66 stated that they were ‘extremely unlikely’. However, these quantitative values are more meaningful when considered alongside the qualitative feedback provided at the same time. The most common indicator of service user satisfaction in case A seems to be the attitude of the service providers or what might be termed ‘positive affective behaviours’ (e.g. politeness). It is also interesting to note that smiling and welcoming behaviour were mentioned more frequently than traditional healthcare qualities such as professionalism, caring and compassion.

The second most frequent indicator of service user satisfaction in case A was time or speed of service provision. However, this was not always a priority and many service users reported a long wait but rated the service highly. The sense that waiting for treatment is expected is also evidence, in part at least, by the surprise registered by some service users at being treated quickly. Other positive themes, that don't rank as highly, include efficiency, locality/convenience and physical environment. Another minor theme identified in the 'extremely likely' and 'likely' categories can be broadly grouped as service user or customer expectation. Some of these responses indicate that service users had a clear expectation of the type of care/treatment that they would/should receive. However, examples are very limited in number. Two themes strongly contribute to service user dissatisfaction in case A ('unlikely' or 'extremely unlikely' to recommend). The first is also highlighted by service providers (4.21) and relates to failure to meet service user expectation. The second source of service user dissatisfaction is rude or discourteous behaviour. This is unsurprising given the high regard that 'positive affective behaviours' such as politeness seem to have. It is difficult to draw clear conclusions from the FFT data since the statements are typically short and lacking in context. However, they provide a valuable point of comparison, particularly regarding dissatisfaction, with the other data sets.

4.32 Convenience and locality issues: participant observation/field note data

The following sections (4.33-4.36) provide discussion and evaluation of the evidence collected during the participant observation phase of data collection. One of the most conspicuous observations in case A was that many service users present for care even when they have received a more appropriate appointment elsewhere. For example, a service user presented requesting removal of sutures (FN: Jan.16, 2015). When asked why they had attended the MIU rather than their practice nurse, the service user stated that it was more convenient since the MIU was closer to their place of work. This type of attendance is common and, although it is not encouraged, ENPs rarely decline to provide treatment since service users have waited to be seen. Other service users are unwilling to

access healthcare at a time or place that is inconvenient to them. For example, a service user presented to have a wound reassessed and redressed (FN: Nov.07, 2014). They explained to the ENP that they had an appointment at a regional specialist centre (RSC) that morning but did not want to attend since it was a 40-minute drive.

Consequently, the ENP had to contact the RSC to cancel the service user's appointment and to ask for advice regarding management. The ENP was able to redress the affected area but did not have access to specialist dressings recommended by the RSC. The unfamiliar process was time consuming and the ENP was careful to record that the service user had been advised to attend the appointment at the RSC but had declined to do so against medical advice. Another service user returned to the MIU because they were in pain and concerned that their injury had not made sufficient progress (FN: Dec.04, 2014). They were seen by an ENP who confirmed the initial diagnosis and reiterated the importance of continuing the treatment provided. Since the injury remained painful, they were also referred to a specialist team at Hospital 2 who offered to review the injury that afternoon.

However, the service user declined the OPA because they were '*too busy*' that afternoon and asked for it to be moved to another day. The earliest the service user could be accommodated (because of clinic schedules) was four days later. The service user agreed to the later appointment since it was more convenient despite the pain that had prompted re-attendance. Another service user presented at Hospital 1 x-ray department with an x-ray request from their GP dated several days earlier (FN: Jan.31, 2015). The service user explained that it had not been convenient to attend at the time because of transport issues. The x-ray was performed but, because the service user had presented outside of office hours and there was no reporting-radiographer available to view the images, they were advised to book-in the MIU for ENP review. The service user's injury and x-ray were reviewed by an ENP and appropriate treatment provided. Although this is a fairly common occurrence in the MIU, ENPs comment that it is more difficult to review these x-rays since the consultation and examination are performed retrospectively.

Finally, a service user with a long history of spontaneous dislocation was brought to case A by ambulance (FN: Nov.15, 2014). The service user stated that they had asked the ambulance crew to take them to case A since it was the closest to their home and because '[case A] is the best place, you always manage to do it [reduce dislocation]'. The ambulance crew confirmed that they had suggested attending Hospital 3 A&E but the service user had insisted on visiting MIU instead. Following treatment, the service user was sent to x-ray to confirm that the dislocation had been successfully reduced. When the service user did not return as expected, the ENP phoned the radiographer to check their progress. The radiographer reported that the service user has been x-rayed some time ago and had asked whether treatment had been successful. Upon learning that it had been, the service user left the x-ray department and the radiographer assumed they had made their way back to case A. The ENP completed to service user's notes documenting that they had left Hospital 1 without informing a member of staff or waiting to receive follow-up care/appointment. In this instance, the service user chose to attend case A based upon two factors: location and previous experience of successful treatment. This also seems to have influenced their decision to leave the hospital without waiting to receive advice etc.

4.33 Reasons service users did not access primary care physicians

One of the emerging themes identified in case A (and B) during the PO phase of data collection was the large number of service users presenting with problems or conditions that would traditionally have been dealt with by their GP or practice nurse (FN: Oct.24, Nov.15, 21, 28, Dec.04, 19, 2014; Jan.09, 16, 23, 28, 31, Feb.11). Whilst many of those who attended case A had attempted to make an appointment with their GP surgery, some - for a variety of reasons - had not. For example, one service user presented to the MIU complaining of general illness for two months (FN: Feb.11, 2015). They reported that they had tried to phone their GP that morning but after 'seven minutes of waiting' had decided to attend case A instead. However, because of the time of day, no GP was available and the service user was seen and assessed by an ENP. The ENP discussed the service user

with an ECC medic who advised that they needed to see a GP. The ENP advised the service user to wait and book in to see the GP at 11.00 but because their companion had another appointment at this time they were reluctant to do so. Consequently, they telephoned their GP practice from the waiting room and made an appointment for later that afternoon.

This was a fairly common occurrence and reception staff often offered to telephone service user's GP practices (with their permission) to book appointments for later that day. Although most service users presenting with primary-care complaints in case A required a GP consultation, some attended because they were unable to make a practice nurse appointment. For example, a service user was treated and discharged following a traumatic injury to their lower body. However, since they were unable to make an appointment with the practice nurse at their surgery, they returned to the MIU for reassessment and redressing (FN: Jan.28, 2015). When the service user explained to the ENP why they had returned, they were given an ENP clinic appointment for their next and subsequent visits.

The ENP clinic provides a high degree of continuity since the medical history and treatment plan are documented in the same set of notes and service users are often seen by the same ENP who originally treated them. Clinic appointments also avoid service users returning to the department as a re-attender. In April 2011, a new set of clinical quality indicators was introduced by the Department of Health (DH) to measure the quality of care delivered by A&E departments in England (DH, 2011b).

One of the clinical quality indicators is unplanned re-attendance within seven days of the original attendance. The purpose of this indicator is to reduce avoidable re-attendances to less than 5% per month by improving care and communication delivered during the first attendance. However, this can be difficult to achieve when service users are discharged from A&E/MIU but are unable to access appropriate follow-up care elsewhere. In these circumstances (and when management is most safely undertaken by an ENP) clinic allows service users to access care in case A (and B) in a planned and

negotiated fashion. Most ENP clinic appointments in case A were arranged because ENP follow-up was the most appropriate and safest course of action (e.g. eye injury review and plaster checks).

4.34 What is reasonable?

Most service users demonstrated realistic expectations regarding the time they had to wait and the type of care and treatment they expected to receive. However, a small proportion of service users seem to have unrealistic expectations that often resulted in disappointment, frustration and/or verbal-aggression. For example, a service user booked in at 11.51 (to see an ENP) and at 12.01 informed the receptionist that they 'couldn't wait any longer' and left without being seen (FN: Oct.24, 2014). Another potential source of tension in the MIU (since it is located within a large general hospital) is service user expectation regarding the provision of diagnostic investigations and, to a lesser extent, medications.

There are numerous examples of dissatisfaction when investigations cannot be provided even when staff offer appropriate explanation. For example, a service user presented following an injury to their upper limb (FN: Jan.09, 2015). The ENP explained during the consultation that that there was no indication for x-ray since bony injury was extremely unlikely and, in the (unlikely) event there was a fracture, the treatment and management would be exactly the same. The service user became very upset and argued that the injury should be x-rayed since it was painful and because they had been told that it required x-ray (person unspecified). The ENP explained in greater detail why x-ray was not necessary in this instance and the service user was eventually discharged with much reassurance. However, the consultation took much longer than normal and the ENP was careful to document why x-ray had not been provided.

Occasionally, service user expectation is inflated as a result of poor or erroneous advice from another healthcare professional. For example, a service user presented at the MIU with a 'referral letter' from an osteopath for a series of spinal x-rays and an MRI scan (FN: Oct.24, 2014). The service user explained that a locum GP had advised them to see the osteopath for management of an

ongoing complaint and the osteopath had, in turn, advised them to attend case A for the investigations requested. The ENP explained that they were unable to provide either of the investigations since they were beyond their clinical remit. They could only advise the service user to return to their GP, who could book the investigations as an OPA, or attend A&E where a doctor might agree to undertake the investigations. The service user and their family became angry and upset since the osteopath had assured them that they would receive the scans that day. The ENPs apologised and reiterated that they were unable to comply. The service user and their family eventually left the department stating that they would return to the GP. As noted in section 5.24, confusion and uncertainty regarding clinical accountability and responsibility is not uncommon at this site.

4.35 Dissatisfaction and service user complaints

There are many reasons why service users complain about the care they have received/failed to receive in case A and elsewhere in the NHS. Some of these are outlined in the FFT data and some are described elsewhere in other contexts. However, the majority of complaints observed during the PO phase of data collection relate to long waiting times, process issues and misunderstanding regarding the availability of services/treatment options. For example, staff received a large number of verbal complaints when it appeared that service users waiting to see the GP were being seen more quickly than those waiting to see an ENP (FN: Dec.04, 2014). In actual fact, the opposite was the case and although those waiting to see the GP were often called through to cubicles (area j1-5) to receive diagnostic assessment, they were returned to the waiting room once these had been completed. Another service user presented with an x-ray form and a letter from their GP following a traumatic injury (FN: Dec.04, 2014). The service user was accompanied by a family member who informed the receptionist that they were expected. When the receptionist explained that they had not received any communication from the GP practice, the family member became angry and asked to see the nurse in charge. An ENP carefully explained that the service user could not be seen by a doctor from

ECC since their injury was traumatic and not medical. They also explained that although the GP had written a letter as a matter of courtesy, the MIU did not accept referrals per se since it was a nurse-led, walk-in service.

The initial misunderstanding was eventually smoothed-out and the service user was sent to x-ray accompanied by the family member. The x-ray revealed a complicated injury and the service user was referred and accepted by a specialist team at Hospital 2 for treatment and management. After transport had been arranged to take the service user and the family member to Hospital 2, the specialist team phoned to say that the service user could be sent home and would be assessed as an outpatient in clinic. The service user and family member were extremely unhappy with this arrangement and complained that it was inappropriate and unprofessional. The ENP advocated on their behalf to the specialist team but with no result. The ENP could only apologise to the service user and their family member who continued to express dissatisfaction and frustration that they were unable to access specialist treatment in a timelier fashion.

A large amount of the work performed by ENPs in case A involves liaising with other healthcare professionals and providers to ensure that service users receive the most appropriate care and management. ENPs are trained to recognise, diagnose and treat a wide range of minor injuries and illnesses but they must always work within their clinical boundaries and scope of professional practice. Consequently, referrals to other teams and agencies, inside and outside the Hospital Trust, are common. Most referrals and redirections are routine and non-urgent whilst some are urgent and potentially life-saving. The referral process is well established but it can be time-consuming and complicated by professional and operational factors. For example, a service user presented at the MIU following traumatic injury to their upper body and head. The service user was assessed by an ENP and, after thorough investigation, referred to a specialist team at Hospital 3 for management. However, the team would not accept the service user until they attended A&E to have their head injury assessed and cleared (FN: Jan.31, 2015). The ENP explained that this had already been done,

and was therefore unnecessary. After a period of discussion and negotiation, the specialist team eventually agreed to review the service user as an outpatient. The ENP commented to a colleague that - in their opinion/recent experience - specialist teams at Hospitals 2 and 3 had become increasingly cautious when accepting referrals and frequently asked for service users to be reviewed by A&E or another team before accepting them. The ENP felt this was probably because specialist teams were being asked to accept an increasing number of referrals. However, the ENP also expressed frustration at how time consuming it could be to find a team willing to accept a referral and how requesting additional review often generated more work for other teams/departments and increased journey time for service users.

In summary, many service users presented at the MIU in case A because it was the most convenient destination - some having received more appropriate appointments elsewhere for the same day. Although this type of attendance was not encouraged by ENPs, they rarely declined to provide treatment once service users had waited to be seen. Service users also attended for booked x-rays and other procedures outside normal working hours. This meant they often had to be redirected there since it was the only destination that provided care at this time. A number of service users also presented at the MIU to see the GPC GP (on a walk-in basis). Whilst many had attempted to make an appointment with their own GP, some (for a variety of reasons) had not. When this occurred, reception staff often telephoned their GP practice (with their permission) to make an appointment for them later that day.

A small number of service users also presented for care because they were unable to make an appointment to see their practice nurse. Overall, most service users demonstrated realistic expectations regarding the time they would have to wait and the type of care/treatment they would receive. However, a small proportion seemed to have unrealistic expectations that often resulted in disappointment, frustration and/or verbal aggression. Another potential source of tension, as noted in the preceding data sets, was misunderstanding regarding the diagnostic investigations offered at

the MIU and Hospital 1. This was exacerbated by the fact that some services had been offered in the past (recently and otherwise) before being relocated to other sites.

The majority of complaints that were observed in case A related to long waiting times, process issues and misunderstanding regarding the availability of services/treatment. A large amount of the work performed by ENPs in case A involves liaising with other healthcare professionals/providers to ensure service users receive the most appropriate care and management. The referral process is well established but it can be time-consuming and complicated by professional and operational issues that are not always in the best interest of the service user.

4.36 Conclusion

Overall, there seems to be broad consensus amongst the data set regarding a number of themes. Firstly, convenience, waiting time, and previous experience of good service were the principle reasons service users chose to attend the MIU in case A. This was influenced to some extent by the availability of primary care services. Secondly, even though service users do not always view themselves as customers of healthcare, they seem to value high standards of customer service from healthcare providers. Similarly, both service users and providers believed that there were clear similarities between healthcare provision and other service industries. However, there was a general lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context. Thirdly, both service users and providers expressed support for shared decision making and co-production of care. However, there was also considerable difference of opinion amongst service users and providers regarding the level of participation considered necessary or desirable. Fourthly, most service users demonstrated realistic expectations regarding the time they would have to wait and the type of care/treatment they would receive. However, a small proportion seemed to have unrealistic expectations that often resulted in disappointment, frustration, verbal aggression and/or complaint. Another potential source of tension was misunderstanding regarding the availability of diagnostic investigations and treatment offered in

case A. Finally, there was a lack of consensus amongst the data sets regarding which type of people were most/least likely to communicate confidently and efficiently with service providers. These themes, and the way the data is presented in this (and the following) chapter, will be discussed further in chapter 6.

Chapter 5: Data from case B

5.1 Introduction

This chapter is structured in a similar fashion to the preceding chapter and broadly reflects the service user 'journey' through case B from the point of view of the service user, service provider and researcher as participant observer. Consequently, evidence from 6 data sets is discussed and evaluated in the following order: environment, demographics/designation, service user interview, service provider interview, FFT responses, and participant observation. However, not all of the sub-headings are exactly the same since some themes identified in case A are represented more/less robustly in case B. This is particularly evident with the FFT data where responses were much less numerous than in case A (see below). Sections 5.2-5.3 examine case B in terms of its relationship to Hospital 4 and the local community it serves. This includes discussion of the physical environment and how it relates to the activity that occurs there. The next sections (5.4-5.5) provide demographic information from service user and provider interviews regarding the types of people who attend case B and how they view themselves when accessing healthcare. Like the corresponding data from case A, it also provides insight regarding the distance they have travelled to receive care and how many times they have attended case B in the past.

The following sections (5.6-5.11) provide evidence from the service user interview participants regarding the decision making process to attend case B. They also explore service user views regarding notions of customer service, changing attitudes to healthcare provision, shared decision making, self-management and, finally, willingness to question/challenge professional judgement. The next sections (5.12-5.17) explore many of the same issues but from the point of view of service providers. That is to say, why they believe service users attend case B, customer satisfaction, shared decision making, self-management and, finally, changing expectations regarding service provision. The penultimate sections (5.18-5.19) provide discussion of the small amount of quantitative and qualitative evidence from the FFT survey at B. The final sections (5.20-5.22) examine and evaluate

the evidence collected during the participant observation phase of data collection. As with case A, this is examined last since it represents my interpretation of events as both insider and outsider.

5.2 The care context in Hospital 4

Hospital 4 was originally constructed in the 1920's on the site of the local Workhouse (opened in the 1830s). In 2013, planning permission was granted to demolish much of the original site and construct a new, purpose-built community hospital. Work started in 2014 and was completed by the summer of 2015. At the time that data collection took place (March - May 2015) case B was still located in the 1920's building awaiting completion of the new hospital. Hospital 4 provides MIU services (case B), a renal dialysis centre, children's ambulatory care unit and a range of diagnostic and outpatient services. Two signs directing service users to case B clearly state: '[Hospital 4] *no A&E*'. Like case A, case B also hosts an out-of-hours GP service after 6pm and a daytime service operated by the same GPC. However, unlike case A, the daytime GPC service is by appointment only and service users must be referred by their own GP practice (or by an ENP from case B) via a local service hub. The service was launched in March 2015 to provide additional support to local GP practices that were struggling to meet rising demand for primary care services and is funded by the Prime Minister's GP Action Fund.

Case B does not provide a 24-hour service and is open between 09.00 and 19.00, Monday to Friday, and 10.00 to 18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when it is closed). The x-ray department is open between 09.00 and 17.00. Hospital 4 is about 18 miles from Hospital 1 and 22 miles from the nearest A&E at Hospital 2 (Fig.1). According to the 2011 UK census, case B town has a district population of 111,700 (covering an area of 314.8 km²) and an urban population of 41,709 (covering an area of 10.2 km²). According to the English IMD for 2015, case B town has 4 (out of 67) LSOAs ranked within the top 10% most deprived in England - 1 of which is within the top 5% most deprived (Department for Communities and Local Government, 2015). Hospital 4/case B is located within this LSOA. A further 6 urban and one district LSOAs are ranked

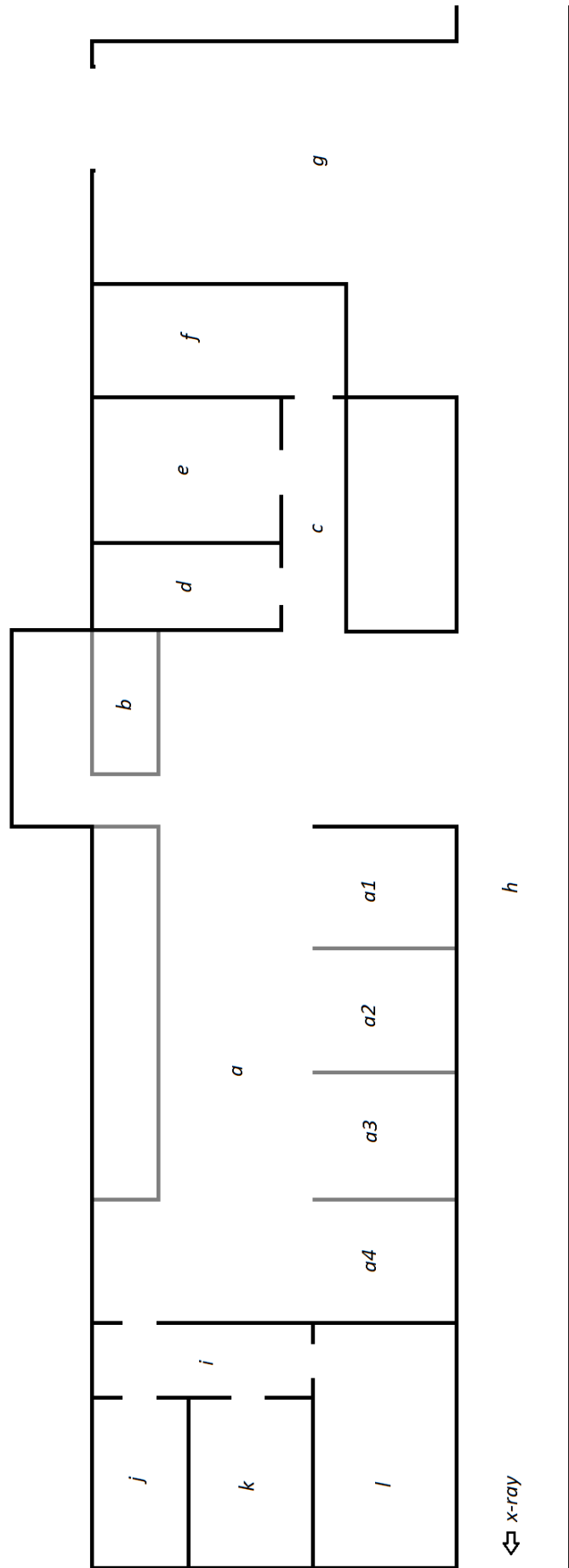
within the top 20% most deprived (Ibid). A large proportion of service users who present for consultation and treatment at the MIU in case B are from the urban population and are often known to staff. There are several reasons for this including the high proportion of service users attending with primary care complaints and difficulty accessing other services (see below).

5.3 The care context in the MIU (case B)

Case B (Fig.3) is much smaller than case A. The workspace primarily consists of a large rectangular area that contains 4 bays/trolleys separated by curtains (*a*). Bay 1 (*a.1*) is nominally the resuscitation bay but is used to assess service users presenting with other complaints. A small sink, work surface and a number of locked cupboards are situated opposite the bays. A printer is located on the work surface nearest to bay 1. The nurses-station (*b*) is situated opposite the entrance to case B and closest to bay 1. There are 2 computers and 2 seats/desk spaces. To the left of the nurses-station is a short corridor (*c*) that leads to an examination room (*d*) that contains a slit lamp and couch. Next to this, the ward manager's office (*e*) is now used as a consultation room for the GPC and out-of-hours GP service. At the end of the corridor is a rectangular room that houses the receptionist and photocopier (*f*). The reception desk faces the waiting room (*g*) and main hospital entrance from behind a transparent screen. Service users book in at the reception desk and the ENP's are alerted to their arrival via the tracking system on their computers. There is no formal triage in operation and the receptionist often alerts staff to service users they consider to be a priority. Otherwise, service users are seen in chronological order. The ENP prints an attendance record and 'collects' them from the waiting room via a connecting corridor (*h*). When the receptionist is unavailable, a notice is left in the waiting room instructing service users to book in at the nurses-station (*b*).

At the other end of case B's clinical area (*a*), a door leads to a short corridor (*i*) providing access to a small sluice (*j*), a store room (*k*) and a staff kitchen (*l*). X-ray is located at the other end of the hospital (a walk of about 2 minutes along corridor *h*). The compact layout in case B, and the fact that there are no other clinical areas attached or adjacent to it, provides a more 'stand-alone' and

Figure 3: Case B



independent feel than case A. The reception area (f) is also easily accessible to the rest of case B (via corridor c) and social interaction and communication between ENPs and receptionist is frequent and relaxed. At the time data collection took place, case B was staffed by 5 ENPs (full and part time) and 1 staff-nurse (no technician support). All of the ENP/nursing staff were experienced practitioners having worked in A&E, ECC or paramedic services for many years previously. A receptionist was available in case B between 09.00 and 17.00 but before/after this time (and during holiday and absence) an ENP/nurse must undertake this role in addition to their own (FN: Mar.11, 18, 25, 2015).

In summary, the physical environment/workspace in case B is much smaller than that in case A. It is situated close to the main entrance at Hospital 4 and stands apart from other services and departments. At the time data collection took place (February - May 2015) case B was staffed by 5 ENPs and 1 staff-nurse (no technician support). Case B does not provide a 24-hour service and is open between 09.00 and 19.00, Monday to Friday, and 10.00 to 18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when it is closed). The x-ray department is open between 09.00 and 17.00. Like case A, case B also hosts daytime GP operated by the same GP collective. However, unlike case A, this service is by appointment only and is funded by the Prime Minister's GP Action Fund and not the Hospital Trust. Case B town has a district population of 111,700 and an urban population of 41,709. It has 4 LSOAs ranked within the top 10% most deprived in England - 1 of which is within the top 5% most deprived. Hospital 4/case B is located within this LSOA. A large proportion of service users who present for consultation and treatment at the MIU in case B are from the urban population and are often known to staff.

5.4 Demographics

In total, nineteen service users and seven service providers were interviewed in case B. An additional service user interview (SU08B) has not been included/analysed since they could not be contacted for member checking. The age range for service users and providers from case B is outlined in Tables 11 and 12. With the exception of SU04B, all interview participants were of white ethnicity and British

nationality. Seven interviews (37%) were conducted with female service users and twelve (63%) with male. On two occasions (SU06B, SU19B) the interview participant's partner also contributed answers. When this occurred, they were consented (retrospectively) and designated (m) or (f) on the interview transcript/data to differentiate them from the principle interview participant. Six service providers interview participants were female and one was male. Most service users from case B (78.93%) had attended on at least one occasion in the past (Table 13). For four service users it was their first visit and one reported attending on over twenty-one occasions (SU14B). However, in the case of the latter, this was because of multiple clinic appointments. In total, 84.2% of service users travelled less than five miles to attend case B. Of these, eight (42.1%) travelled less than two miles from their home or the site of their accident (Table 14). No service users travelled more than ten miles to receive care. The highest educational qualification for service users from case B ranged from none to Masters level (Table 15). All service providers possessed an appropriate professional qualification. Service user occupation was varied with four retired service users (21.05%), three unemployed (15.78%) and no students (Table 16)

5.5 How service users described themselves

Service users and providers from case B were asked to identify which word best described them when accessing or receiving healthcare. As in case A, many interview participants from case B felt that the terms were too prescriptive and combined them in order to reflect the complex nature of this activity. Table 17 summarises the variety of combinations selected by service users from case B. It is interesting to note that the term 'patient' was individually selected by over half of the participants (52.63%) and by a further seven (36.84%) combined with another term/terms. Two participants selected the term 'member of the public' and none selected 'consumer' either individually or in combination. Two of seven service providers favoured the term 'patient' when accessing healthcare for themselves. The remaining five selected a variety of different terms including 'all of them' to describe themselves (Table 18). When service providers from case B were

asked to select which term/s best described OTHER people accessing healthcare in case B, their answers were similarly diverse with two service providers selecting 'customer' and 'consumer' in combination with other terms (Table 19). For example, SP01B strongly identified as a customer of healthcare when describing themselves:

"Customer. Yeah probably. I don't use the word patient as much. If I worked on a ward setting I would probably use the word patient. Your mentality changes doesn't it. But because we have people coming in and out I think that's affected my thought as well" (ENP with 10 years' experience).

Similarly, when describing others seeking healthcare, they were quick to remark:

"See those [words] 'consumers' and 'service user'. I don't know why they've leapt out at me".

Other members of staff were more conflicted when trying to describe others seeking healthcare. For example, SP02B commented:

"The first one that would jump out would be member of the public. And then I would say patient because that's their expectation. They are a patient. They're not a service user. They don't. The term service user I think is actually fairly apt because certain people use it out of necessity and some people use it all the time. Therefore, it covers a broad spectrum but a member of the public doesn't give you any pre-conceived notions. So I would probably say any one of those three" (ENP with 1 years' experience - previously paramedic).

SP05B, on the other hand, thought that patient was the most appropriate term when accessing healthcare since it indicated 'need':

"Member of the public and patient. We are all members of the public so you treat them equally. But this particular member of the public has a special need which makes them a patient" (GP with 20 years' experience).

Table 11: Service user age (case B)

	18-25	26-35	36-45	46-55	56-65	66-75	76+
	4	1	4	3	3	3	1
(= 100%)	21.05%	5.26%	21.05%	15.78%	15.78%	15.78%	5.26%

Table 12: Service provider age (case B)

	18-25	26-35	36-45	46-55	56-65	66-75	76+
			3	3	1		
(= 100%)	-	-	42.84%	42.84%	14.28%	-	-

Table 13: Number of previous attendances (case B)

	None	1-5	6-10	11-15	16-20	21+
	4	11	1	1	1	1
(= 100%)	21.05%	57.89%	5.26%	5.26%	5.26%	5.26%

Table 14: Distance in miles from home/location of accident to case B

	<2 miles	2-5	6-10	11-15
	8	8	3	
(= 100%)	42.1%	42.1% %	15.79%	-

Table 15: Service user highest educational qualification (case B)

	None	C&G NVQ	GCE GCSE	A level	Cert.HE Dip.HE	Degree	Masters
	3	2	7	3	1	2	1
(= 100%)	15.78%	10.52%	36.84%	15.78%	5.26%	10.52%	5.26%

Table 16: Service users' self-description of their occupation/status (case B)

	Business & Management	Civil Service	Customer Service	Driving	Health & Social Care	Manual	Retired	Teaching	Unemployed
	1	1	2	1	3	3	4	1	3
(= 100%)	5.26%	5.26%	10.52%	5.26%	15.78%	15.78%	21.05%	5.26%	15.78%

Table 17: How service users viewed themselves when accessing healthcare (case B)

	Member of Public	Patient	Patient + Customer	Patient + Member of Public	Patient + Member of Public + Customer	Patient + Member of Public + User + Citizen
	2	10	1	4	1	1
(= 100%)	10.52%	52.63%	5.26%	21.05%	5.26%	5.26%

Table 18: How service providers viewed themselves when accessing healthcare in case B (and elsewhere)

All	Client	Customer	Member of Public + Service User	Patient	Service User
1	1	1	1	2	1
(= 100%)	14.28%	14.28%	14.28%	28.56%	14.28%

Table 19: How service providers viewed OTHERS who accessed healthcare in case B

Client + Customer	Consumer + Service User	Member of Public + Patient + Service User	Member of Public + Patient	Service User + Citizen + Member of Public
1	1	2	1	1
(= 100%)	14.28%	28.56%	14.28%	14.28%

In summary, this information provides a degree of context regarding the types of people presenting for care in case B. Most interview participants were male (12/19) but there was an appropriate variety of people in terms of age, education and employment status overall. Over 80% of service users travelled less than 5 miles to attend case B. The data also provides insight regarding how service users and providers view themselves when accessing healthcare. As noted in 3.14 and 4.18, this is adapted from the *Creating Citizen Consumers* study and establishes a starting point for assessing consumer thinking and behaviour in both groups. Like case A, a number of service user interview participants (7/19) felt that the terms provided were too prescriptive and chose to combine them. However, only one selected 'patient and customer' and most (10/19) selected 'patient' as their preferred designation. There was little consensus amongst service providers regarding the most appropriate designation (for service users) and a range of views was expressed. Detailed comparison and analysis of the key similarities/differences between case A and B is provided in the following chapter.

5.6 Reasons service users chose to attend case B

The following sections (5.6-5.11) provide discussion of the evidence collected during the service user interviews. A number of service user interview participants explained why case B was their first choice of care provider. Convenience, waiting-time and previous experience of good service all figured highly. For example, SU11B explained that they had attended case B because it was closer to their home than their GP surgery and because they were unsure whether their surgery would be able to provide the correct/additional dressings:

"I was quite happy to come here because I live nearer to this hospital than I am to my GP. I would have been quite happy to do either...[but]...I wasn't sure if I went down to my surgery if they'd have a dressing and, if I needed another dressing, which actually it did do, whether they'd have had the right one down there" (61-year-old male, retired engineer).

When asked why they had attended case B, SU02B and SU17B described how previous experience had influenced their decision:

“It’s been a pretty good service when I have been here. Never had a problem with the hospital, everyone’s really kind and it’s normally pretty quick. I’ve seen that one [ENP] before. I’ve seen her I think twice. I’ve seen her with my stepson as well” (39-year-old male, carer).

“Convenience and waiting time. That’s the main factor, waiting time is next to nothing here. And especially when I brought the kids here before I mean some people might see it unfair but they do prioritise kids. My son, I brought him here two years ago. He had a fall in the garden and [describes injury]. No sooner had we booked him in they called him straight in so they could obviously deal with him being a young child. I like the fact that they do prioritise certain things and the kids first” (29-year-old male, mechanic).

SU12B and SU18B commented on location and waiting time:

“I injured my [limb] and it was the closest place to home...I have been over to [other MIU] and felt that the wait was really a long time over there whereas here I’ve always been seen quickly” (48-year-old female, unemployed).

“I was literally up the road. I work up the road and this is where I normally come if anything happens” (20-year-old male, team leader).

A number of service users also explained why they valued local services. For example, SU11B and SU13B commented:

“I would like to see smaller hospitals like this covering their area. So instead of trying to work out what you’ve got to do and where you’ve got to do it. For instance, I’ve been sent up to [Regional Centre] but I ended up in [Hospital 3] where they’ve got a [clinical specialist] who’s looking into it first. So I could be going to [Hospital 4, Hospital 3 or the Regional Centre] with the same kind of illness because there are different disciplines looking at it at the same

time...You don't know if you are going to be well enough to travel on the day and then you've got so many weeks afterwards for another appointment" (61-year-old male, retired engineer).

"I also brought my father here...It was the weekend and the fact that we were able to visit here in [case B town], a mile and a half away from where we live, was a big advantage to having to travel to [Hospital 3] or [Hospital 4] because at the time my father was also quite ill with [medical condition] and it was important to us to have something that was local" (53-year-old male, civil servant).

5.7 Customers of healthcare?

A total of 52.63% of service user interview participants from case B described themselves as patients when accessing healthcare and 89.47% as patients when combined with another term/terms.

Although most service users described how they valued positive affective behaviours when accessing healthcare only a small number described themselves as customers of healthcare or believed that healthcare should be more customer focused. At the same time, there was evidence that customer service skills were valued were considered relevant in a healthcare context. For example, SU13B described what they considered to be the similarities between the NHS and other service providers:

"I've paid my taxes all my working life. It's here to serve us so yes I am a customer...I think probably a lot of the same skills are required. If you are behind a till at Tesco or whether you are behind a curtain in a consultation room. There are some transferable skills there" (53-year-old male, civil servant).

SU10B also explained how the surrounding environment influenced their expectation of the quality of care when accessing healthcare:

“I know it costs the Government or the NHS or whoever lots of money but I do think there should be a lot more updating done within the actual building itself because it does look a bit drab and dreary. Considering if you go somewhere like [Hospital 3] or somewhere else. It’s a lot different. It’s not so old looking. They look more inviting, more like it’s all right, I feel OK. Whereas you come here and it’s just old” (25-year-old male, unemployed).

SU19B(f) explained how customer service skills permeate many working environments and how this impacts on people’s expectations when accessing healthcare:

“When you are self-employed in our sort of hospitality industry...it doesn’t matter what it is you notice standards and you notice care...cleanliness, whether people are pleasant. It’s all the things that you do and it’s part of everyday life. You desperately notice it. Like the guy on reception...If I was on reception in our little office or whatever and I greeted someone like that, it gets my back up” (66-year-old female, guest house manager).

SU20B also remarked how customer service principles have permeated peoples’ expectations of service delivery but also drew attention to differences regarding healthcare:

“The buzz word in industry at the moment is that lovely phrase ‘outstanding customer service. We are trying to achieve outstanding customer service’. Some do and some don’t. Some do the little things...You don’t want to feel like you’re a number...I don’t think you can compare healthcare to that side of business or industry because they are trying to attract a customer, keep a customer by outstanding customer service...Repeat business is everything...When it comes to our National Health Service you don’t have to win the customers because they are going to come to you. It’s looking after them when they are here so when they go out you are not getting complaints...That’s the difference and I think you strive for it and do very well. You’re always going to get complaints. You are always going to get moaners” (60-year-old male, lorry driver).

SU15B identified some similarities between hospital care and other service provision but they were also careful to point out where they believed the similarities ended. However, their view is almost certainly influenced by the fact they also work as a nurse at Hospital 3:

“We all provide a service. We are all meant to get the best outcome for the customer or the patient...I don’t believe that the customer is always right. A patient is never always right. Not never ever right but not always right...They can be very demanding. In a shop, a customer comes in and they say they want this or they want that. So you do everything to please the customer. If they come into the NHS saying they want this and they want that, you can’t always do that so they are not always right so it’s not the same as having a customer because they can’t demand the services they want. They get the services they need” (39-year-old female, nurse)

SU09B also remarked:

“There are differences. If you take a piece of clothing back to Tesco’s the customer is always right and ‘sorry, sorry, sorry’. I think when you come to the NHS they are not as attentive really, which is fair enough. I think they are quite overworked and underpaid for the work that they do and so I do think they are not valued enough to be honest” (25-year-old female, teaching assistant)

SU01B explained why they did not identify themselves as a customer of health care:

“I don’t feel like a customer. I feel like a patient. I need looking after when I’m ill. We all pay our taxes and our insurance and I work really hard...so I expect a good service but I’m under no illusions that it’s not, you know, the money isn’t there. Maybe the service would be better. Maybe there would be more healthcare if there was more money in the system” (41-year-old female, tree-surgeon).

Similarly, SU07B discussed why they objected to the terms 'customer' and 'consumer' of healthcare. However, they also recognised that the relationship between service users and providers is complicated and nuanced regarding professional knowledge and authority:

"A customer pays. We're patients. Yes we pay via taxation...but, at the end of the day, the relationship between a patient and the health service has to be something different from the paying customer. A paying customer has different rights and I also think it would be very difficult for the health service to...prioritise in terms of care what can be done if it's a customer based service. I don't like it. I really dislike it. I want it to be patient focused...I think there needs to be a very clear idea of what a patient is and what the patient/professional relationship is and I don't think we're clear about that. I think each professional...might have his own idea about whether or not the relationship is different whether he is in a position of power and authority. And he is not in a position, he shouldn't be in a position of power. Authoritative yes, authority no. It is complicated but that is the reason I don't like customer because I suspect it is the thin edge of the wedge and once we start being customers we are going to have to pay £10 to see somebody" (70-year-old female, retired civil servant).

When asked why they objected to the idea of a customer of healthcare, since it may provide greater leverage to improve standards of care for service users, SU07B replied:

"That is true but then how do you deal with the situation where you are in an A&E and someone turns up and they are a paying customer...There should be a differentiation based on need and need has to be there and that is where the patient bit comes in. They [service users] have more clout and they demand what they want not necessarily what they need. That's the problem with the customer. The customer demands what they want not what they need".

SU09B also explained why they viewed themselves as a patient rather than a customer. When asked if they would like to be viewed as a customer or consumer of healthcare they replied:

“Well technically we are...I’m not on benefits so I pay my national insurance and everything you know. So technically I pay for the service we get. I think the standard of care probably would be better if you were considered a customer and you felt that are a customer. But then I do feel that some people push boundaries when they feel they are the customer who is always right and they can kind of challenge everything when they feel they are a customer and that’s probably where people might have come unstuck a little bit. I don’t come to hospital and see myself as a customer. I see myself as a patient or a member of the public. I know there are priorities and I will be seen according to my priority, you know, how urgent my care is” (25-year-old female, teaching assistant).

5.8 Changing attitudes, changing service

Most service users reported high levels of satisfaction with the standard of care provided in case B and the NHS as whole. SU06B described how they valued the service provided in case B:

They always listen when you come here...every time I come in here I felt that they’ve been interested in what you’ve come for. You are a person not a number. You are never shoved around. (81-year-old female, retired).

However, they also explained how standards within the NHS had, in their opinion, declined over the last 30 years. When asked when they thought the NHS was at its best they replied:

“From when it started to about 1978. No, to about 1988. From there it has deteriorated slowly. But from the 90’s it’s got worse and worse and worse and that’s where you took management...it’s not just one hospital it’s every one. It doesn’t matter which one you go in we found”.

It is interesting that SU06B highlights the period after 1988 as the point they noticed a decline in standards of care in the NHS (*Working for Patients* was published the following year). Conversely, SU19B (aged 70) described how they have noticed a positive change in attitudes within the NHS:

“I’ll tell you what’s noticeable - the changes. People’s approaches, the nurses approach. Everybody’s approach now. It’s true. [Name] has had several ops, one thing and another, this time yeah you are treated much more courteously...Don’t forget, years ago, you’d become a child, you didn’t question or you didn’t ask and actually you were quite in fear if you had to go to the authority of a doctor. So much has changed, it’s changed over the years” (70-year-old male, guest house manager).

Similarly, SU07B commented how professional and social attitudes have changed:

“When I was young and had [surgery] the consultants used to come around the ward, they talk over your head. You were just a lump of meat in the bed. And you were ignored. That was the way it was dealt with. Even the nurses were sort of like that. We are not a deferential society any more. (70-year-old female, retired civil servant).

5.9 Service user views regarding shared decision making

Most service users from case B stated that they wanted to be involved in the decision making process to some extent. However, like case A, there was considerable difference of opinion regarding the level of participation considered necessary or desirable. For example, SU05B explained why they valued discussion and explanation of the decision making process:

“Well if there is a discussion you know what they’re thinking and they know what you’re thinking. If they just make a diagnosis and don’t say anything and then just say that’s what we’re going to do then you really don’t know their thought process or how they got there” (62-year-old male, retired managing director).

SU12B emphasised the personal aspect of shared decision making:

“It’s personal, it’s about me. It involves me and in the past I have had doctors stand at the foot of my bed and discuss me like I’m not there. I can appreciate that I won’t understand everything that they’re talking about, you know all the technicalities, but I am the person

that they're talking about and I think it is only right that I should be involved as much as I can" 48-year-old female, unemployed).

Some service users expressed a strong desire to be involved in all aspects of the decision making process. For example, SU16B explained how they wanted to achieve a thorough understanding of their care:

"Well there is a train of thought that would say these are professionals who know what they are doing. They've been doing these jobs for a very, very long time and we have no reason not to trust their judgement because they deal with these situations every day. It's what they do. However, I'm the kind of person who wants to know why. I like details and if what you find in the details you don't like you need to say" (47-year-old male, unemployed).

When asked if they valued the opportunity to be involved in the consultation process SU13B remarked:

"Definitely. I think to be involved and to feel that you are being taken seriously and you're viewed as a credible individual with a mind of your own is important. So yes I would expect to have the opportunity to be involved and I would value that" (53-year-old male, civil servant).

When asked if this included clinical decision making and treatment options they replied:

"Yes, absolutely. I would expect to have a hand in those decisions. Obviously they need to be informed decisions. But yes, I would expect to be able to make some of those decisions and have opinions myself without being told what was best for me necessarily...I think that people should have the confidence and freedom to feel they can ask and challenge rather than be told because professionals don't always get it right...No one is going to know your own body as well as you know it yourself and I think people need to listen sometimes and you need to challenge".

SU13B distinguished between different types of consultation and how their relationship with health professionals alters according to their level of need. When asked if they were offered an opportunity to participate in the consultation in case B they replied:

“I don’t think so but then we weren’t looking at a very complex scenario. Perhaps if it was something chronic or if it turns out to be something chronic I was advised that if this didn’t clear up to come back in four or five days, then I would expect that I would be faced with more options and more decisions to make. The consultation today was quite a basic thing and I was really seeking advice”.

A number of service users also discussed the concept of control and ownership during consultation and treatment. For example, SU15B explained how they valued being offered choice and how difficult it could be when control is removed:

“...sometimes people don’t realise actually what that other person is doing in their lives so they need to be able to make decisions and to be in control as well. Being sick you lose all your control. And that’s quite difficult have your control taken away from you” (39-year-old female, nurse).

Like case A, some service users from case B did not want participate in the decision making process, particularly when it involved diagnosis and treatment options. For example, when asked if they wanted to be involved in the decision making process SU03B remarked:

“Not really...I don’t know. It’s just if there’s something wrong you come in, you’re seen and you go” (36-year-old male, carpenter).

SU11B also remarked:

“No, I don’t think I do. I need someone who is qualified to do the decision making and I go along with it” (61-year-old male, retired engineer).

SU01B seemed content to defer to professional judgement regarding clinical decisions but expressed a strong desire to be involved in decisions regarding where they received healthcare and to remain informed throughout:

“I think it depends on what those decisions are. I think if the medical decisions are about what they’re having to do, no. I think they should have the say so because they are the professionals, they are the experts and I’m not. But I do like to be informed continually about what they’re doing just so I know...For me personally, I like to have a bit of say if possible, where I’m going to be going. And that’s only because of, like I was given a choice of either going to [Hospital 3] or [Hospital 2]. For me, I like to have the choice of where to go because it’s transport and obviously if you are relying on friends or family to help you then it’s easier for them” (41-year-old female, tree surgeon).

Similarly, SU01B and SU02B both explained that they had a great deal of confidence in health professionals and seemed unlikely to query their advice or judgement:

“I trust medical staff because that’s their profession. They know what they are talking about. I like to think they do. I’ve never had any reason to doubt it in anything that I’ve had wrong with me or any of my friends or family. I don’t have any bad words to say about anybody in the profession” (41-year-old female, tree surgeon).

“Obviously with them being the professionals they should know what they are talking about. Hopefully they know what they are talking about” (39-year-old male, carer).

For these service users, understanding the decision making process seems more important than active participation and contribution. They welcome the information provided by the healthcare professional but were content to be directed regarding care and treatment options. Some also expressed concern that too much involvement could be detrimental to clinical outcome. When

asked if they thought greater involvement in the decision making process would lead to a better outcome for service users SU15B replied:

“No, I don’t think it would be. In some aspects it can be and in some aspects it can’t be because people have their own ideas about what they want and how they are going to achieve it. So if they push for something and the consultant or the doctor lets them [pauses]. They [health professionals] would have their medical knowledge and whether or not the person goes along with it is a different matter. It could be detrimental” (39-year-old female, nurse).

Similarly, SU11B commented that although the NHS was customer focused they did not think the customer should be in-control:

“I think it is customer focused. I’ve not found any problems anyway. Even when I was working I could say ‘no, I can’t get in that day’ and they put me in another day...I don’t think the customer is in control. I don’t think that bears any relationship to it really. You go into any customer situation and you come out with what they want to sell you don’t you. Which doesn’t happen in the NHS. It would mean you come out with the wrong diagnosis or the wrong treatment and waste everybody’s time and money...So really you rely upon your professional healthcare people to help you through really. It’s a helping thing rather than a customer relationship” (61-year-old male, retired engineer).

5.10 The impact of the internet on information-seeking behaviours

Service users from case B were generally prepared to manage minor medical issues at home but valued professional advice regarding anything they considered more serious. SU13B and SU14B explained how researching their health using the internet can be a positive experience in terms of self-management and in terms of avoiding unnecessary consultation:

“Well I don’t really like going to the doctors. I will put it off as a lot of people do. One of the reasons I put it off is perhaps because I might have looked something up and I think ‘oh no that’s fine. It’s just that’ or ‘It’ll get better. Let’s wait and see’” (53-year-old male, civil servant).

“If you’ve got a problem it’s handy to check it out on the internet because it could find that it’s something that you could do yourself as I’ve said before. You know your own body, I know what I can do with mine sort of thing. And it could be that you think ‘oh well, I’ll just see what the herbal fellas say’ and you never know, because there is so much out there, and you might find that it’s better for you. Once you know there is a problem I’m fine. Go out there and chase everything down on the internet because you don’t want to spend three hours with the doctor, because it’s his time not put to good use” (55-year-old male, carer).

Fourteen service users from case B (73.7%) confirmed that they regularly researched their health using the internet and five (26.3%) stated they did not use the internet, or tried to avoid doing so, since they felt it increased anxiety or that it was a waste of their time. The ages of the service users who did not use the internet to research their health were: 29, 39, 60, 61 and 81. Some service users described how they consulted the internet during their time at the MIU in case B. For example, when asked whether they researched their condition before a consultation, afterwards or both, SU15B replied:

“During. To show them that I’m right [laughs]” (39-year-old female, nurse).

Similarly, SU18B described how mobile-phone technology enabled them to research health related issues in any location, at any time:

“It’s just nice to know what options are there. So it gives you all your options and what to look out for so it’s nice to actually be updated on what’s going on...We are in a world where we’ve got mobile phones now so when you are on the go you can look at anything you want.

Even on my way here I was having a quick read of stuff” (70-year-old male, guest house manager).

Those who used the internet, often researched health related issues before seeking medical advice to check attendance was necessary. For example, SU09B commented:

“Google is my friend. I’d Googled all the symptoms you see...Not that I’m not trusting or anything but usually you get some sort of a diagnosis or you get sort of like a bracket that you can research around because you don’t always fall under one umbrella” (25-year-old female, teaching assistant).

A number of service users commented that although they did not to use the internet to self-diagnose they found it useful to check or supplement information provided by health professionals. For example, SU05B described how they used the internet following consultation:

“Probably afterwards. Just to check that if what they’ve said I’ve got fits with what Wikipedia says...I think it just gives you some choices in that if you’ve got a bit more knowledge” (62-year-old male, retired managing director).

Similarly, SU10B explained how they used the internet to clarify diagnosis and treatment if it had not been explained in sufficient detail or in clear terms. They also drew attention to issues of reliability and detail:

“There are a few times where I have gone home and they’ve just wrote it down ‘oh it’s this’ but they don’t explain to you what that is, what it means, anything about it. Just ‘there you go’. And then I’ll go home and I’ll look that up myself. But obviously you wouldn’t just look on one site so I look on a lot of different sites to make sure you are getting the correct information. If you just stick to one site it could just be filled with the bare minimal of information...They don’t go into any detail of what things could be. It is just ‘that is what it

is'. 'Why didn't you tell me that? Why did it take me to go on the computer to look it up?'"

(25-year-old male, unemployed).

SU16B described how they had researched their health using the internet but expressed concern that it could lead to harm rather good if people were trying to self-diagnose:

"Professionals know what they're talking about. They are the people to talk to. But I have looked at things [on the internet]. I just kept looking and yeah I've had that that that that that and you think it can't possibly all be right can it. I have looked things up but the bottom line is it really truthfully a silly thing to do. Go and talk to a professional...not having that expertise it is really stupid to do so and I think that people who are of that kind of ilk and try to self-diagnose make a grave mistake. A big error. Make themselves worse if they are not careful" (47-year-old male, unemployed).

SU07B also recognised that some websites were more reliable than others and that it was the service user's responsibility to exercise caution:

"Yes sometimes I do [use the internet]. It depends what it is. At the end of the day I think these days that it you've be fortunate enough to have an education and everything else you are going to be able to work things out for yourself. You have to be careful with the internet. Never trust just one site" (70-year-old female, retired civil servant).

SU12B was very reluctant to use the internet because of concerns regarding accuracy:

"You have to pick your case and I always make sure that I look at an NHS site or at least an English site not an American one. Often you'll get American sites come up which sometimes are not relevant...I would rather speak to someone in person" (48-year-old female, unemployed).

Finally, SU13B explained how they thought the internet could contribute to assertive and demanding behaviour by some service users:

“I think a little knowledge can be a dangerous thing. We’ve got a lot of information available now on the internet. I would like to think that if I thought something serious was going on I would at least try and inform myself to a degree so that I can ask those questions but not so much that I became intolerable as a patient and I would think some people could be because they’ve read this and they’ve read that and they’ve seen it on the internet and they think they’ve got a right to this and that. I think they would be very tricky. I would like to think I wouldn’t be like that” (53-year-old male, civil servant).

5.11 Willingness to question and challenge healthcare professionals

Most service users from case B (78.9%) stated that they were prepared to challenge professional opinion if they thought their advice was incorrect or inappropriate. However, like case A, many service users also explained that they uncomfortable doing this or lacked confidence. There was also considerable difference of opinion amongst service users regarding which age group was most/least able to communicate confidently and efficiently with health professionals. SU12B and SU19B described how they had become more confident as they had got older:

“I would now. In earlier years I wouldn’t have had the self-confidence to do that but I think with age you gain that confidence...For me, it would be previous experience of dealing with particular doctors and particular situations” (48-year-old female, unemployed)

“It could be maturity and age and the fact you’ve gone through it. (70-year-old male, guest house manager).

SU05B explained why they did not always trust health professional’s advice:

“Well medical people are not infallible. My private GP used to be my next door neighbour and so I know doctors socially and I know they are just as vulnerable as anyone else and they make decisions and they must think ‘I don’t know if that was right’. I think some have got

more expertise than others. I take what they say with a pinch of salt and then I want a second opinion” (62-year-old male, retired managing director).

SU05B also thought that people who were used to confrontation as part of their work were more likely to challenge medical opinion:

“I would think probably more professional people are used to dealing with business people and are more used to challenging people. People who have to make decisions at work I mean. I was a managing director for 30 years so I challenge quite a lot and have been challenged quite a lot over those periods of times. And professionals, be they accountants, lawyers or whoever, constantly challenging you and you’re challenging them. Whether it is employment law or all the things that happen in the work place”.

When asked what the thought gave people confidence to challenge professional opinion, SU01B commented:

“I think some people are just better at communicating than others full stop. I think I’m quite good at communicating because I’m not a shy person. But I think if you are a shy person then you might have a problems speaking out to say what you think or ask questions if you’re not sure. I don’t have that problem...Maybe age, I think confidence comes with age. Experiences, maybe what you do for a living. I don’t know. I’ve been brought up being able to speak my mind. Not in a rude or in a horrible way but I think that it’s good that you are able to communicate in whatever way you need to...Maybe it isn’t an age thing, maybe that’s just me personally that my confidence has grown with my age but I think it is more to do with the way that you’ve been brought up and how you’ve been educated and how to speak how you like to be spoken to” (41-year-old female, tree surgeon).

SU13B explained that they were reluctant to challenge medical opinion because of their upbringing but also felt their professional background had increased their confidence:

“I wouldn’t say that I’m quite happy to challenge authority but I think it may be a generational thing. There was certainly a lot more deference shown to doctor behind the desk. I was taken as a child to see my GP that was shown and the responses and the way my parents approached professionals. So I think some of it is a generational thing maybe; not that I have any, not that I’m showing any disrespect but I feel that times have moved on and we don’t tug our forelocks perhaps as much as we used to. Also, I’m a civil servant and I’ve worked in a law enforcement agency throughout my career in the civil service and you get used to a certain amount of confrontation and dealing with people from all sorts of walks of life and perhaps that also plays a part. I don’t have too much of an issue I don’t think” (53-year-old male, civil servant).

However, SU06B described how they lacked qualifications but still felt confident to challenge medical opinion:

“I’ve not got a lot of qualifications or anything but I take things in and I’m nosey and I like to know what is happening. And I will have my say and some [health professionals] don’t think you should...Just because they have trained as doctors and they’ve got qualifications it doesn’t mean to say that the patients are idiots and don’t know anything about what’s wrong with them” (81-year-old female, retired).

SU09B believed that trust and experience were important considerations when asked why some people were more confident than others when discussing their health with health professionals:

“Well I suppose a variety of reasons. A confidence thing. A lot more people are more trusting than others. I’m naturally sceptical about many things. Experience probably more than anything” (25-year-old female, teaching assistant).

When asked if they were confident to challenge medical opinion, SU10B replied:

"I would do yeah, because I am that sort of person. I think a lot of people probably wouldn't...They would just go 'oh OK then. Thank you very much. Goodbye'. But I wouldn't. I would be like 'I'm not happy with that. I want someone else to have a look at it'" (25-year-old male, unemployed).

Conversely, SU03B did not feel able to challenge professional opinion because they lacked understanding and knowledge:

"I don't know whether I'd say anything or not. Because I don't understand that kind of thing you know what I mean. I can't really understand that side of it. I'm not clued up" (36-year-old male, carpenter).

In summary, the views and opinions expressed by service user interview participants from case B are broadly comparable with those from case A. They explained that convenience, waiting time and previous experience of good service were the principle reasons they chose to attend case B as their first choice of care provider. They also explained how customer service skills were relevant in a healthcare context and how this impacted upon expectation of care/treatment. At the same time, some service users felt there were clear differences between healthcare and other consumer goods/services and explained why they viewed themselves as patients rather than customers. Most service users from case B wanted to be involved in the decision making process but, as in case A, there was considerable difference of opinion regarding the level of participation considered necessary or desirable. Some welcomed the opportunity to take greater responsibility for co-production of care whilst others were content to defer to professional judgement. For these service users, understanding the decision making process (as explained by a healthcare provider) was more important than active participation or contribution. Over 70% of service users from case B (14/19) reported that they regularly used the internet to research their health or check information they had received. There was also widespread recognition regarding the reliability of some information available online as well as their own/others ability to interpret it. One service user also expressed

concern that the internet may contribute to more assertive and demanding behaviour by some service users. Finally, 78.9% of service users from case B (15/19) stated that they were prepared to challenge professional opinion if they thought that it was incorrect or inappropriate. However, like case A, many also explained that they were uncomfortable doing so or lacked confidence. There was also considerable disagreement regarding the type of people most/least likely to communicate confidently and efficiently with service providers.

5.12 Service provider views regarding the reasons service users choose to attend case B

The following sections (5.12-5.17) provide discussion of the evidence collected during the service provider interviews. Service provider interview participants from case B also identified convenience, waiting time and previous experience as the principle reasons that service users attended to receive care. For example, when asked what attracts service users to case B, SP01B commented:

Once they realise...our waiting times are a lot less than A&E we get a lot of repeat people who say 'I wouldn't go anywhere else because we tend to be seen quicker here'" (ENP with 10 years' experience).

Regarding convenience and previous experience, SP02B remarked:

"We have a lovely gentleman who comes every day for redressing...He shouldn't be here but to be fair to him he has certainly made the attempt to go to the practice nurse but he is the first to say 'I prefer it here anyway'...we are very grateful but again we are the product of our own success. It's not right. We shouldn't be having daily dressings and daily repeats and people saying 'well last time I was here the lady was so nice'. And you think 'well that is really great but that doesn't mean we want you to come back unless you need it'...They don't want to be a number, they want to be a person. So they'll come back here" (ENP with 1 years' experience - previously paramedic).

This point is reiterated by SP03B:

“We end up seeing the patients over and over and over again, you end up starting to feel for the patients and you build a rapport with the patients” (ENP with 10 years’ experience).

SP01B remarked that another reason service users attend case B is because they often have limited choice because of money:

“...if you’ve got no money, and you are worried about the ambulance taking you one way and not being able to get home, they often choose to come to us with things that shouldn’t be here...because it’s a poor community...they haven’t got the money to go elsewhere so they come looking for help here and hope that we can help them rather than send them on” (ENP with 10 years’ experience).

Similarly, SP07B commented:

“There are a high level of patients who require redressings and they can’t get an appointment with the practice nurse and also when you’ve got a little old lady that lives just up the road here and she has to get a taxi three times a week to go to [GP surgery] what are you going to say?...It’s against everything I believe in to say to that lady ‘no, I’m sorry, you have to pay £7.50 to get the taxi to go and sit in the GP surgery for an hour waiting for the practice nurse. And then you have to pay for the return instead of just walking across the road” (case B manager and ENP with 12 years’ experience).

SP01B proposed that another reason service users present with complex and potentially life-threatening problems at the MIU in case B is because they view it as a ‘place of safety’:

“I think we are seeing more things that aren’t minor illness especially...we see a lot of chest pains here. We do a lot of assessments for chest pain and then move them on but we do the assessments...People come as a place of safety...I have seen a lot of really unwell asthmatics that shouldn’t be here even though there is a sign saying no A&E”.

The senior manager drew attention to the contrast between case A and B regarding access:

“A high proportion here [case A] drive and park and pay. A high proportion there [case B] bus or walk. So, if you want to get somewhere quickly. If you haven’t got a vehicle you can’t get to A&E...you go to where you can. You know they’ll sort it even if it means treat and transfer. It is a trust thing...It is a learnt experience. I went there, they made it better” (senior manager with 19 years’ experience as an ENP).

She also drew attention to the fact that although service user numbers are increasing across all emergency care sites at the Hospital Trust they are rising most rapidly in case B:

“I can’t find the e-mail now but I can find it and send it to you. It literally is a huge amount. Something like 135% up. And all of the others are 102%, 103%, 108%...And they [Trust managers] were saying ‘is it to do with the fact the GP is now there’ but actually, unlike here [case A], the GP patients aren’t booked on this system so it is a true increase in workload”.

5.13 Service provider perspectives regarding primary care

All service providers from case B stated that they felt an increasing number of service users were attending MIU because they were unable to access primary care services. Service providers from case B commented on how difficult it was for local people to access GP services and how they often had to assist or advocate on their behalf. For example, SP02B commented on the scale of the problem for the local community:

“...access to GP services is proving a challenge certainly in [case B town] as far as I can see and that is probably our biggest issue. The first thing people say is ‘I can’t get a GP appointment. I rang the GP this morning and well there is no appointment for three weeks’. Well that is ridiculous I’m sorry” (ENP with 1 years’ experience - previously paramedic).

Similarly, SP06B remarked:

“Well at this place, you’ve picked it up already, the GP system in [case B town] is collapsing. We’ve had one surgery shut so [name of surgery] has now got [name of surgery] part two in it” (staff-nurse with 40 years’ experience).

At the same time, service providers from case B were aware that not all local surgeries were failing and some provided a very good service. For example, SP07B remarked:

“I know there are a couple of surgeries that are very good. So [first surgery] is very good and [second surgery] because they’ve got practice nurses. But particular practices [third surgery] they have real problems. They had no practice nurses or they had one and she was on maternity leave or she was only there on certain days. So you have times in the year, in the summer, when it’s especially bad because they’ve got to have their holiday” (case B manager and ENP with 12 years’ experience).

Consequently, even when service users are seen by practice nurses it is often inconsistent. SP03B explained how this had affected the care one service user was currently receiving:

“She’s been seen by her practice nurse, the practice nurse can’t see her for the whole week. So then we’ve taken her on board for these five days or seven days” (ENP with 10 years’ experience).

Service providers from case B also seemed to feel a great deal of responsibility for the local community and SP04B explained:

“...you can’t turn them away. I wouldn’t like it if I got something and had to think ‘where do I go?’ They are stuck. If there are no appointments at the practice nurse where are they going to go? (ENP with 6 years’ experience).

Similarly, SP05B was sympathetic towards the pressure on working people to access healthcare at a time convenient to them:

“If I were a working man and I wanted a GP appointment nowadays I would have to phone up at eight o’clock that morning, perhaps phone half a dozen times because I was in a queue, eventually you get through. If I were very, very lucky I might be told I can have an appointment that day. Chances are, I’ll be told...’phone back tomorrow morning’. Now I’m a working man, I’ve told my boss I might not be in that day. So what’s easiest? Don’t even bother. Turn up at the minor injuries unit...because you can just pitch up and the hospitals are under legislative pressure to process people within four hours. So you don’t have to make any phone calls, no receptionist to deal with, you can just go along to your local casualty department, you’ll sit in the waiting room, you’ll sign and the GP will see you in a hospital environment with all the investigations and nurses available. What would you do? It’s a no brainer” (GP with 20 years’ experience).

A number of service providers from case B explained how the lack of primary care provision had contributed to the creation of the ENP clinic. For example, SP03B commented:

“The problem we had was the fact that re-attenders, obviously against the clinical guidelines, our re-attendance numbers were looking rather high. So we had to make a clinic diary so that patients come back to ‘clinic’. They are booked in under the clinic ethos so it doesn’t look like our re-attendance figures are as high as they are” (ENP with 10 years’ experience).

Similarly, SP04B remarked:

“Yes because our re-attender numbers were massive and I think to Government was going to start looking into it. And when they looked at it, it was the ones coming in for re-dressings and things like that. So they’ve now given us a clinic book and we click that are coming back especially like the ones that are packed daily” (ENP with 6 years’ experience).

Service providers from case B acknowledged that they would continue to see large numbers of service users with primary care complaints regardless of whether the GPC service persisted or was withdrawn. SP01B remarked:

"...we are getting a lot more minor illness people attending and I think we need to adapt to that because they are coming. So we need to build up our knowledge base to deal with them and I think that is one reason why they are starting a project here so that we can provide the GP. But the problem is that if we keep adapting too much we are going to end up with a full A&E here...The problem is our staff need to be trained. It can't be all on the job learning" (ENP with 10 years' experience).

Finally, SP05B explained why primary and secondary care needed to adopt a more integrated approach:

"I've had people come along today, not emergencies but urgent primary care issues, vulnerable people, elderly who have been offered appointment for [date in three weeks' time]. Well that's just absurd isn't it...so they pitch up at the minor injuries unit. And I think people are quite good at that, people aren't as ignorant as we perceive in deciding what's non-urgent and what is A&E and what is appropriate for a minor injuries unit. It seems the natural choice to come here. That's why they'll be this natural amalgamation. It cannot be stopped. General Practice will become, or primary care on this site, on any hospital site...they'll be lots of specialists, nurses and other healthcare workers working to algorithms on evidence-based principles, looking after chronic illness in the community" (GP with 20 years' experience).

5.14 Service provider views of customer satisfaction

Service providers from case B were conscious of the customer service element of their role and explained how they tried to ensure service users felt welcomed and valued. When asked whether they thought the customer service element of their role was important, SP01B remarked:

“I believe that when people come to the desk you smile at them and you kind of welcome them in that way rather than scowl because it’s their initial impression of you” (ENP with 10 years’ experience).

Similarly, when asked whether they thought service users should be viewed as customers of healthcare SP01B, commented:

“I do actually. I think we should have that mentality because...we are providing a service...otherwise you get the mentality that existed when I first started A&E twenty years ago and inappropriate attenders we used to use that term. We labelled people inappropriate attenders and actually when you think about it people are having more trouble getting hold of GP appointments depending on the practice and therefore they are looking for another way and it’s not their fault. So we are filling a gap in the market”.

At the same time, there was a general lack of consensus amongst service providers from case B whether customer service modes of behaviour should always be applied in a healthcare context. For example, SP05B did not view service users as customers of healthcare per se but did believe the NHS should be more customer focused, providing a balance could be achieved regarding co-production of care:

“It should be a more customer focused service but that is a knife that cuts both ways. We will endeavour to provide a service to meet your needs but also the customer is required to cooperate with that. We just cannot give you everything. We are a business and we’ll try to help you. We will try to cut the cloth to suit you but we require things from you. For one

thing, if you were just to meet every need of your client, it is not sustainable because eventually if you are too paternalistic people give up responsibility for their own health” (GP with 20 years’ experience).

Some service providers were strongly opposed to the notion of service user as customers, not because they objected to the provision of individualised care but because they believed it encouraged unrealistic expectations and detracted from co-production of care. For example, SP02B commented:

“They are not a customer. They are not buying a product. I associate customer with Tesco’s...I appreciate...we are supplying a product, we are supplying a service but...a customer makes them detached in the sense of ‘those are your choices, pick one, put it in your trolley’...rather than be involved in your service. I think people need to be more involved. If you are going to be a customer, you are going to demand X, Y and Z...Maybe it’s just a word...If you go to a restaurant and you want a good service you will leave a tip. It’s that kind of mentality almost put them in the demanding scenario of what they want and what they will and won’t have and then we are going to be forever saying ‘we can’t meet your expectation’ and I think that could provide to be fundamentally a bad development in that we are always going to be seen as ‘them and us’ and not ‘we’” (ENP with 1 years’ experience - previously paramedic).

5.15 Service provider views regarding shared decision making and accountability

All service providers from case B expressed support for shared decision making and co-production of care with service users. SP05B offered strong encouragement for a more participatory approach:

“I think it is important to give them ownership of the problem really. So they know what is going on and if you want them to comply with the plan of management that sounds like its true, I think if they’ve at least had a part in coming up with the plan, or at least knowingly agreed to what you suggested, they are more likely to go the course” (46-year-old male, GP).

SP01B also recognised that many GPs seemed professionally motivated to offer a shared approach to decision making and treatment options:

“I’ve been working with them [GPs] a quite a lot recently - they’ll say to the patient ‘what do you think is the matter?’ or ‘what will you be wanting from today?’ I think we are missing that and we need to develop it...I think that’s where we need to adapt now and find out what...they are expecting. It’s not always right what they’re expecting but at least...we can explain” (ENP with 10 years’ experience).

SP01B proposed that involving service users in the decision making process represented a safer system for both the service user and provider:

“Once I’d read about ‘no decision about me without me’ I thought ‘oh yeah’...I think they should be involved and they should see what I’m seeing. And I write in front of them most of the time so they can see what I’m writing about them because it’s related to them...I think the only way forward for us is if we involve them and it’s safer for them and safer for us”.

At the same time, SP03B explained that it can be difficult to accommodate choice and decision making when it contradicts clinical guidelines or established clinical evidence:

“I think their clinical decision become difficult when we’ve got guidelines, strict guidelines to follow...But I do think patients generally should have choice about their care” (ENP with 10 years’ experience).

SP02B also described how some service users preferred to abdicate responsibility for healthcare decisions:

“Some people just want it sorted for them. No complications, just tell them where they’ve got to be and when they’ve got to be there. And they’re happy with that. Because a lot of them I think...are too busy and it’s a necessary evil. As long as someone sorts it out for them it’s one less thing they need to worry about I think...I would say that they like it nicely packaged and

then they just have it done and go again” (ENP with 1 years’ experience - previously paramedic).

5.16 Service provider views regarding 'Google diagnoses' by service users

Service providers from case B confirmed that service users were increasingly researching their health using the internet before they attended for consultation. In some cases, this was beneficial since it led to greater understanding and a better managed outcome. In other cases, however, it resulted in misunderstanding and confusion which could negatively impact on partnership working between service user and provider. For example, SP01B commented:

“I think it is all down to Dr Google, they know what they are looking for. They know what they want and if you don’t give them what they want, or if you don’t agree with what they think they’ve got, there can be disagreement” (ENP with 10 years’ experience).

SP05B made the point that attitudes to healthcare are changing as information becomes more readily available to all:

“I used to see it as a class thing, like the middle class people from affluent areas would come in with their Times supplements saying ‘I want this, why am I not on this, why haven’t you done it yet?’ where the more working class people, and these terms are old fashioned now...were more willing to just let you plot the course. I think middle class people are exactly the same but I think working class people now are better informed, without doubt. They’re better informed and they do have suggestions to make. And they are often quite well read up on the subject: internet, news. We live in a different age in terms of information that we did 25 or 15 year years ago” (GP with 20 years’ experience).

SP05B also pointed out that some of the anxiety created by internet diagnosis can have a positive outcome for some service users:

“The internet, like the newspapers, bad news sells. No one buys the newspapers for good news...Likewise, the internet when it comes to illness...[service users] are often led down a gloomy avenue simply by going on the internet which doesn’t actually reflect what is going on in their bodies...It generally scares them and to a degree that might be advantageous because if they’re scared enough they might come to their GP with something that previously they wouldn’t...It does generate more work but there is nothing wrong with that...It’s not a problem reassuring people...I’d sooner reassure people than give them bad news”.

The senior manager outlined how knowledgeable patients, particularly those who presented with chronic (as well as minor) conditions, help to improve professional knowledge and standards of care:

“The main thing I’ve noticed over the course of my career is patient expectation is far greater. They expect far more...It can cause friction. I think it depends on the practitioner themselves and how comfortable they are in their own skin. If a patient is expert in something that I know nothing about I am extremely honest...And it does keep you on the ball. You have to, this sounds awful, be better than your patients, more knowledgeable and it makes you think well actually you can’t just know about that ankle, you do have to treat the whole person. And so you have to learn. When I first trained as a nurse practitioner all I had to concentrate on was ‘that’s an ankle, that’s a toe, that’s a finger’. And now my knowledge is so much greater and I have to think sideways the whole time. It’s made me a better practitioner” (senior manager with 19 years’ experience as an ENP).

5.17 Dissatisfaction, complaint and managing changing expectations about service provision

According to service providers from case B, the principle reason for customer dissatisfaction and complaint is service user expectation regarding waiting time and the type of care available. SP02B remarked that:

“Some people...are unrealistic in their expectation of what they want done [and] how quickly they want it done...It’s not everybody but I think their expectation is [snaps fingers] it should happen now. It should have happened yesterday...managing the demand and the expectation has become quite a challenge” (ENP with 1 years’ experience - previously paramedic).

Although service providers from case B identified that it was only a small minority of service users that made inappropriate demands for services or treatment, they also felt that it was becoming more commonplace. For example, SP02B remarked:

“I think service users in general are becoming far more, demanding is a strong word but it’s probably bordering on demanding...It seems to have really increased over the last maybe five or six years that this demand and expectation has excelled beyond reasonable proportion”.

When asked why they thought this was the case, SP02B commented:

“...we are just a more demanding society really...I think our general perception of everything is faster, bigger, greater, better because that’s society isn’t it...I don’t think it’s specific necessarily to the NHS. It’s just general perception of the world as a competitive place and it’s becoming more so all the time...I don’t think there is that separation. It’s just a global way of thinking isn’t it, very demanding”.

When asked which service users were the most assertive regarding their healthcare, SP01B remarked:

“I think the younger ones are...and I don’t mean this in a horrible way...not as grateful as the older generation. They expect to see us and it’s part of their rights. I think that there is a generational thing there” (ENP with 10 years’ experience)

SP02B thought that service users in their late thirties-early forties were probably the most demanding.

“...it would be unfair to pick a specific group because there is always an exception but I would say...probably my generation or slightly younger are the more demanding” (ENP with 1 years’ experience - previously paramedic).

Most service providers from case B described how they often felt under pressure to provide investigations that were either unnecessary or not clinically indicated. The most common example was pressure from service users and/or their families to x-ray when clinical examination indicated that there was no reason to. SP03B remarked that:

“Parents often get quite upset if...[their child]...hasn’t had a x-ray. But then sometimes you send them for x-ray, a non-weight bearing limb, and you say ‘you haven’t broken it’ and they walk out. So that’s obviously really frustrating. You knew it didn’t need an x-ray” (ENP with 10 years’ experience).

Service providers also recounted how they were often unable to request/provide certain diagnostic investigations because of competence issues. For example, SP04B described an incident where a service user presented with a long history of chest infection for which they had been prescribed regular courses of antibiotics by their GP:

“...he was demanding [a chest x-ray] and it got very heated and in the end...he just upped and left and the language was foul...I’m saying ‘if I feel you need a chest x-ray then I need to refer you on to A&E...to see a doctor” (ENP with 6 years’ experience).

SP02B commented on the difficulty of providing everything that service users want and also identified how high expectations can lead to disappointment and negative disconfirmation.

“The more you want the more you need. The more you need the more you want...It [the NHS] will never live up to people’s expectations because expectations are always so high. Some people, we exceed their expectations and that’s great but the majority, we are always going to slightly play catch up” (ENP with 1 years’ experience - previously paramedic).

However, SP02B also proposed that the staff work-ethic in case B may have contributed to high expectation:

“...maybe we are a product of our own success, they are not wrong to think that. A lot of the time we will fulfil that expectation because we work hard, we process patients quickly...I clearly remember a lady, very irate, saying ‘I’ve been waiting for an hour and I should only have to wait ten minutes’...this is the expectation we’ve created because people often don’t have to wait very long”.

In summary, like service users, service providers identified waiting time and convenience as the principle reasons service users presented to receive care at the MIU in case B. One service provider suggested that another reason service users attended case B was because they had limited choice because of money. According to the senior manager, service user numbers were increasing in case B much faster than other Hospital Trust sites offering similar services. All service providers from case B stated that the reason for this was because service users were unable to access local primary care services in a timely fashion. They commented that whilst some GP practises were providing a good service, many were unable to offer GP and practice nurse appointments when required. This had resulted in the creation of an ENP clinic to treat those with primary care complaints who required regular (often daily), long-term care. At the same time, there was widespread agreement that greater integration between primary and secondary care services offered benefit to service users and providers. Service providers from case B were conscious of the customer service element of their role and explained how they tried to ensure service users felt welcome and valued. However, as in case A, there was a lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context. Whilst some supported the notion of service users as customers of care, others rejected this designation on the basis that it encouraged unrealistic expectations and detracted from co-production of care. All service providers expressed clear support

for shared decision making and co-production of care. One felt that it represented a safer system for both service users and providers.

However, there were also concerns that it could be difficult to accommodate if it contradicted clinical guidelines/protocols and that some service users were reluctant to engage with the idea of shared decision making even when encouraged to do so. Service providers confirmed that, in their opinion, service users were increasingly researching their healthcare etc using the internet. In some cases, this was beneficial since it led to greater understanding but, in others, it resulted in misunderstanding and anxiety. Service providers commented that, in their opinion, the principle reason for dissatisfaction and complaint in case B was high expectation regarding waiting time and the type of care available. Although they identified that it was only a small minority of service users that exhibited unrealistic expectations, they believed it was becoming more commonplace. When asked why they thought this was, one service provider replied that society had become more demanding as they world became a more competitive place. However, there was no agreement regarding which types of service provider were most assertive (e.g. age, education etc). Finally, service providers from case B speculated that meeting and exceeding service users' expectations in the past may have created high expectation and further demand.

5.18 Friends and family test (FFT) data: service user perspectives

The following sections (5.18-5.19) provide discussion of the quantitative and qualitative evidence from the FFT survey conducted once service users have been discharged from case B. The total number of FFT responses for case B are much lower than case A (189 compared to 1394). This reflects the fact that case A is much larger than case B and is open 24-hours a day, whereas case B has limited opening hours. It may also be indicative of the fact that data collection in case B took place over a slightly shorter period of time as I became more experienced in my role as researcher (see 3.17). Category 1, or 'extremely likely' to recommend the service, represents the most common response and accounts for 74.07% of total responses from case B. Category 2, or 'likely' to

recommend, accounts for a further 17.98%. The most common indicator of service user satisfaction from case B seems to be positive affective behaviours (38 responses). The words 'lovely', 'helpful' 'friendly' and 'polite' are frequently used collectively to describe this experience. For example:

"lovely nurse, very helpful and polite" (05/2015).

"lovely warm and welcoming staff" (04/2015).

"very friendly and helpful advice and treatment" (03/2015).

"It is very convenient, staff are friendly and extremely helpful" (04/2015).

It is interesting that professionalism and outcome are only referred to on four occasions and even then it is alongside positive affective behaviours:

"I could not have better treatment from reception to departure. The staff were friendly, professional and the treatment was first class" (04/2015).

"I had received poor care from my GP and was looking at a longer recovery. However the nurse at the hospital tried a different treatment option which worked. She was very kind and helpful. I left feeling relieved" (04/2015).

The second most frequent indicator of service user satisfaction in the FFT data is time or speed of service provision (27 responses). For example:

"quick and friendly service in and had x-ray sorted and back out in 30 minutes any other hospital you don't even get seen in 30 minutes" (03/2015).

However, speed of service was not always a priority for those rating the service as 1 and 2. Some service users still rated the care they received highly, despite the fact that they had to wait. For example:

"I got there at 8am not realising you didn't open until 9am...but no matter how long you wait the nurses are brilliant" (05/2015).

On the other hand, waiting time (and expectation of waiting time) appears to be the principle reason why some service users rated the service 2/'likely' to recommend, as opposed to 1/'extremely likely' to recommend. For example:

"I gave it a two because I was there for two hours the treatment was fine" (04/2015).

"quick X-ray department and brilliant nurse would have scored higher but unusually long waiting time for minor injuries" (04/2015).

Other comments provide comparison between case B and the time it takes to be seen/treated by other local service providers. For example:

"have been seen for various reasons in other depts in other hospitals and have had to wait hours just to be seen...but the treatment etc...was top class" (04/2015).

The third most important indicator of satisfaction fromt case B was efficiency (6 responses) and caring/kind/compassion (6 responses). It is not always clear from the feedback how the service or staff member have demonstrated efficiency and, like many of the themes, the term is often applied in conjunction with other indicators of satisfaction. For example:

"Very polite, extremely helpful, efficient and fairly quick" (05/2015).

The remaining indicators of satisfaction (appendix 13) are referred to on no more than two occasions.

5.19 Dissatisfaction

The category 3 comments (neither likely nor unlikely' to recommend service) account for only 2.11% of the total responses from case B (4 responses). Some of them indicate disappointment that treatment did not meet expectation. For example:

"didnt even get a xray. Didnt get a xray for ribs" (04/2015)

"Long waiting times" (04/2015).

Others are less enlightening:

“the service wasnt great, however, it wasnt too poor either” (04/2015).

The total percentage of respondents who were ‘unlikely’ (4) or ‘extremely unlikely’ (5) to recommend the service is also small (5.28%). Nine service users (4.76%) stated that they were ‘unlikely to recommend’ and only one (0.52%) stated that they were ‘extremely unlikely’. However, in two cases, the scores are probably erroneous since the feedback reads:

“Friendly staff” (03/2015).

“Find it very good and helpful and very nice staff” (03/2015).

Moreover, only two of the remaining category 4 respondents provided feedback which further limits interpretation. However, it is important to try to understand the reasons why the following views are expressed:

“the nurse on duty was very nice but didnt seem to know what she was looking for and whether I would need surgery, and I was therefore referred to [Hospital 3]” (03/2015).

“went to minor injuries because high fever of 39.4, pain in limbs, all over rash, pulse 110, trouble breathing and coughing up blood. Was told you shouldnt come to minor injuries with minor health issues by the nurse seeing to me. Disgusting treatment. I had no method of transport to get to my GP 12 miles away and felt urgent medical advice was needed hence why I went to my nearest hospital” (03/2015).

The first comment states that although the nurse was ‘nice’, she didn’t know whether the service user required surgery and had to refer them to Hospital 3. This type of referral is common and reflects the fact that ENPs are trained to diagnose and treat a wide variety of minor injuries and illnesses but are not qualified to offer specialist opinion beyond their sphere of competence.

Although the journey to Hospital 3 was inconvenient for the service user it probably represented the safest course of action and is in line with ENP protocol. The second comment also expresses

dissatisfaction regarding the distance the service user must travel to access care and frustration that they cannot be treated at their 'nearest hospital'. It reflects the common assumption that all hospitals are able to offer a full range of services.

In summary, the total number of FFT responses for case B are much lower than case A (189 compared to 1394). This reflects the fact that case A is much larger than case B and is open 24-hours a day. It may also be indicative of the fact that data collection in case B took place over a slightly shorter period of time. Category 1 and 2 responses ('extremely likely' and 'likely' to recommend) account for 92% of the total from case B. Like case A, the most common indicator of service user satisfaction seems to be positive affective behaviours. Similarly, the second most frequent indicator is time or speed of service provision. The category 3, 4 and 5 comments are few in number and it is difficult to provide meaningful analysis. Confusingly, two of the category 4 responses seem to be complimentary and endorse the service. However, overall, the chief indicator of dissatisfaction seems to be failure to meet expectation regarding treatment.

5.20 Convenience and locality issues: participant observation/field note data

Some service users attended case B even when they had received a more appropriate appointment elsewhere. For example, the partner of a potential service user at the MIU in case B reported to the ENP at reception that they had been generally unwell for three weeks and they were waiting in the car (FN: Mar.11, 2015). The ENP advised that, in view of the history provided, the service user would need to see a GP. The partner reported that they had already phoned the on-call GP service and had received an appointment for later that day. However, they wanted to be seen at the current time since it was inconvenient to return later. The ENP explained that even if they were seen immediately by a nurse they would still need to return later to see the GP. They left and returned to see the GP as arranged. Another service user presented at the MIU in case B and asked to be referred for a non-urgent USS (FN: Apr.01, 2015). They were informed that they needed to discuss this investigation with their GP since an ENP could not make the referral. The service user stated that they did not

have a GP and the ENP explained how to register with a local practice. Approximately two weeks later, the service user returned to case B and requested the same investigation. They stated that although they had completed the paperwork to register with a GP they had not returned it yet. They also stated that they wanted to register with the GP based in case B since it was closer to where they lived. The ENP explained that the GPC service was not available on a walk-in basis and that the USS report must be sent to the service user's GP practice for discussion and follow-up care if necessary. The ENP could only reiterate the importance of registering with a local GP as soon as possible.

Another service user phoned case B for advice following a traumatic injury two weeks earlier (FN: Mar.18, 2015). They were advised by an ENP that, in view of the history they had provided, it would be best to attend A&E at either Hospital 2 or 3 since it was likely they would require surgical opinion/intervention not available in case B. However, the service user stated that they would rather attend case B since it was closer and more convenient. Following examination, the service user was referred to Hospital 2 for surgical opinion as originally advised. The service user accepted that this was necessary but stated they had hoped the telephone advice provided by the ENP was incorrect since they had not wanted to travel to A&E. A similar example of this type of outlook also occurred when another service user phoned to ask whether they could attend following a recent traumatic injury (FN: Mar. 11, 2015). The ENP explained that, on the basis of the information provided, the service user may require a particular type of x-ray that could not be performed at Hospital 4 and the opinion of specialist doctor located at Hospital 3. However, the service user declined to attend Hospital 3 A&E since the wait would be '*too long*' and case B was closer. They were also referred to Hospital 3 after initial assessment.

Case B is also a source of advice and reassurance for those who don't necessarily require medical care or treatment. For example, a service user presented complaining of generalised, non-specific illness (FN: Mar.04, 2015). They were advised at reception that, in view of their history, they should make an appointment to see a GP. However, the service user insisted that they would rather speak

to an ENP. On discussion, the ENP learned that the service user actually wanted to discuss a sensitive and potentially compromising situation that had arisen as part of their job as a privately-employed healthcare worker. The service user had raised the same concern previously with another healthcare professional but wanted further advice. In this instance, the ENP was able to offer independent and impartial professional advice and reassurance regarding the service user's concerns.

Finally, a service user presented complaining of a recurrent life-threatening medical condition (FN: Mar.11, 2015). When asked why they had not phoned 999 the service user's partner replied that they had been treated in case B before and hoped that the ENPs would be able to 'rule it out' and 'send them home'. Following investigation, it was clear that the service user required emergency treatment at either an ECC or A&E. An ENP arranged immediate transfer to ECC at Hospital 1 and phoned the department to alert them. These types of behaviour suggest that service users not only have a high degree of confidence in the care provided by case B but they also use the service as a type of local triage or assessment service in lieu of specialist care provided at a distance. The senior manager described how the familiarity between service users and providers in case B has probably contributed to this:

...a lot of it at [case B] is they have brilliant treatment and they go again regardless of what is wrong...the one thing I have noticed down there is that they have immense trust in their nurses...Their head could be hanging off and they would pitch up to [case B] because they recognise them. It's like...in the old days when you always had your own GP, [case B] has become that. They are too good if you know what I mean...You don't see that so much at [case A]. Here we are local so they'll try us first and get a bit pissed-off if we send them elsewhere, delighted if we treat them" (senior manager with 19 years' experience as an ENP).

5.21 Reasons service users did not access primary care physicians

One of the emerging themes identified in case B during the PO phase of data collection was the large number of service users presenting with problems or conditions that would traditionally have been dealt with by their GP or practice nurse (FN: Mar.04, 11, 18, 25, Apr.01, 07, 22, 27, 2015). Most of those who attended case B had attempted to make an appointment with their GP surgery but had been unable to get an appointment for that day. The principle reason for this seems to be that they had not phoned the surgery in time. For example, a service user presented with a history of non-traumatic pain to their upper body (FN: Mar.18, 2015). They explained that they had wanted to see their GP but had been unable to book an appointment since they had phoned after 08.00 (by which time the surgery was fully booked for the day). Although the service user was eventually referred to the GPC by an ENP, it was a time consuming process since they had a complicated past medical history and numerous co-morbidities.

Another service user who presented with their child, stated they had not attempted to make an appointment with their GP because of the surgery's telephone triage system (FN: Mar.25, 2015). They explained that the process was complicated and involved waiting for a call-back interview. The service user reported, with some frustration, that there was no guarantee of an appointment and that if the telephone call was missed ('because you were on the toilet') the whole process would have to start again. The service user felt that the system discouraged people from making appointments and they had chosen to attend case B because - in their opinion - it was quicker and more convenient. In the event, the presenting problem was appropriate for ENP review rather than GP appointment. The most common reason that service users presented at the MIU in case B with primary care complaints was because of a shortage of practice nurse appointments. Several service users attended case B for post-operative wound review/dressing change (during the data collection period) since the unit manager considered it to be in their best interest to be treated by one clinical team on a permanent basis.

Another common reason that service users present with primary care complaints is for second opinion or reassurance. For example, a service user presented with a two-week history of non-traumatic pain to their upper body (FN: Apr.01, 2015). They explained to the ENP that they had already seen their GP but felt they were 'not doing anything'. Another service user presented with a history of chronic pain (FN: Ibid). They had seen their GP five days earlier who had prescribed medication and provided advice regarding management. The service user explained to the ENP that they did not like 'taking tablets' and disagreed with the advice they had received. The ENP could only reiterate the GP's advice and encourage the service user to take the medication as prescribed.

For the most part, service users' GPs provided appropriate care and treatment and ENPs could only offer reassurance that the information/management they had received was correct. On occasion, however, ENPs provided additional advice or advocated on service users' behalf to help them achieve the best outcome. For example, a service user presented with a long and complex history of non-traumatic pain (FN: Mar.25, 2015). They described to the ENP how they had seen a number of different GPs and had been prescribed a variety of medications all with poor effect. The ENP explained that there were a number of differential diagnoses for their complaint and, since the medication was not working, they would benefit from further investigation. Since the ENP could not refer the service user for investigation directly, they coached them how to describe their symptoms to the GP in order to achieve the outcome they required. This type of consultation occurs at both sites but service users in case B seem generally more in-need and appreciative of advice and support of this nature.

5.22 What is reasonable?

During the PO phase of data collection, the researcher witnessed that most service users demonstrate realistic expectations regarding the time they will have to wait and the type of care and treatment they would receive. However, a small proportion of service users seem to have unrealistic expectations that often resulted in disappointment, frustration, complaint and/or verbal-aggression.

For example, a service user waited for 20 minutes before informing the receptionist that the wait was longer than they had expected and they would make an appointment to see their GP later that day. Service users do not wait to receive care for a variety of reasons but this (and other) examples demonstrate that some would rather seek alternative provision, or forgo care altogether, rather than wait for an unspecified length of time.

Another source of tension in case B is service user expectation regarding the provision of diagnostic investigations and, to a lesser extent, medications. For example, a service user presented with a history of non-specific illness (FN: Apr.22, 2015). During the consultation it transpired that the primary reason they had attended was to request a new limb support since the one that they wore was old and dirty. The ENP provided a new support but declined the service user's appeal for further 'spare' supports because of limited stock. However, they advised the service user that they were welcome to return in the future when the new support was no longer fit-for-purpose. The service user became verbally aggressive and stated their dissatisfaction with the service provided in case B and by the NHS in general. This exchange highlights the difficulties of fulfilling some service user's expectations and distributing finite NHS resources in an equitable, clinically-appropriate and cost-effective manner. Service users do not always receive good customer service and are encouraged to bring this to the attention of the appropriate healthcare provider or health service ombudsman. However, in this instance, the service user did receive good customer service but it did not meet their expectation regarding what they were entitled to receive. Finally, a service user presented requesting strong analgesic medication because they had forgotten to bring it with them on holiday (FN: Mar.11, 2015). The service user became angry and verbally aggressive when the ENP explained they could not provide the prescription/medication (since it was not a stock item/they were not qualified to do so) and they would have to attend A&E or contact their own GP.

In summary, like case A, many service users presented at the MIU in case B because it was the most convenient destination - some having received more appropriate appointments elsewhere.

However, a large number of service users attended case B because they were unable to access primary care services at an appropriate time. This created a culture where service users often chose to attend case B as their first choice provider because they had received satisfactory treatment in the past and developed trust and confidence in the service provided. This sometimes resulted in service users attending with complex and, on occasion, life threatening complaints that were not appropriate for an MIU. However, because the ENPs provided initial care and rapid referral/redirection, service providers also used case B to 'triage' complaints rather than attend A&E at distance. The senior manager described how case B had become a victim of its own success having inadvertently encouraged local service users to attend by providing a flexible and personalised service. Overall, most service users demonstrated realistic expectations regarding the time they would have to wait and the type of care/treatment they would receive. However, like case A, a small proportion seemed to have unrealistic expectations that often resulted in disappointment, frustration, verbal aggression and complaint.

5.23 Conclusion

Like case A, there seems to be broad consensus amongst the data set regarding a number of themes. Firstly, convenience, waiting time and previous experience of good service were the principle reasons service users chose to attend case B. This was strongly influenced by poor availability of local primary care provision including practice nurse services. This resulted in the creation of an ENP clinic to treat those with primary care complaints who required regular (often daily), long-term care. In turn, this contributed to a culture where service users increasingly chose to attend case B as their first choice provider because of trust and confidence they had developed in the practitioners and the service they provided. Secondly, both service users and providers explained how customer service skills were relevant in a healthcare context and how this impacted upon expectation of care/treatment. At the same time, there was a general lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context. Thirdly,

service users and providers expressed support for shared decision making and co-production of care. However, there was also considerable difference of opinion amongst service users and providers regarding the level of participation considered necessary or desirable. Fourthly, most service users demonstrated realistic expectations regarding the time they would have to wait and the type of care/treatment they would receive. However, a small proportion seemed to have unrealistic expectations that often resulted in disappointment, frustration, verbal aggression and/or complaint. Another potential source of tension, identified by the FFT data, was misunderstanding regarding the availability of treatment in case B. Finally, there was a lack of consensus amongst the data sets regarding which type of people were most/least likely to communicate confidently and efficiently with service providers. The following chapter will compare and contrast the data from the two cases.

Chapter 6: Cross-case analysis

6.1 Introduction

This chapter compares commonalities and differences at both cases to further explain the behaviour and viewpoints expressed at each unit of analysis. This involves close evaluation of the environment, activities and processes (otherwise known as the context) at each case as well as the data sources. Cross-case comparison also supports the creation of clusters of phenomena that can be ordered into typologies that share patterns of behaviour and experience (Khan and VanWynsberghe, 2008). In terms of structure, this chapter is organised in a similar way to chapters 4 and 5 and commences with discussion of demographics and designation (6.2-6.3). The next section (6.4) considers similarities and differences re: environment, clinical governance and location before moving onto the main themes: primary care, customer service, co-production of care, internet and dissatisfaction (6.5-6.9). However, not all of the section headings in chapters 4 and 5 are exactly the same which requires explanation regarding the cross-case analysis. The most notable disparity between the two chapters is the number of FFT sections (4.24-4.31 and 5.18-5.19). The total number of FFT responses for case A was much higher than case B (1394/189) and reflects the fact that case A is much larger than case B and is open 24-hours. Data collection in case B also took place over a shorter period of time which may have partially contributed to the lower number of FFT responses (Table 20). Consequently, there was less data to consider and analyse in case B and this is reflected in the disparity between the section headings.

The only difference between the case A and B service user interview section headings is the inclusion of 'Service user views regarding customer service and environment' (4.10) and 'Self-management' (4.14) in case A, and 'Changing attitudes, changing service' (5.8) in case B. Thematically, 4.10 could have been combined with the following section ('Customers of healthcare') but, because of the quantity of data, it seemed sensible to present the information as two complimentary sections (4.10-4.11). Conversely, 'Self-management' (4.14) is a very short section (4 quotations) with no directly

comparable data from case B. Although self-management is examined in other sections in chapters 4 and 5 (4.13 and 5.10), it is in relation to the internet and the use of IT. 'Changing attitudes, changing service' (5.8) is also a very short section (4 quotes) and could have been included in the preceding section ('Customers of healthcare'). However, since it principally deals with how social and professional attitudes have changed, it seemed sensible to discuss this issue discretely.

In the service provider interview sections, chapter 4 contains one additional section, 'Services on demand' (4.21), and the following sections, 'Managing expectations about service provision' and 'Dissatisfaction and service user complaints' (4.22-4.23), are combined in chapter 5 as 'Dissatisfaction, complaint and managing changing expectations about service provision' (5.17).

More service providers were interviewed in case A since it is a bigger department and staff numbers are higher (Table 20). Consequently, this resulted in more data available for analysis from case A which is reflected in the additional sections. However, thematically, the same content is discussed at both. In the participant observation/field note sections, case A has an additional section entitled 'Dissatisfaction and service user complaints' (4.35). The reason for the omission of this section in case B is simply because very little of this type of behaviour was observed. The small amount of evidence presented is included in 'What is reasonable' (5.22). The final sections in this chapter (6.10-6.11) examine issues regarding replication of findings and the creation of typologies.

6.2 Demographics

Twenty-one service users and 10 service providers were interviewed in case A. Nineteen service users and 6 service providers were interviewed in case B (reflecting the smaller number of staff and limited opening hours). The senior manager was interviewed following data collection in order to address some of the emerging themes and to provide an overview of both cases (Table 20). Although more female service users were interviewed in case A (15) than case B (6), gender distribution across both cases is fairly consistent (21 female and 19 male interview participants). The age range is also

roughly comparable, with an average age of 49.7 years in the first and 50 years in the second (Table 21).

Table 20: Case A and B summary information

Case	Opening times	Population served*	Total MIU staff	Co-located GPC service	Shifts worked by researcher as ENP/participant observer	Interview participants
A	24 hours, 7 days a week, 365 days a year	Urban 54,880 District 151,200	14 ENPs 7 technicians (nursing support staff) 5 receptionists	Walk-in service (11.00-21.00 Mon-Fri, and 08.00-20.00 weekends) Funded by NHS Hospital Trust	17 th , 24 th Oct. 2014 7 th , 15 th , 21 st , 28 th Nov. 2014 4 th , 5 th , 18 th , 19 th Dec. 2014 9 th , 16 th , 23 rd , 28 th , 31 st Jan. 2015 7 th , 11 th , 19 th Feb. 2015	Patients: 21 [15 female, 6 male] Service providers: 10 [ENP = 7, GP = 1 Technician = 1, Receptionist = 1]
B	09.00-19.00, Mon-Fri, and 10.00-18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when closed)	Urban 41,709 District 111,7000 * 2011 UK census	5 ENPs 1 staff nurse No technician support 1 receptionist	Appointment only (11.00-21.00 Mon-Fri, and 08.00-20.00 weekends) Funded by Prime Minister's GP Access Fund	26 th Feb. 2015 4 th , 11 th , 18 th , 25 th Mar. 2015 1 st , 7 th , 22 nd , 27 th Apr. 2015 4 th May 2015	Patients: 19 [6 female, 13 male] Service providers: 7 [ENP = 5, GP = 1 Staff nurse = 1]
						Senior manager: 1 (works at both sites)

More service users from case B (78.93%) than case A (61.89%) had attended their local MIU on at least one occasion in the past (Table 22). For 8 service users from case A (38.09%) it was their first visit to the MIU compared with 4 (21.05%) from case B. This is partly explained by the fact that the location of case A has a much higher percentage of students than case B and 3 of the 8 first-time attenders were university students. Eighty-four percent of service users attending case B travelled

Table 21: Service user age (case A and B)

	18-25	26-35	36-45	46-55	56-65	66-75	76+
Case A	4	3	1	4	2	6	1
Case B	4	1	4	3	3	3	1

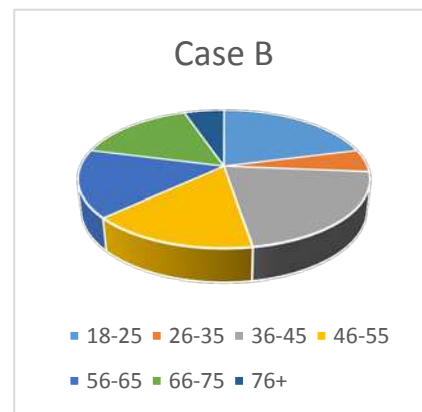
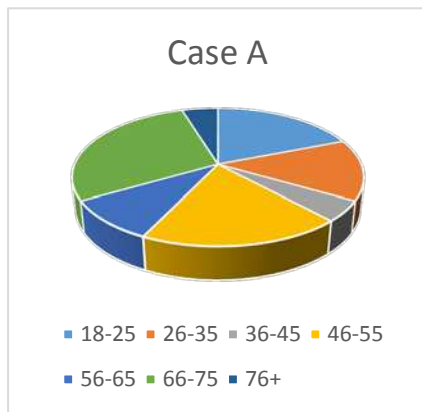


Table 22: Number of previous attendances (case A and B)

	None	1-5	6-10	11-15	16-20	21+
Case A	8	9	3	-	-	1
Case B	4	11	1	1	1	1

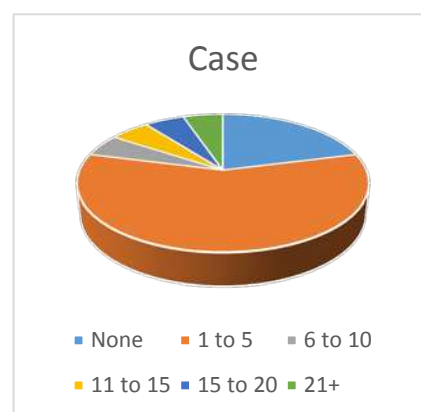
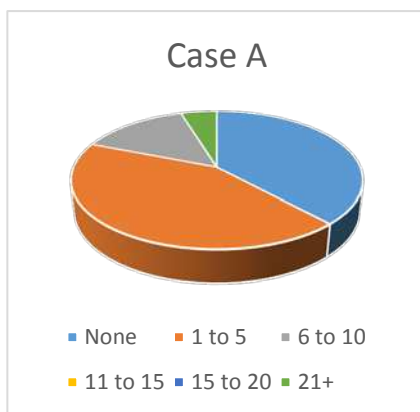


Table 23: Number of miles from home/location of accident to case A and B

	<2 miles	2-5	6-10	11-15
Case A	6	5	7	3
Case B	8	8	3	-

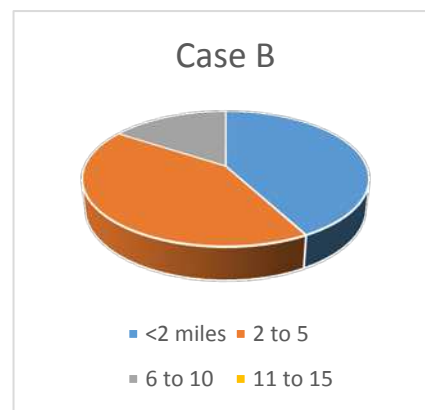
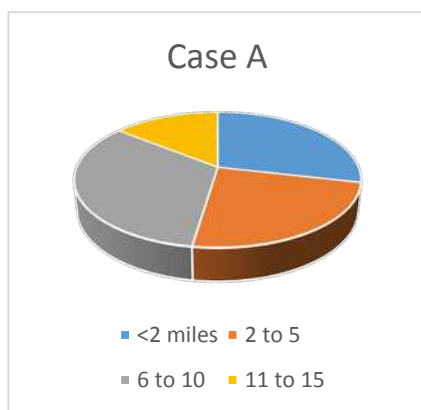


Table 24: Service user highest educational qualification (case A and B)

	None	C&G NVQ	GCE GCSE	A level	Cert.HE Dip.HE	Degree	Masters
Case A	5	-	6	4	2	1	3
Case B	3	2	7	3	1	2	1

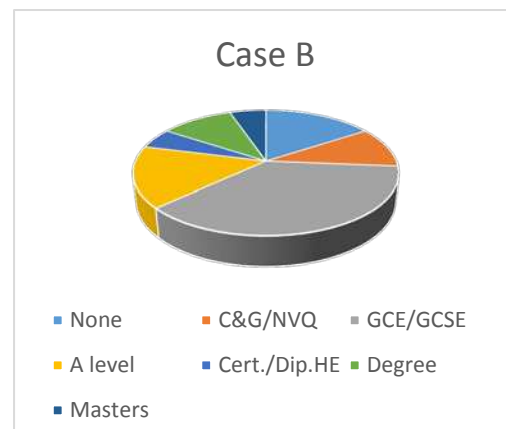
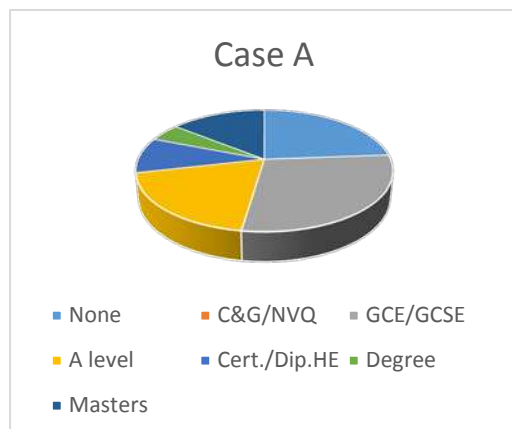


Table 25: Service users' self-description of their occupation/status (case A and B)

	Business & Management	Civil Service	Customer Service	Driving	Health & Social Care	Manual	Mother	Retired	Student	Teaching	Unemployed
Case A	1	-	1	1	1	1	1	8	4	2	1
Case B	1	1	2	1	3	3	-	4	-	1	3

Table 26: How service users viewed themselves when accessing healthcare (case A and B)

	Customer	Member of Public	Patient	Patient + Customer	Patient + Member of Public	Patient + Service User	Patient + Member of Public + Consumer	Patient + Member of Public + Customer	Patient + Member of Public + Service User	Patient + Member of Public + Service User + Citizen	Don't know
Case A	2	-	10	-	4	1	1	-	2	-	1
Case B	-	2	10	1	4	-	-	1	-	1	-

Table 27: How service providers viewed themselves when accessing healthcare in case A and B (and elsewhere)

	All	Client	Customer	Member of Public	Member of Public + Service User	Patient	Service User
Case A	-	-	-	1	1	6	2
Case B	1	1	1	-	1	2	1

Table 28: How service providers viewed OTHERS who accessed healthcare in case A and B

	Client + Customer	Consumer + Service User	Member of Public	Member of Public + Patient + Service User	Member of Public + Patient	Patient	Service User	Service User + Citizen + Member of Public
Case A	-	-	1	-	1	6	2	-
Case B	1	1	-	2	1	1	-	1

less than 5 miles from their home/place of injury compared to 52% in case A (Table 23). No service users attending case B travelled more than 10 miles to receive care, compared to 3 (14.2%) from case A. The highest educational qualification for service users at both cases is roughly equivalent with case A demonstrating slightly higher values at the two extremes (Table 24). All service providers possessed an appropriate professional qualification with the exception of SP02A and SP03A where it was not required. More interview participants from case A were retired than from case B, whereas there was a slightly higher number of unemployed service users in case B (Table 25). Four of the service user interview participants from case A were students compared to none in case B. Other than this, the occupations of those presenting for care at the MIUs in cases A and B is broadly comparable.

6.3 Designation

When asked to identify which word best described them when accessing or receiving healthcare, a number of service users from case A and B felt that the terms provided were too prescriptive and combined the words to create new phrases. Table 26 summarises the variety of combinations selected by service users from cases A and B. Ten service users from each case considered themselves to be 'patients'. A further 8 from case A, and 7 from case B, considered themselves 'patients' with one or more additional terms. Two service users from case A considered themselves 'customers' of healthcare and 2 from case B 'members of the public'. There was less agreement amongst service providers from case A and B when asked how they viewed themselves when accessing healthcare (Table 27). Sixty percent of service providers from case A viewed themselves as 'patients' whilst only 28.5% did from case B. When they were asked to select which term/s best described OTHER people accessing healthcare in case A or B, their answers were similarly polarised (Table 28). Service providers from case A continued to favour the term 'patient' whilst, in case B, the terms became even more nuanced. This may reflect the different relationship that service providers in case B seem to enjoy with many of those attending for care (see below). It is also interesting to

note how ENPs from case B, and the senior manager, were often conflicted regarding these terms.

For example, SP02B commented:

“The first one that would jump out would be member of the public. And then I would say patient because that’s their expectation. They are a patient. They’re not a service user...The term service user I think is actually fairly apt because certain people use it out of necessity and some people use it all the time. Therefore, it covers a broad spectrum but a member of the public doesn’t give you any pre-conceived notions. So I would probably say any one of those three” (ENP with 1 years’ experience - previously paramedic).

Similarly, SP03B remarked:

“Probably member of the public and service users. However, I still write patient in my notes. But to me patients are individuals who are ill in hospital. So I suppose I put patient because that’s what I’ve always written but not because; but they are more service users because they are using the service of our hospital and they are not patients because most of them are ambulatory” (ENP with 10 years’ experience).

SP05B, on the other hand, thought that patient was more appropriate when accessing healthcare because it indicated ‘need’:

“Member of the public and patient. We are all members of the public so you treat them equally. But this particular member of the public has a special need which makes them a patient” (GP with 20 years’ experience).

The senior manager explained why she preferred the term ‘patient’ but also understood that, in essence, they were ‘customers’ of healthcare:

“They are customers. I never call them customers and customer care because they are patients and always will be. I call them patients but that’s because I’m happy with that because I’m old and I’ve always called them patients. But the thought process behind those

words is they are customers. They are using the service and it's their service" (senior manager with 19 years ENP experience).

6.4 Similarities and differences

Case A and B both provide MIU services on behalf of the same Hospital Trust and are managed by the same senior manager. In this sense, there is great deal of homogeneity between the two cases. ENPs from case A and B undertake the same training and adhere to the same clinical competencies and protocols when providing care to service users. They are known to one another and, when necessary, work at other sites (including Hospitals 2 and 3) to cover ENP sickness and staff shortage. The senior manager regularly e-mails both teams regarding clinical practice, training opportunities and operational/procedural issues including the FFT report. The working culture is also very similar in case A and B. Both teams are well established and there is a high level of familiarity and respect between ENPs and other staff members. ENPs from both cases work autonomously and manage their own workload during the shift. However, there are also a number of notable differences between the two cases that - to a greater or lesser extent - can be explained by environmental and demographic factors.

Firstly, case A serves a more diverse and affluent population than case B and, it was noted in chapters 5 and 6, the town where case A is located has no LSOAs ranked in the top 10% most deprived in England, whereas case B town has four. Case A is also much bigger than case B and is situated within a large general hospital. As a result, the working environment in case A conforms closely to the operational norms at Hospital 1 (e.g. it provides a 24-hour service throughout the year) and employs a greater number of clinical and non-clinical staff than case B. Consequently, ENPs from case A can delegate appropriate investigations and treatments to clinical support workers (NHS band 1-4) whereas ENPs from case B must undertake these activities themselves. The workspace in case A is also physically connected to the ECC at Hospital 1 (Fig.2) whereas the workspace in case B is self-contained and independent (Fig.3).

Since case A and ECC were originally combined (and designed) as a single A&E department, historic and practical ties unite the two units. At the same time, there are also tensions regarding the most appropriate use of clinical support staff and who takes responsibility for providing care when service users require assessment/treatment from both units. The physical environment in case A also compartmentalises clinical and non-clinical staff and social interaction is typically limited and purposeful. In contrast, the compact layout in case B provides a more unified feel so that communication and social interaction between clinical and reception staff is more frequent and relaxed. This lack of formality is encouraged and augmented by the fact that many service users present for treatment at the MIU in case B on a regular basis. This is partly because they live locally and partly because they are unable to access services elsewhere. Consequently, since staff numbers are limited, service providers from case B often recognise and get to know service users quite well. This sense of familiarity is in contrast to case A where it is rare for service providers to recognise service users. The senior manager commented on the contrast between case A and B regarding the size of the unit and the relationship between service users and providers:

“There are only six members of staff down there and two on at a time. So they [service users] get to see faces they now know. In those massive GP surgeries, they never get to see the same GP twice. Three quarters of them are locums anyway so they’ll never see them ever again. And people like to go in and recognise that nurse, so the minute a new nurse is there you must have had it “oh, you’re new.” But they know them, they know them by name”
(senior manager with 19 years ENP experience).

She also remarked how this has almost certainly contributed to case B’s popularity and exacerbated repeat attendance:

“A lot of it at [case B] is they have brilliant treatment and they go again regardless of what is wrong...the one thing I have noticed down there is that they have immense trust in their nurses...Their head could be hanging off and they would pitch up to [case B] because they

recognise them. It's like...in the old days when you always had your own GP, [case B] has become that. They are too good if you know what I mean...You don't see that so much at [case A]".

This is also reflected in the overall satisfaction rating for case B recorded in the FFT test.

6.5 Primary care

Another important difference between case A and B is the way in which the GPC operates in both cases. In case A, the GPC provides a walk-in service where service users can self-refer if they are unable to make an appointment with their GP. Consequently, the number of primary care complaints seen by ENPs during the day is fairly negligible. The GPC service in case B, on the hand, was established with a different mandate and funded by the Prime Minister's GP Action Fund rather than the Hospital Trust. It was intended to provide additional support to local GP practices that were struggling to meet rising demand for primary care services in case B town/district. Consequently, at the time of writing, service users are referred by their GP practice via the service hub if they cannot offer an appointment. Although this system is well understood by healthcare professionals it often led to confusion with service users who were familiar with the walk-in system at the MIU in case A (and elsewhere) and attempted - unsuccessfully - to self-refer at the MIU in case B (FN: Mar.25, Apr.01, 2015). The working relationship between ENPs and GPs was not well-established in case B when data collection took place. Nonetheless, ENPs were receptive and positive regarding the benefits the new system offered service users attending case B. The senior manager commented on the GPC service in case A and B:

"This one's [case A] going probably soon. This one we employ and they are costing a small fortune...It's not helping with ECC which is why it was brought in. So that's being looked at. It's a different system at [case B]. We don't employ them. The rent our room. That's the overflow from the GPs because of the problems with GPs [in case B town]. They are a booked

*system from GP services. Whereas this one [case A] is taking patients that we feel a GP could sort out. So there are two different systems”.*⁸

Whilst the GPC in case B helped to reduce the number of service users seen by ENPs because they were unable to make an appointment to see their GP, it did not reduce the number attending because they could not book practice nurse appointments. Staff from case B felt that they had a duty of care and responsibility for the local community. SP04B explained:

“...you can’t turn them away. I wouldn’t like it if I got something and had to think ‘where do I go?’ They are stuck. If there are no appointments at the practice nurse where are they going to go?” (ENP with 6 years’ experience).

The senior manager also highlighted how the workload in case B is increasing faster than the other emergency care providers within the Hospital Trust:

“I can’t find the e-mail now but I can find it and send it to you. It literally is a huge amount. Something like 135% up. And all of the others are 102%, 103%, 108%...And they were saying is it to do with the fact the GP is now there but actually, unlike here [case A], the GP patients aren’t booked on this system so it is a true increase in workload”.

Although staff from case A provided some primary care type services, it was much less frequent and rarely involved long-term clinic appointments. There was also little sense of community responsibility in case A and the working relationship between service providers and users was much more transitory and transactional.

6.6 Customer service

Although very few service users from case A or B identified themselves as customers or consumers of healthcare per se, there was a strong sense (at both cases) that high standards of customer

⁸ The GPC service in case A was withdrawn in October 2015 (pending consultation on a new model of care for MIU/ECC) and reinstated at the beginning of 2016. The GPC system in case B remains the same at the time of writing.

service were important and desirable. The FFT data from both cases also identified that positive affective behaviours were highly valued and strongly contributed to overall service user satisfaction. At the same time, service users and providers from case A and B identified how customer service skills were firmly embedded in most working environments and how this impacted on people's expectations when accessing healthcare. For example, SU14A saw little difference between the type of customer etiquette observed in a supermarket and that expected in a hospital. For them shopping and healthcare both involved rules and socialised modes of consumer behaviour:

"I would tend to use customer because that's what I've probably used in my life at work...It just seems appropriate. All the way through my life dealing with the public and in my different jobs that I've had we've always spoken about the customer. You know, I'm the customer today or you're the customer...It's a bit like when you go shopping at the end of the week for your groceries, you don't just go bowling in there and say 'I want that, that, and that and that' and jump the queue and things like that. Everything has a system so you have to stick to that system" (60-year-old male, retired stock manager).

SP07A also identified how choice and convenience are no longer confined to traditional consumer activities such as shopping:

"I think people do now view it maybe as more of a consumer experience. They're used to going to the supermarkets and having an express service and I think that transition has come into healthcare to a certain extent. You know the expectation is that 'I've presented here for an express service, this is a hospital and will treat me quickly'. Whereas if they are going to maybe a GP set-up then they expect a slightly different type of approach" (ENP with 7 years' experience).

Similarly, SP10A noted that consumer attitudes and behaviour that are acceptable (and encouraged) in other transactional situations seem to be becoming more common in a healthcare context.

“...if you’ve got a choice of fifteen different providers for your internet there is a tendency to get quite argumentative and assertive with the provider because you are saying ‘I’ve got choice, I can go elsewhere. And I can understand it...I wouldn’t want them to skip into deference but, on the other hand, it goes too much the other way sometimes. What people do, in my view, is use the communication strategies that they use elsewhere...the same type of assertive behaviour that they’ll use in Curry’s or in KFC or when they go to Travel Lodge”
(ENP with 11 years’ experience).

Service providers from both cases identified that a small minority demonstrated demanding or inappropriately assertive behaviour when seeking healthcare. However, they also felt that the incidence of this type of behaviour was increasing. The senior manager noted how service user expectation had increased over the years but also explained how this can be harnessed to improve service provision:

“The main thing I’ve noticed over the course of my career is patient expectation is far greater. They expect far more...It can cause friction. I think it depends on the practitioner themselves and how comfortable they are in their own skin. If a patient is expert in something that I know nothing about I am extremely honest...And it does keep you on the ball. You have to, this sounds awful, be better than your patients, more knowledgeable and it makes you think well actually you can’t just know about that ankle, you do have to treat the whole person”.

The senior manager also drew attention to complaints regarding poor customer service across the Hospital Trust. Although she recognised that workload pressures often contributed to, and exacerbated, the incidence of this type of complaint she was also adamant that all service providers must view interactions from the point-of-view of the service user and be able provide appropriate information in a polite and professional manner:

“I believe that everybody should be on the other side of things at least once. I remember taking a friend of mine to an A&E and the receptionist...didn't even look up and said 'I've got to finish this. You'll have to wait'. Not 'would you mind I've just got to finish this'. Didn't even check to see that he wasn't having a heart attack...Then she said 'name?' Not 'good afternoon, sorry about that, do you want to book in?' nothing, just 'name'...A triage nurse called him in...and she was as rude and abrupt...So we need to be better”.

Finally, although some service users from case A and B saw little difference between the hospital and the high-street in terms of customer service, others were careful to point out what they considered to be important differences. Many of them demonstrated considerable insight regarding the tension between providing what service users' want and prioritising care on the basis of clinical need. For example, SU07B remarked:

“There should be a differentiation based on need and need has to be there and that is where the patient bit comes in. They [service users] have more clout and they demand what they want not necessarily what they need. That's the problem with the customer. The customer demands what they want not what they need” (70-year-old female, retired civil servant).

6.7 Co-production of care

Almost all service users from case A and B stated that they wanted to be involved in the decision making process regarding their healthcare management. However, there was also considerable variation amongst service users at both cases regarding the level of participation considered necessary or desirable. Some expected a high degree of involvement whilst others preferred a more prescriptive approach. For example, when asked if they expected health professionals to ask their opinion regarding care decisions SU12A answered:

“Well I don't know because you get to a situation sometimes where a doctor will say 'what do you want me to do?' and I feel like saying 'I've come to you. You're the doctor'. But this is

how they are. I think doctors along with a lot of other medical people are very frightened of litigation aren't they these days? They are afraid of getting things wrong perhaps. But to my mind...you go for a consultation and that's what you expect isn't it" (71-year-old female, retired cook).

Similarly, SU20A believed that healthcare professionals should not defer responsibility to the individual on the basis that it is their right to choose:

"I think personally doctors should be more straight-forward when it comes to things like that...It would help if doctors said 'stop or else you are going to die', be more blunt about it. Frighten people perhaps into looking after their health. I think there is a sort of general 'it's up to you. It's your human rights. You are entitled to do it'" (67-year-old female, retired IT engineer).

The extent to which service users chose/wanted to be involved in the decision making process will be discussed further in chapter 8 in relation to types of consumer activity in case A and B and typologies of healthcare consumer behaviour. In general terms, most service users from case A and B were content to be directed and advised by healthcare professionals providing care and treatment options were discussed and explained to them. A small number were distrustful of healthcare professionals whilst others expressed concern that too much involvement could be detrimental to clinical outcome. For example, SU11B commented:

"I don't think the customer is in control. I don't think that bears any relationship to it really. You go into any customer situation and you come out with what they want to sell you don't you. Which doesn't happen in the NHS. It would mean you come out with the wrong diagnosis or the wrong treatment and waste everybody's time and money...So really you rely upon your professional healthcare people to help you through really. It's a helping thing rather than a customer relationship" (61-year-old male, retired engineer).

All service providers from case A and B expressed clear support for shared decision making and co-production of care with service users. The senior manager explained why ownership is important for service users and how it benefits service providers:

“They should have ownership of it. It’s not my injury, it is theirs. And the more information they are given the more part of the plan they are, the more they can decide, even if they don’t want to have the treatment they know what is likely to happen...They are better advised if it happens again in the future, they are better equipped”.

SP05B also offered strong support for a more participatory approach:

“I think it is important to give them ownership of the problem really. So they know what is going on and if you want them to comply with the plan of management that sounds like its true, I think if they’ve at least had a part in coming up with the plan, or at least knowingly agreed to what you suggested, they are more likely to go the course” (GP with 20 years’ experience).

6.8 The internet

Another similarity between case A and B is the way in which service users use the internet to research their healthcare. Thirteen service users from case A (61.9%) and fourteen service users from case B (73.7%) confirmed that they regularly researched their health using the internet. Eight service users from case A (38.1%) and five from case B (26.3%) stated that did not use the internet to research their health, or tried to avoid doing so, since they felt that it increased anxiety or considered it a waste of time. Although most of the service users in the latter group were aged over 60 years, three from case A were aged 20, 30 and 39, and two from case B were aged 29 and 39. Those who used the internet, often researched health related issues before seeking medical advice (to check attendance was necessary) and afterwards (to check that the information provided was accurate/inform management).

Almost all service users in both cases demonstrated a high level of insight regarding the potential limitations of the information that could be accessed online. This included the accuracy of the information presented, the reliability of the website hosting the information and their own/others ability to interpret potentially complex information in a meaningful way. Moreover, service providers from case A and B confirmed that, in their experience, service users were increasingly researching their health using the internet before they attended for consultation. In some cases, this was beneficial since it led to greater understanding and a better managed outcome. In other cases, it resulted in misunderstanding and confusion which could negatively impact on partnership working between service users and providers. For example, SP07A commented:

“There is more knowledge available and people don’t come to hospital now with no knowledge...They have researched a little bit about their condition, about what they expect...and that affects what they think the outcome should be. So if you aren’t adhering to that expectation and things deviate from that, in their interpretation they could see that as having failed their expectation” (ENP with 7 years’ experience).

SP05B also made the point that attitudes to healthcare are changing as information becomes more readily available to all:

“I used to see it as a class thing, like the middle class people from affluent areas would come in with their Times supplements saying ‘I want this, why am I not on this, why haven’t you done it yet?’ where the more working class people, and these terms are old fashioned now...were more willing to just let you plot the course. I think middle class people are exactly the same but I think working class people now are better informed, without doubt. They’re better informed and they do have suggestions to make. And they are often quite well read up on the subject: internet, news. We live in a different age in terms of information that we did 25 or 15 year years ago” (GP with 20 years’ experience).

This may explain why there does not seem to be an obvious correlation between internet research activity and other demographic factors such as age, education and environment.

6.9 Dissatisfaction

Most service user interview participants from both cases reported high levels of satisfaction with the standard of care provided and with the NHS as whole (discussed further in chapter 8). However, the FFT and PO data highlight some examples of service user dissatisfaction. In the case of the former, almost all of the examples provided are from case A. According to the senior manager, FFT complaints are rare in case B because of the sense of community created as a result of the demographic factors discussed above. During the data collection period in case B, only one service user stated that they were 'extremely unlikely' to recommend the service and this is almost certainly an error since the feedback read: 'Friendly staff' (03/2015). The PO data from case B identified a small number of service user complaints (section 5.22) but the majority of complaints are from case A (sections 4.30-1, 4.34-5). Part of the reason for this probably relates to the fact that case A offers a 24-hour/365 day-a-year service and is situated within a large general hospital. Consequently, expectation regarding the type and range of services provided seems to be higher.

According to service providers from cases A and B, the senior manager and the FFT data, the principle reason for service user disappointment and dissatisfaction is failure to meet expectation. Sometimes this is because service users are unfamiliar with process and management issues. At other times it is because they have been misinformed or misunderstood advice and information from other parties and agencies (including healthcare professionals). Another common misconception identified by service providers from case A and B is the idea that hospitals are able to provide care in all circumstances. For example, SP07A remarked:

"I think historically people are used to coming to hospitals...People have always associated illness, ill health with coming to hospital. I think they are not aware of all the different provisions...as we are, because we are healthcare workers. So they default back to a hospital

quite often. And because hospitals cannot say 'no'...it is almost a learned behaviour in that respect" (ENP with 7 years' experience).

SP01B also proposed that another reason service users continue to present with complex and potentially life-threatening problems in case B is because they view it as a 'place of safety':

"I think we are seeing more things that aren't minor illness especially...we see a lot of chest pains here. We do a lot of assessments for chest pain and then move them on but we do the assessments... People come as a place of safety... I have seen a lot of really unwell asthmatics that shouldn't be here even though there is a sign saying no A&E" (ENP with 10 years' experience).

In case A, the problem is exacerbated by confusion regarding the status of the hospital and the MIU itself. Almost all service providers from case A commented on the confusion created by misleading or ambiguous signposting. For example, SP09A remarked:

"There is one sign down the road outside the police roundabout that says 'A&E Hospital', you come along the road [and] there is the sign for Hospital and underneath it says Minor Injury Unit. So there are conflicting signs. It doesn't say A&E on the main hospital board, it says Emergency Care Centre. That in itself is confusing for people because Emergency Care is undertaken in an Emergency Department and A&E" (ENP with 9 years' experience).

The senior manager provided further insight regarding why many service users remain confused about case A/Hospital 1's status:

"Historically it was an A&E so they were brought here by their parents or they came themselves and they still come...It is very confusing because if you live on one of the roads to [Hospital 1] and your neighbour was taken to [Hospital 1] with a heart attack [and] all you've got is a broken wrist you are going to go to the same place...but if they've had a road traffic

accident or a neck injury [Hospital 1] doesn't take it. And yet they see the heart attack as something worse so if they can take that they can surely take this".

Although case B demonstrates that a high number of service users attend with problems that should be assessed/treated in a more appropriate clinical environment, there does not seem to be the same level of disappointment as that demonstrated in case A. This is probably due to the fact that there is no ambiguity regarding its minor injury status and the fact that it is situated within a small community hospital with limited opening hours. The senior manager also identified how the community approach to care in case B has engendered a much higher degree of trust amongst service users:

"Because if they've been before and it's worked; they've got good care and they've come out, whatever they went with, something in their eye, a little finger injury and it's trust. They trust those nurses. Down there it purely is a little family thing of trust. And they will pitch up, the more serious the more likely you want to go to somebody you know. And they want to go somewhere quickly... You know that they'll sort it even if it means treat and transfer. It is a trust thing. They just know that they'll sort it. And it is definitely that sort of trust there".

6.10 Replication

Cases A and B were selected since it was predicted there would be a high degree of similarity (replication) between the data sets despite the fact the cases were located in contrasting urban areas and exhibit a number of historical and environmental differences. This is because they both provide MIU services on behalf of the same Hospital Trust and are managed by the same senior manager etc. (see section 6.4). For the most part, this seems to be the case and there is a high degree of literal replication regarding service user attitudes towards consumer modes of behaviour when accessing healthcare services. Service providers at both cases also acknowledge that customer care is important (and increasingly relevant) when interacting with service users and demonstrate a similar approach to their work and working environment. They also acknowledge the advantages

and challenges that are associated with coproduction of care and shared decision making. At the same time, however, there were also some contrasting features and service providers from case A (for the most part) continued to view service users as 'patients' whilst, in case B, service providers preferred a broader range of terms and designations including client, customer, consumer, member of the public and service user. This probably reflects the different relationship that service providers from case B seem to enjoy with many of those attending for care as a result of local issues regarding the availability of GP provision in case B town. Increased deprivation (as identified by the English IMD) may also be significant since it is thought to lead to distance bias (Bourlakis et al, 2011). That is to say, the ability to travel, and therefore choice of other service providers, is reduced by low income etc. The senior manager commented on the contrast between cases A and B regarding local demographics and access issues:

"A high proportion here [case A] drive and park and pay. A high proportion there [case B] bus or walk. So, if you want to get somewhere quickly. If you haven't got a vehicle you can't get to A&E...you go to where you can" (senior manager with 19 years ENP experience).

This type of contextual divergence is important to note since it produces contrasting results for predictable reasons - a theoretical or systemic replication (Yin, 1994). It is likely that if cases A and B had exhibited a greater degree of social and economic homogeneity literal replication would have been even higher. It is beneficial to consider whether different events/circumstances at each case could account for the same outcomes but, in the absence of any evidence to the contrary, it seems unlikely.

6.11 Differences in behaviour by personality trait or typology

There is a long history of categorising and classifying people on the basis of the way they think and behave (Ellis et al, 2009). For example, Freud proposed that personality development depends on the interplay of instinct and environment during the first five years of life (Stevens, 1995; McLeod, 2014). This involves instinctual drives, unconscious processes and early childhood influences

(especially parents). Freud (1923) also proposed that personality is structured into three parts (i.e. the id, ego and superego) all developing at different stages in our lives. According to Carl Jung's theory of psychological types (1971) people can be characterised by their preferences. These preferences are dichotomies or oppositions where each pole represents a different a way of making sense of the world. For example, sensation versus intuition (perceiving), thinking versus feeling (judging) and introversion versus extraversion (attitude). Jung also proposed that either the function of perception or the function of judging will prove dominant (Thorne and Gough, 1991). Isabel Briggs Myers (1980) developed this theory and suggested that the judging-perceiving relationship represented a fourth dichotomy influencing personality type. Consequently, according to Briggs Myers, there are 16 different types of personality resulting from the combinations of these four preferences (sensing/intuition, thinking/feeling, extraversion/introversion and judgement/perception). This forms the basis of the Myers-Briggs Type Indicator (MBTI) often used a descriptive tool to assess how people perceive themselves and the world around them (Sternberg, 1995).

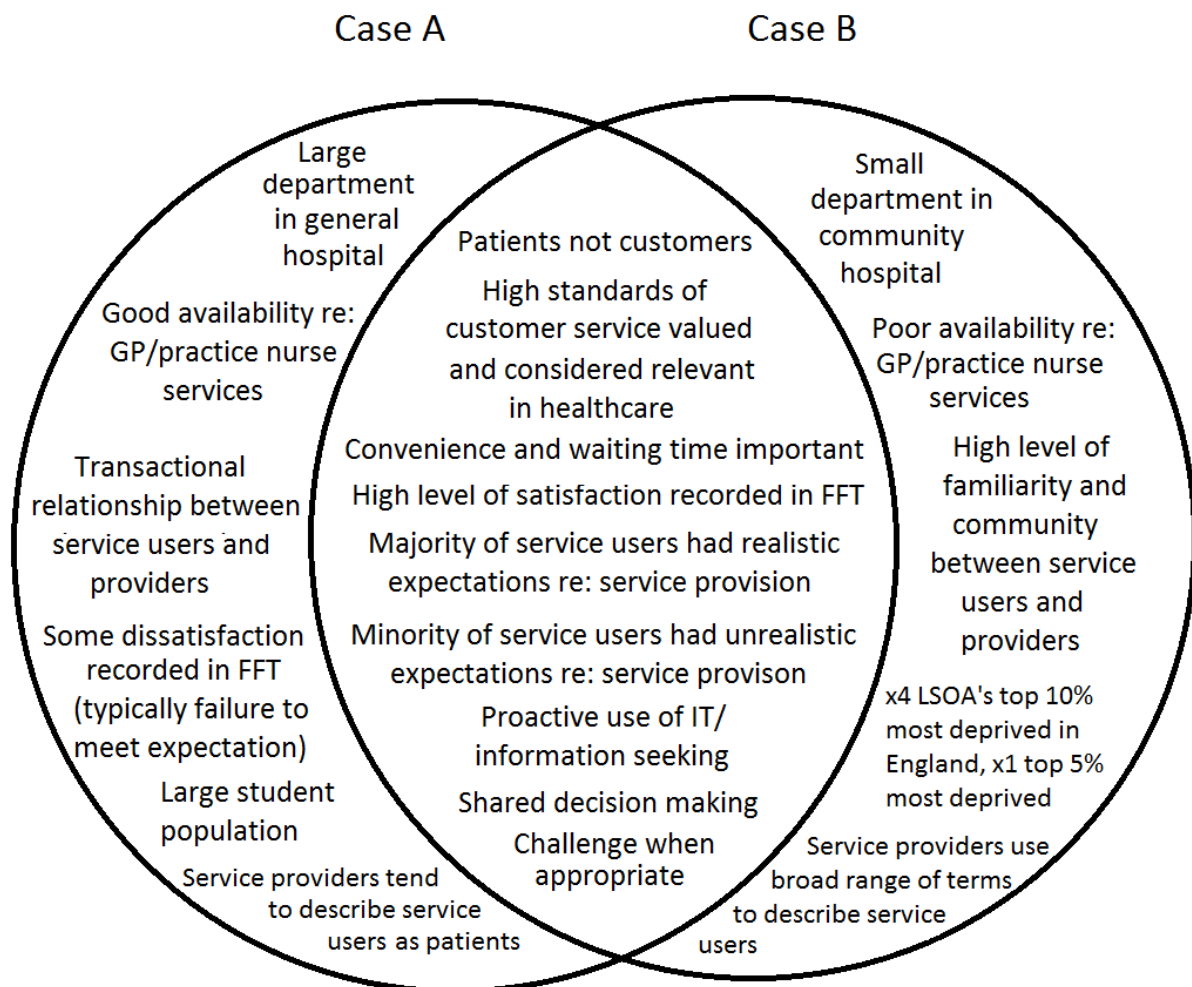
Another influential theory was developed by Eysenck (1947) who identified two main dimensions of personality: emotional stability versus emotional instability (neuroticism) and introversion versus extraversion. According to Eysenck, the two dimensions combine to form a variety of personality characteristics (Mcleod, 2014). Eysenck (1966) added a third dimension, psychoticism, at a later date to account for those who lacked empathy etc. Gregorc (1985) took a different view and suggested that are four main cognitive types or styles based upon the possible combinations of two different dimensions: concrete versus abstract and sequential versus random. In respect of the data collected for this study, individual preference, attitude and judgement; together with perceptions of the world about them (including knowledge of available services, past experience and what was/not available to them elsewhere) all played a role in service users' decisions whether to access an MIU, and once there, how, to a certain extent, they behaved. Access to information also seemed to contribute to the way in which service users interacted with healthcare professionals and, to some extent, shaped their expectations of the type of care and services they expected to receive.

As might be predicted, other factors, such as personality type and prior experience of healthcare delivery, also shape and influence attitudes towards participation in the decision making process and co-production of care. It is difficult to identify and pick-out all of the factors or personality traits that might encourage or drive individual behaviour amongst service users accessing care at the MIU in case A and B but there is some evidence for modes of behaviour that seem to influence decision making. The data suggests that there are a number of different healthcare consumer typologies that broadly reflect and predict the predominant behaviours exhibited by service users when accessing healthcare and interacting with healthcare providers. The characteristics and qualities that inform the different typologies were observed in case A and B and described by service user and provider interview participants. However, there was a single service user interview participant from case B who seemed to straddle several typologies and was therefore considered atypical. The 5 healthcare consumer typologies, and the negative findings, are discussed and evaluated in the following chapter. The discussion moves iteratively between the literature, the data and the researcher's observations before engaging in theoretical generalisation about the types of behaviour exhibited by service users when seeking healthcare in case A and B.

6.12 Conclusion

Figure 4 summarises the key demographic and thematic similarities and differences between case A and B. Most service users presented at both MIUs because it was the most convenient destination (some having received more appropriate appointments elsewhere for the same day) and/or because waiting time was less than other service providers. Overall, service users at both locations viewed themselves as patients (often combined with another designation). At the same time, however, there was general consensus that high standards of customer service were both valued and relevant in a healthcare context. The majority of service users in case A and B demonstrated realistic expectations regarding the time they would have to wait and the type of care/treatment they would

Figure 4: Demographic and thematic comparison between case A and B.



receive. However, a small proportion seemed to have unrealistic expectations that often resulted in disappointment, frustration and/or verbal aggression towards staff. Most service users at both cases expressed support for shared decision making and co-production of care. This was often reinforced and assisted by the use of IT to research healthcare options and treatment before and/or after consultation. Finally, high levels of satisfaction were expressed in both cases but service users stated they were prepared to challenge professional opinion if they felt their needs were not being met. The differences between the two cases are mostly demographic, particularly regarding access to local primary care services and the relative prosperity of the towns in which each was situated. Thematic differences include the relationship between service users and providers in case A and B, and the terms used by service providers to describe those accessing their services at both cases. The

FFT responses from case A also record higher levels of dissatisfaction than case B which will be discussed and evaluated in the following chapter.

Chapter 7: Discussion, Conclusion and Recommendations

7.1 Introduction

Before discussing and evaluating the typologies I have identified from the data, I will recapitulate the primary aim of research which was to understand whether the introduction of market reforms to the NHS, designed to encourage and improve choice and experience, have influenced the way in which service users access care and interact with service providers at two MIUs in the south of England. In order to answer this question, it is useful to re-examine and discuss the three secondary research objectives in relation to data presented in the preceding chapters. Consequently, sections 7.2-7.4 examine whether service users view themselves as 'customers' or 'consumers' of healthcare and, if so, is this reflected in their relationship with service providers? This includes discussion of how language and terminology influence the relationship between healthcare service users and providers. It also revisits the 'unmanageable' consumer (first discussed in chapter 2) and explores how service users make different choices in different circumstances (also discussed later in the chapter). Sections 7.5-7.7 examine the second research objective: why do service users choose to attend MIUs rather than an alternate healthcare provider? This includes discussion of the conflict experienced by both service users and providers when choosing/recommending where to access care. It also evaluates whether the findings from this study agree/disagree with those from similar settings in the UK.

Sections 7.8-7.10 examine the third and final research objective: do service users wish to participate in healthcare decision making? This includes evaluation of service users as co-producers of care and the possible implications of greater consumer autonomy and authority regarding healthcare provision in the future. There is also discussion of the tension between the collective values of the NHS and the individual ethos of consumerism. Having discussed the data in relation to the research objectives, the next section (7.11) examines the case study propositions identified in chapter 3. Although these are primarily intended to direct data collection and analysis, it is interesting to see

how far, if at all, they are supported by the evidence. Sections 7.12-7.14, discuss the formation of the healthcare consumer typologies I have tentatively posited from the data including evaluation of their analytical dimensions (with examples provided from the service user interview transcripts). Section 7.15 explains how the research findings and typologies make an original contribution to knowledge in this area, whilst the final sections, 7.16-7.19, outline the limitations of the study, draw conclusions and make recommendations for practice with reference to my own professional development.

7.2 'Positions' and insights when accessing healthcare

The first research objective for this study is: do service users view themselves as 'customers' or 'consumers' of healthcare and, if so, is this reflected in their relationship with service providers? Service users and providers from case A and B were asked to identify which word best described themselves (and others) when accessing or receiving healthcare. The terms were: citizen, client, consumer, customer, member of the public, patient and service user. These words are important since they construct an identity that conveys meaning about their attributes and also identify differing relationships and power dynamics between service users and providers (McLaughlin, 2009; Powell and Greener, 2009; Jackson and Hutchinson, 2016). As McDonald (2006) notes:

"The words we use to describe those who use our services are, at one level, metaphors that indicate how we conceive them. At another level such labels operate discursively, constructing both the relationship and attendant identities of people participating in the relationships, inducing very practical and material outcomes" (p.115).

A study commissioned by the NHS Institute and National Voices to examine how language and terminology influence the relationship between healthcare users and the NHS found that language designed to support change in the relationship between service users and the health system often resulted in confusion and cynicism (Ereaut and Whiting, 2013). The authors comment that:

“Over the years, those seeking to move away from a picture of the patient as passive and grateful recipient of the doctor’s skills (and the NHS’s benevolence) have developed a number of ways of talking about patients differently - alternative ‘positions’ they might be seen to occupy. One can see several common ‘positions’ buried within the language...[including]... customer; citizen; community; partner; and leader...The problem with all of these ‘positions’ - and indeed the fact that there are so many - is that they become confused and confusing”.

Consequently, although people select or are attributed a particular term to describe themselves in relation to the services they access, this meaning is not always clear and is often used interchangeably by those writing healthcare policy and the service providers themselves. For example, the term ‘patient’ is frequently combined with apparently similar or overlapping terms in NHS and professional literature (e.g. ‘patient and public involvement’). According to Ereaut and Whiting (2013) this creates inconsistency of meaning even amongst those within the field. In both of my cases, the term ‘patient’ was favoured by approximately 50% of service users (respectively) when describing themselves accessing or receiving healthcare. In general usage (in this context) the term ‘patient’ tends to imply a person seeking or receiving healthcare from a registered healthcare professional. The term also has a number of negative connotations and can imply passivity and deference to a paternalistic or biomedical model of provision. Furthermore, it may not always be the most appropriate term to describe those in a non-hospital environment or healthy people maintaining their health or receiving health promotion information (Jackson and Hutchinson, 2016). However, despite these concerns, the term patient remains popular amongst service users and providers alike (Deber et al, 2005; Simmons et al, 2010; Anczewska et al, 2011; Jackson and Hutchinson, 2016) so that phrases such as ‘patient experience’, ‘patient engagement’ and ‘putting patients first’ continue to appear in health policy and literature without apparent question or opposition from service users or providers alike.

7.3 'Member of the public' and other terms

Only two service users and one service provider used the term 'member of the public' to describe themselves when accessing healthcare. The term implies a sense of belonging to the general population of a country/nation and has connotations with public accountability (e.g. funding and allocation of resources). Eight service users (20%) regarded themselves as both 'patients and members of the public' whilst five more (12.5%) added at least one other term to these descriptors (32.5% in total). This suggests that they continue to identify with the wider social group (and their rights and responsibilities) whilst receiving healthcare and treatment. Two service users and one service provider considered themselves to be 'customers' of healthcare. The term 'customer' is typically associated with somebody who chooses to buy goods or services from a shop or other service provider. When asked to explain the difference between a 'customer' and a 'patient', SU19B replied:

"As far as I am concerned, the customer is someone who goes to the shop or goes to the garage. A patient is if there is something wrong you've got to go to a health professional and that's it" (70-year-old male, guest house manager).

In healthcare (and other public services) the word 'customer' has been appropriated and embraced since it implies that power (and choice) reside in the hands of the customer rather than the professional. The professional is available to offer advice and guidance to the customer on behalf of their organisation but they are accountable to the customer as well as their profession. No service users or providers selected the term 'consumer' to describe themselves when accessing healthcare although one service provider used it to describe others. The term consumer has been discussed at length in chapter 2 and is often used interchangeably with 'customer' in a healthcare context. According to McLaughlin (2009) 'consumer' signifies a relationship in which welfare and healthcare are viewed 'as a product for the consumer, managed by a case or care manager who is accountable to the state and their manager much more so than to their profession or those using the service'

(p.1104). During the interviews, many service users and providers seemed unfamiliar with the term 'consumer' and asked for clarification of the context for this word. The term 'customer', on the other hand, was well understood.

Another term that has also been discussed in chapter 2 is 'citizen' and, like 'member of the public', it describes a member of a state/nation who has certain rights and responsibilities. However, it also seems to incorporate greater emphasis on political participation and playing an active role in society (e.g. being a 'good citizen'). No service users or providers selected the term 'citizen' to describe themselves when seeking healthcare (unlike 'member of the public') although it was combined with other terms on two occasions. SU13B (53-year-old male, civil servant) remarked that 'citizen sounds a bit revolutionary, member of the public will do me'. In chapter 2, it was noted that - broadly speaking - the term 'citizen' involves a sense of shared rights, entitlements and obligations to society as a whole, whereas the term 'consumer' promotes a system of individualism, self-determination, privacy and commodification. It is interesting that, for the most part, both of these terms were rejected by the interview participants.

The term 'service user' was selected by three service providers and one service user (in combination with patient). Of all the terms, it is probably the most generic (since it can apply to any 'service' provided) and therefore perhaps the most sterile. SU07B (70-year-old- female, retired civil servant) remarked that 'service user' sounded 'too American' and SU19A (73-year-old female, retired nurse) referred to it as 'just gobbledegook'. However, SP04B commented:

"I would probably say service user more than anything because sometimes we relate everybody as patient but sometimes they're not. People see patient as someone being poorly when they are probably not, so service user I think" (ENP with 6 years' experience).

The final term that was identified by one ENP (SP06B: staff-nurse with 40 years' experience) to describe themselves when accessing healthcare (and combined with 'customer' to describe others) is 'client'. The word client is generally associated with those receiving a service from a professional

person/organisation in return for payment and SU13B (53-year-old male, civil servant) rejected the term because it sounded 'too businessy'. In health and social care, it has gained some acceptance since it reflects greater autonomy and choice for the individual and a rejection of biomedical domination (Jackson and Hutchinson, 2016). However, it is more commonly associated with social work/care and mental health services which may partly account for the fact that it was not popular in this context (McNicoll, 2012).

Overall, although most service users considered themselves patients when accessing healthcare, they also identified that different labels were appropriate at different times and in different circumstances. For example, SU08A commented:

"I suppose you put these labels on yourself depending on what you are doing in everyday life at that particular moment...In my normal life I'm a consumer of loads of stuff. I am a customer as well. I am a member of the public. I wouldn't call myself a patient unless I was coming here [case A] or to a similar establishment. I am a service user of all sorts of different things I suppose" (54-year-old female, lecturer).

Similarly, service providers from case A favoured the term patient but also recognised that people continue to demonstrate a range of characteristics and traits when accessing healthcare that are influenced by a variety of social factors and influences. Service providers from case B selected a broader range of combined terms to describe those accessing healthcare which seems to reflect the diversity of social interaction that takes place there (see below). The term 'patient' is a convenient designation therefore; but it is not always appropriate when describing those seeking health-related advice, second-opinion, undertaking health maintaining activity or being treated for minor injury or illness. At the same time, none of the other terms are entirely satisfactory or accurate since healthcare incorporates such a wide variety of investigations, interventions and treatments (undertaken by healthcare professionals) as well as self-management and choice of treatment options etc. (undertaken by the individual). SU07B explained why they objected to the term

'customer' of healthcare but they also recognised the importance of terminology when describing the relationship between service user and provider:

"It is about terminology. I think there needs to be a very clear idea of what a patient is and what the patient/professional relationship is and I don't think we're clear about that. I think each professional...might have his own idea about whether or not the relationship is different whether he is in a position of power and authority. And he is not in a position, he shouldn't be a position of power. Authoritative yes, authority no. It is complicated but that is the reason I don't like customer because I suspect it is the thin edge of the wedge and once we start being customers we are going to have to pay £10 to see somebody" (70-year-old female, retired civil servant).

7.4 The 'unmanageable consumer'

According to Edwards (2000) consumers are often portrayed as either chooser (confident and independent people making decisions that influence their future) or as victim or dupe (somebody who is gullible and easily manipulated by market forces). For example, the idea of the consumer as confident chooser embraces the notion of 'consumer sovereignty' whereby the consumer actively helps to determine the goods and services produced and offered for sale based upon collective endorsement and choice (Dixon, 1992). In other words, 'good consumers' have the potential to help others by targeting consumption of particular products or through complaint (Simmons and Powell, 2009). This contrasts sharply with the view of the consumer as victim or dupe where the consumer is fooled or seduced into purchasing or 'choosing' products and services that they neither want nor require. Gabriel and Lang (2006) identify a number of typologies to classify the diverse motivations for consumer behaviour and activity. These include the consumer as chooser, communicator, explorer, identity-seeker, hedonist, victim, rebel, activist and citizen. However, none of these representations satisfactorily epitomises the fragmentation of contemporary consumer activity, hence Gabriel and Lang (2006) argue that:

“The notion of an average consumer has become a fiction. In a world where everybody claims the consumer for her- or himself, the consumer must now be deemed unmanageable, claimed by many, but controlled by nobody, least of all by consumers themselves” (p.194).

Consumers become ‘unmanageable’ because of their ability to move between different positions - in some circumstances they are rational choosers, but in others they are activists or any of the other possibilities (Greener, 2008). This view of multiple, and frequently overlapping, motivations adds far greater depth to our conception of consumer behaviour and demonstrates how difficult it is to impose a one-size-fits-all model to consumer activity. The consumer is no longer a person who simply desires, buys and uses a commodity. They now explore, interpret and decode information necessary to inform their decision to buy or reject a product and may experience an emotional reaction, or total indifference, towards the commodity (Gabriel and Lang, 2006). ‘Consumption’ of healthcare services share many of these characteristics and Victoor et al (2012) remark:

“Patients’ choices are determined by a complex interplay between a variety of patient and provider characteristics. There is no such thing as a typical patient: different patients make different choices in different situations...It can thus be argued that the choice process is much more complex than is often assumed” (p.13).

Although most service users from case A and B did not view themselves as customers or consumers of healthcare per se, they all valued high standards of customer service and some expressed dissatisfaction when it was not provided. A number of service users from both cases also explained how positive affective behaviours associated with customer service activities, formed an integral and important component of most workplace interactions and were both welcomed and expected in a healthcare context. Some provided examples of positive and negative interactions they had experienced when accessing healthcare services and compared them with contrasting examples from independent sector service providers (e.g. Specsavers). Service providers from both cases also commented that - in their opinion - consumer attitudes and behaviour acceptable and encouraged in

other transactional situations seem to be becoming more common in a healthcare context. For example, SP10A commented:

“...if you’ve got a choice of fifteen different providers for your internet there is a tendency to get quite argumentative and assertive with the provider because you are saying ‘I’ve got choice, I can go elsewhere. And I can understand it...I wouldn’t want them to skip into deference but, on the other hand, it goes too much the other way sometimes. What people do, in my view, is use the communication strategies that they use elsewhere...the same type of assertive behaviour that they’ll use in Curry’s or in KFC or when they go to Travel Lodge”
(ENP with 11 years’ experience).

Service providers from both cases were all conscious of the customer service element of their role and reported how they tried to ensure service users felt welcome and valued at all times. For example, in an e-mail to staff at the MIU in case A, the senior manager explained how they must endeavour to make service users feel welcome even when they have presented for care in the wrong place:

“We can’t do anything about the fact we cannot order an MRI but we can give better explanations or check that people have understood our explanation. This is especially relevant if they are in an inappropriate place. We must try and not make them feel that they are not welcome, while at the same time educating them for the future” (senior manager with 19 years’ experience as an ENP).

However, there was also a general lack of consensus regarding whether customer service modes of behaviour should always be applied in a healthcare context. SP06A remarked how difficult it can be to maintain an outwardly welcoming countenance at all times:

“...some days you are very happy, some days you are probably a little bit down but you have to have to a smile on your face because you can conquer the world with a smile [laughs]. And

I try to keep it on but it is so stressful at times, the work, you can't always have a smile" (ENP with 2 years' experience).

Service providers also expressed concern that 'patient pressure' and the threat of complaint may lead to inappropriate decision making and investigation (see below). They also explained how Web 2.0 enabled devices and social media had the potential to undermine participation, cooperation and trust between service users and providers if the former recorded/uploaded images and dialogue without consent. However, despite the fact that most service providers did not favour the term customer (or consumer) there was general consensus that it was increasingly appropriate to view service users in these terms. There was also recognition that the NHS was not a static organisation and that outlooks and working practices continued to evolve in response to social and technological advances. For example, SP07A remarked:

"...things are changing and it's never good to stand still, it's never good just to tread water. Although there is much criticism of how things have changed, and changed very quickly, perhaps that's the crux of the problem that, you know, it's too quick, too much change too quickly. But...we can't have an NHS that's the same as it was at conception because society has changed, expectations have changed, treatments have changed, everything has changed. So we have to change, things have to change. If it's done constructively without blame or criticism and involves us in that way then there isn't a problem that I can see" (ENP with 7 years' experience).

Another reason that service providers from both cases seemed generally receptive to a customer-led approach is that this view is actively encouraged and reinforced by the Hospital Trust through a variety of different media including internal correspondence, FFT updates and customer service training. These, in turn, are instigated in response to healthcare policy developments and DH advice regarding patient and public participation and choice. SP01B commented that:

“Once I’d read about ‘no decision about me without me’ I thought ‘oh yeah’...I think they should be involved and they should see what I’m seeing. And I write in front of them most of the time so they can see what I’m writing about them because it’s related to them...I think the only way forward for us is if we involve them and it’s safer for them and safer for us”
(ENP with 10 years’ experience).

It is interesting to note how this view combines participation and customer service with professional considerations such as patient safety, transparency and documentation as a legal record.

To summarise the first research question, the findings confirm that ‘patient’ remains the most popular designation despite attempts to conceptualise those who access healthcare services as ‘customers’ or ‘consumers’. Part of the reason for this seems to be inconsistent use and application of terms in healthcare literature/policy to describe those who access services. There is also a sense that none of the other terms are entirely satisfactory given the multifaceted nature of healthcare provision. Finally, when discussing healthcare consumer activity, it is important to be aware that consumerism entails both positive and negative attributes. The notions of the ‘empowered chooser’ and ‘gullible dupe’ occupy either extreme of the spectrum - with a wide range of alternative positions in between. Consequently, it is difficult to apply terms such as ‘consumer’ and ‘customer’ to healthcare without a degree of explanation regarding context. This is reflected, to some extent, in the consumer typologies discussed in sections 7.12-7.14. It also helps to explain why service users’ valued high standards of customer service at the MIU in case A and B even when they did not consider themselves customers or consumers of healthcare. Similarly, service providers at both cases were conscious of the customer service element of their role but rejected the notion that customer service modes of behaviour should always be adopted in a healthcare setting.

7.5 Why do service users attend MIUs?

The second research objective is: why do service users choose to attend MIUs rather than an alternate healthcare provider? Most service users identified convenience (in terms of estimated

waiting-time and location) as their primary motivation. Whilst this is not surprising, it is interesting to note the number of service users who attend with problems or complaints they know are more appropriate for GP or A&E assessment/treatment. For example, when asked why they had attended case A rather than their GP surgery, SU05A replied:

“Because this is where I came last time and last time they sorted it out straight away...It takes two weeks to get a doctor’s appointment and when this happens I can’t really wait that long. I need it fixed quickly. It affects my work. I’m supposed to be working on Monday” (32-year-old male, undertaker).

In case B, SP05B was sympathetic towards the pressure on working people to access healthcare at a time and place convenient to them:

“If I were a working man and I wanted a GP appointment nowadays I would have to phone up at eight o’clock that morning, perhaps phone half a dozen times because I was in a queue, eventually you get through. If I were very, very lucky I might be told I can have an appointment that day. Chances are, I’ll be told...’phone back tomorrow morning’. Now I’m a working man, I’ve told my boss I might not be in that day. So what’s easiest? Don’t even bother. Turn up at the Minor Injuries Unit...because you can just pitch up and the hospitals are under legislative pressure to process people within four hours. So you don’t have to make any phone calls, no receptionist to deal with, you can just go along to your local casualty department, you’ll sit in the waiting room, you’ll sign and the GP will see you in a hospital environment with all the investigations and nurses available. What would you do? It’s a no brainer” (GP with 20 years’ experience).

There is a conflict, therefore, between encouraging service users to access the most appropriate service provider for their need and encouraging them to choose the service that offers them the best outcome. As SP05B notes, legislation requires emergency care providers to assess, treat, discharge/admit service users within a maximum of four hours. This sense of entitlement and

expectation is reinforced by the FFT survey that encourages service users to recommend the service to others if they found it to be satisfactory. Service users from both cases stated how previous experience had influenced their decision to return for treatment. For example, SU02B commented:

"It's been a pretty good service when I have been here. Never had a problem with the hospital, everyone's really kind and it's normally pretty quick. I've seen that one [ENP] before. I've seen her I think twice. I've seen her with my stepson as well" (39-year-old male, carer).

Similarly, FFT responses from both cases provide evidence of positive confirmation that - in keeping with the ethos of FFT - suggests recommendation is likely:

"everyone was very friendly and helpful and seemed that they couldn't do enough, and although they were very busy...she [ENP] wasn't stressed still very smiley and professional" (case A: 10/2014).

"i was in and out within 10 minutes! I never thought that was possible in a hospital" (case A: 11/2014).

"I had received poor care from my GP and was looking at a longer recovery. However the nurse at the hospital tried a different treatment option which worked. She was very kind and helpful. I left feeling relieved" (case B: 04/2015).

"quick and friendly service in and had x-ray sorted and back out in 30 minutes any other hospital you don't even get seen in 30 minutes" (case B: 03/2015).

The senior manager compared seeking healthcare at the MIUS in case A and B to customer loyalty when shopping:

"It is a learnt experience. I went there and they made it all better, they made me feel better. I'll go there again. If you go shopping and you go to a shop and the very first time you go in, they're rude and the thing you wanted wasn't there anyway. And someone says 'try so and so' and you think 'I don't want to try there. It's crap'. You've only walked in once but your

perceived idea is that was absolutely dire. 'I'll go back to the one I know because I know they'll be nice. Even if they haven't got exactly what I want they'll be lovely and understand'. We all do it and we do it with shopping and supermarkets. People have their favourite supermarket because of the experience they've had in it and what they've found. And people do that with healthcare" (senior manager with 19 years' experience as an ENP).

A study by Hunter et al (2013) explored how service users with long terms conditions chose which healthcare provider to access during a crisis. They used the term 'permeability' to conceptualise the barriers and obstacles that service users encounter when trying to access healthcare services and concluded that:

"In contrast to the 'deficit' model that underlies the view that patients need education to reduce their emergency care use, our findings demonstrate that patients with long term conditions are highly knowledgeable and discriminating in their healthcare choices. They prioritise experiential knowledge when choosing between services" (p.340).

Although this study focused on those with long term conditions, it highlights how service users' choice of healthcare is often dependent on learned experience in relation to how much 'work' they must undertake to access services and how eligibility to access is 'continuously negotiated in patient-practitioner interactions' (p.339). The same issues are equally relevant in case A and B and service users demonstrate a high level of insight regarding where they will receive the best care/treatment.

In case B, SP05B also commented:

"I think people are quite good at that, people aren't as ignorant as we perceive in deciding what's non-urgent and what is A&E and what is appropriate for a minor injuries unit. It seems the natural choice to come here" (GP with 20 years' experience).

There was also a strong sense of community and familiarity in case B that further encouraged service users to favour the unit to alternative providers and may have contributed to additional work for service providers. SU16B commented that:

“I’ve never been treated better in any other hospital than I have here...I’m treated as an individual, it stands quite a long way above how I feel I’ve been treated in other hospitals. Bigger ones are much less personal and it’s almost as though you’re a number and they just wheel you in, wheel you out kind of thing. But that’s never happened here” (47-year-old male, unemployed).

SP03B also commented how staff develop an ongoing relationship with those seeking care/treatment:

“We end up seeing the patients over and over and over again, you end up starting to feel for the patients and you build a rapport with the patients” (ENP with 10 years’ experience).

7.6 ‘Convenient care from expert strangers’

The Patients Association (PA) and Royal College of Emergency Medicine (RCEM) report examining patient perspectives when accessing A&E services (2015) identifies that the decision to attend, for many, is a combination of confidence in the service provided and convenience to attend at a time of their choosing (p.6). Owens (2012) proposes that choice can provide patients with ‘more convenient services that are sensitive to their particular circumstances, as well as to the beliefs, values and preferences they have about their treatment’ (p.25). He also remarks that this may prevent the development of meaningful clinical relationships between service users and providers and lead to what Adam and Guthrie (2001) describe as ‘convenient care from expert strangers’ (p.129). This view reflects concern that increasing marketisation of healthcare services is progressively diminishing qualities of intimacy and trust between clinicians and patients particularly in relation to primary care. Most service users who attend case A seem to present with minor illness or injury that

is appropriate for ENP assessment or review. They expect to be treated by 'expert strangers' since their complaint is often new and unanticipated. Some attend with primary care complaints because of access issues with their GP surgery or because it offers a more convenient service. Typically, they have a sense of expectation regarding the type of services/care they will receive based upon previous experience and/or independent research. This can lead to positive or negative confirmation/disconfirmation. In case B, a larger proportion of service users presented with primary care complaints than case A. However, they also attend because case B offers a strong sense of community and belonging that is seemingly unavailable elsewhere. The senior manager commented on how this had contributed to its popularity and exacerbated repeat attendance:

"A lot of it at [case B] is they have brilliant treatment and they go again regardless of what is wrong...the one thing I have noticed down there is that they have immense trust in their nurses...They are too good if you know what I mean...You don't see that so much at [case A]".

The fact that the quality of service provision in case B may be inflating service user expectation and demand is recognised by the staff at both cases and SP02B commented:

"...maybe we are a product of our own success, they are not wrong to think that. A lot of the time we will fulfil that expectation because we work hard, we process patients quickly...I clearly remember a lady, very irate, saying 'I've been waiting for an hour and I should only have to wait ten minutes'...this is the expectation we've created because people often don't have to wait very long" (ENP with 1 years' experience - previously paramedic).

The senior manager also commented how workload for all emergency care providers at the Hospital Trust is increasing but that case B is increasingly at a significantly faster rate. It is possible that if case A continues to provide a high quality service, that is favourably rated and recommended by service users, it too will see an increase in those choosing to attend/re-attend with complaints that are more suitable for other service providers. In market-terms, providing a high quality service that creates greater demand for business is clearly desirable (and potentially profitable). However, in

both cases, there is no mechanism (or money) to provide more staff to accommodate increased numbers and this leads to longer waits and lower customer satisfaction. SP02B commented on how high expectation can lead to disappointment and negative disconfirmation.

“The more you want the more you need. The more you need the more you want...It [the NHS] will never live up to people’s expectations because expectations are always so high. Some people, we exceed their expectations and that’s great but the majority, we are always going to slightly play catch up”.

There is a paradox, therefore, between providing a first-class service that increases (and encourages) demand and continuing to meet expectation regarding convenience and quality. The Hospital Trust provides ‘mixed-messages’ regarding attendance and service provision at both MIUs. On the one hand, they provide information on their website (and elsewhere) regarding the types of services that are offered at both cases in order to signpost service users to the most appropriate provider. During the winter period they also pay for local newspaper and radio advertisements discouraging service users from attending urgent care providers unless absolutely necessary.

However, at the same time, the FFT survey encourages service users to rate the care they received and to ‘recommend’ it to others. The results and comments are often published and service users can read about positive experiences or how the Hospital Trust intends to remedy poor experiences. In either case, the feedback tends to read as an endorsement of the service and service users are therefore encouraged not only to return but to recommend it to others. Members of the public are increasingly familiar with consumer rating reports and the customer focused language of the FFT does not identify or differentiate between appropriate and inappropriate attendance. As noted above, many service users were satisfied with the care they received but, in some cases, should have attended an alternative and more appropriate service provider.

7.7 'Brand strength'

To some extent, therefore, both cases have become victims of their own success since some service users who have had a positive experience (often expressed in terms of short waiting time, convenience, efficiency, friendliness etc.) view them as their first choice for healthcare.

Consequently, there is inconsistency and conflict between choice and customer service, and providing healthcare as a matter of urgency to those most in need. The PA and RCEM report (2015) found that the 'A&E brand is particularly strong' and, as a consequence, 'redirection [to other service providers] has been repeatedly shown to be ineffective' (p.8). This is almost certainly because the service provided at A&E and other urgent care providers such as MIUs, is more convenient and probably quicker than that provided elsewhere. One of the surveyed patients commented:

"Ease of access and flexibility of service are the main reasons to go to a co-located GP in A&E. Otherwise, I have to take time off work to make the GP appointment, which is not possible as I am a busy professional and it feels so lame to take time off work for a relatively minor ailment like mine" (p.8).

The key message of the PA and RCEM report (2015) is to replicate the 'brand strength' that exists within traditional A&E provision by 'co locating out-of-hours primary care facilities in A&Es...[to]... help properly rationalise and focus A&E service provision and make the best use of GP out-of-hours resources' (p.645). This sentiment was echoed by the GPs working in case A and B who favoured a much more integrated approach between primary and secondary care:

"For quite a long time now it has been a massive divide between GP's doing something in the community and hospitals doing things completely differently. And I think a lot of duplication of work is going on because of that. So I think they [hospitals] need to be more streamlined in the way they actually function and I think that's probably wasting a lot of money by not being streamlined...There is potential for that happening if there is no proper communication between the two" (GP with 5 years' experience working for GPC).

“...they’ll be this natural amalgamation. It cannot be stopped. General Practice will become, or primary care on this site, on any hospital site...they’ll be lots of specialists, nurses and other healthcare workers working to algorithms on evidence-based principles, looking after chronic illness in the community” (GP with 20 years’ experience).

Another RCEM report from 2015 highlighted that 43% of UK A&E departments have a co-located out-of-hours primary care facility and the joint PA and RCEM study (2015) concluded that ‘co-located services should include the full range of emergency medical services and out-of-hours primary care services that are necessary to meet both emergency and urgent care needs’ (p.8). The benefit of co-location of primary care for meeting urgent health needs has been recognised and advocated by Monitor, Trust Development Authority, Directors of Adult Social Service and NHS England (2014). It is also supported by the organisation that represents the majority of GP out-of-hours providers - Urgent Health UK (PA and RCEM, 2015).

To summarise the second research question, most service users identified convenience, in terms of waiting time and location, as their primary motivation when attending MIU. This is supported by the evidence presented by the PA and RCEM survey (2015) particularly regarding those attending with primary care complaints. In case B, service users often presented with primary care complaints because of lack of choice in the first instance. However, once they realised that the service provided in case B was more convenient, and at least as good as that provided by their GP practice, they returned out of choice. This is also supported by the findings from Hunter et al (2013) who concluded that service users were knowledgeable and discriminating when making choices regarding their healthcare during a crisis. The PA and RCEM survey (2015) and Hunter et al (2013) both rejected the notion that service users required re-education to reduce urgent care attendance. Instead, they confirmed that service users seemed to be acting rationally based upon their own knowledge and the expectation created by the healthcare provider. Service providers from both cases were aware that by providing treatment to those who attended with primary care complaints,

they were establishing a precedent and a sense of expectation for future care. They also suggested that consumerist notions of personal choice and expediency contributed to this way of thinking and the senior manager compared the reasons for attending a favourite supermarket with the reasons for attending a healthcare provider. This view is reinforced by the FFT survey that encourages patients to rate their experience and 'recommend' it to others.

7.8 Participation and shared decision making

The final research objective that needs to be understood is: do service users wish to participate in healthcare decision making? Coulter (2002, 2011) comments that the rights of health consumers have traditionally been smothered by the paternal authority of professional providers and that patient engagement in treatment and health management decisions is not only desirable but improves health outcomes. A number of older service users explained how the relationship between service users and providers had changed for the better since they were children. For example, SU02A remarked:

"I grew up in an age when you were frightened of doctors. Doctors didn't converse with you they told you what was happening. This is changing, their attitudes towards patients are changing and that's much better because if you feel part of the process, and you feel that you have a say, you equally feel that you are being listened to" (50-year-old male, support worker).

Coulter (2011) proposes that service users must be viewed as 'partners in the business of healing...managers of healthcare resources, and experts on their own circumstances, needs, preferences and capabilities' (p.1). The concept of service user as 'joint provider' or 'co-producer' of health is thought, therefore, to reinforce the value of their opinion in relation to that of healthcare professionals and most service users from both cases described how they wanted to be involved in the decision making process. However, there was also considerable difference of opinion at both cases regarding the level of participation considered necessary or desirable. Some service users

demonstrated a high level of personal autonomy regarding their health and wanted to actively participate in the decision making process regarding all aspects of their care and treatment. They were more likely to challenge professional opinion and did not always trust the advice and recommendation healthcare professionals provided. Other service users felt that it was not appropriate to be involved in the decision making process either because they lacked knowledge and understanding (and felt that their contribution was unnecessary) or because they demonstrated a high level of trust and confidence in professional knowledge and experience. However, at the same time, those who did not wish to participate in the decision making process still valued explanation of their care and treatment since it helped them to understand why it was necessary, increased confidence in professional recommendation, and made them feel valued. There were no clear demographic indicators to suggest why individual service users held these views although different types of health consumption behaviour can be identified and are discussed below.

7.9 Adopting a responsible position

Service users were also divided regarding whether increased choice and participation would lead to better service provision. Some agreed that it would whilst others expressed concern that too much influence/authority may lead to demanding and self-interested behaviour. Service providers at both cases noted that, in their opinion, an increasing number of service users were questioning and contesting professional opinion and clinical decision-making particularly regarding investigation. Although they acknowledged that these service users represented a minority group there was concern from both service users and providers that this type of assertive behaviour could lead to unnecessary investigation/treatment/second-opinion as service providers became increasingly defensive in order to avoid complaint and confrontation. In some cases, service user demands could actually prove detrimental to health. For example, a service user presented at the MIU in case A following a traumatic injury to a lower limb (FN: Dec.05, 2014). X-ray revealed that there was no bony injury and the service user was provided with an appropriate support, crutches and clinic

appointment for the following week. They were also advised that they may require USS if the injury did not improve. However, the service user was not satisfied with the treatment provided and stated that they wanted a full plaster cast to be applied to the affected limb. The ENP explained that this would be detrimental to the injury and would almost certainly prove dangerous since the cast would be heavy and hinder mobility. The service user left the MIU in case A stating that they would seek a second opinion elsewhere. SU14A also expressed concern that service users of all ages were becoming more demanding when interacting with healthcare professionals and that this may encourage a more assertive approach amongst people who were previously less demanding:

“I would like to say that all the older generation are happy and look at it the same way I do but I think it’s going slowly [the other way] because they are just finding that they have to shout so that they can get themselves in. I’ll probably get to that stage sooner or later” (60-year-old male, retired stock manager).

Service users at both cases were generally prepared to manage minor medical issues at home but valued professional advice regarding anything they considered more serious. Most believed that people should take responsibility for their health but some also felt that health professionals had a responsibility to draw attention to poor health choices/behaviour etc. rather than defer responsibility to the individual on the basis that it is their right to choose. For example, SU20A remarked:

“I think personally doctors should be more straight-forward when it comes to things like that...It would help if doctors said ‘stop or else you are going to die’, be more blunt about it. Frighten people perhaps into looking after their health. I think there is a sort of general ‘it’s up to you. It’s your human rights. You are entitled to do it’ (67-year-old female, retired IT engineer).

Finally, 62% of service users from case A, and 74% from case B, confirmed that they regularly researched their health using the internet both before and after consultation. Service providers at

both cases commented that, in some cases, this was beneficial since it led to greater understanding and a better managed outcome. In others however, it resulted in misunderstanding and confusion which could negatively impact on partnership working. The process of 'information ownership' is growing rapidly as mobile technology becomes an increasingly ubiquitous part of everyday life for most of the UK population. There is little doubt that it will continue to transform the way in which service users and providers interact with one another, as the former are able to access more-and-more information and choose how they utilise it to manage their health both independently and in co-operation with healthcare professionals.

7.10 Consumer society and shared healthcare services

It is difficult to account for the broad range of views and positions demonstrated and articulated by service users in relation to healthcare consumption in purely demographic terms. Social and financial issues can be said to have influenced (and limited) choice of destination to some extent (particularly in case B) but age, education, occupation and gender do not seem to predict or determine how service users interact and communicate with healthcare staff and services. Although many service users and providers from both cases expected or anticipated a correlation between age, education, occupation and/or assertive/deferential behaviours, this is not supported by the evidence.

Regarding age and confidence, service user views are often diametrically opposed. There is general agreement amongst service providers (from both cases) that younger service users are more likely to access healthcare services based upon expediency. However, the interview and PO data indicate that they do not seem more/less respectful or assertive than older service users when interacting with healthcare professionals despite speculation that this might be the case from some service user interview participants. It seems therefore, that individual attitudes and ways of behaving when accessing/using healthcare services probably reflect and incorporate broader social values and practises that have developed in response to consumer society and culture as well as previous experience of accessing healthcare service.

Although very few service users from either case identified themselves as customers or consumers of healthcare per se, there was a strong sense (in both cases) that high standards of customer service were important and desirable and that customer service skills were firmly embedded in most working environments including healthcare. According to Potter (1995) the primary role of consumerism is to place consumers' preferences on the agenda rather than encourage them to take account of the preferences of others. Consumer culture emphasises the value of individuality and encourages what Hochschild (2003) terms 'cowboy' or 'cowgirl' behaviour: 'alone, detached, roaming free' (p.21). The well-known trope 'because you're worth it' encourages the idea that consumerism is less about 'stuff' than about maintaining your own sense of self-worth and value in a society where failing to do so is tantamount to neglect. However, although some service users from case A and B exhibited self-interested behaviour when seeking healthcare/treatment, the data suggests that most continue to value the fact that care is prioritised according to greatest need. For example, SU14A commented:

"I think there are certain members of the public who see the health service just as their own little service, which it is to some extent. But they'll walk in and expect to be seen in the next five minutes. All their whims and wants taken care off. But, if you like, it is a bit like we were used to queuing, now we are not used to queuing. Nobody wants to queue anymore, nobody wants to wait. Nobody sees that there are other people there and you might have a splinter in there and the other guys just broken his leg. No because I was here first. And it's just you have to take everything as it comes. If somebody's in more need they should go first" (60-year-old male, retired stock manager).

Many service users also identified that NHS funding was inadequate and that service providers sometimes struggled to meet demand. Consequently, the need to carefully allocate resources according to the principles of equity will often be a constraining factor that prevents some service user's choices from being satisfied (Owens, 2012). Some service users were able to rationalise or

intuit that it was not in their (or others) interest to 'consume' resources in a purely self-serving or wasteful fashion since it could lead to deficit in the future that may negatively affect their/others ability to access services when required. Clarke et al (2007) also found that public service users were able to see beyond their own needs and expressed a desire to share quality public services with others (see 8.15). At the same time however, there was concern from both service users and providers from both cases that some service users were increasingly employing assertive modes of behaviour, acceptable and encouraged in other consumer-provider interactions, to gain advantage when attempting to access healthcare treatment and/or investigations. This typically involved the threat of complaint, or asking for second-opinion, to 'pressure' service providers into offering services that may not be clinically indicated. Service providers felt that it was important to encourage service users to be involved in the consultation/decision making process since it encouraged trust and transparency.

However, there was also concern from service providers (and some service users) that too much 'customer control' could influence healthcare professionals' ability to prioritise care effectively. For example, SU07B explained why they did not think the term 'customer' was appropriate in a healthcare context because:

"They [customers] have more clout and they demand what they want not necessarily what they need. That's the problem with the customer. The customer demands what they want. Not what they need" (70-year-old female, retired civil servant).

There is a seeming conflict, therefore, between the 'individual' ethos of the consumer (and consumer society) and the 'public' and collective values of the NHS. Each of the service users interviewed in both case expressed a strong sense of satisfaction with the care provided by the NHS as a whole even though many described poor or inadequate care provided by local healthcare services. This is probably because attitudes are learned and develop over a period of time following direct and indirect experience of services and products as well as exposure to marketing (Schiffman

et al, 2012). The majority of people in the UK, aged below 65 years of age, have, in all senses, been born into the NHS, whilst those who remember the pre-1948 years have almost certainly benefited from the provision of free healthcare. Consequently, service users are able to differentiate between local failings in care provision and the aims and ambitions of the NHS as a national institution. For each episode of poor care directly or indirectly experienced by service users, the NHS is still revered and respected by most people for the provision of universal access to healthcare that is free at the point of delivery. It remains a key election issue for all political parties and the idea that the NHS is something to be cherished and protected has permeated the national consciousness in a way that few other public institutions have. In this sense, the NHS retains high 'brand value' that is difficult to displace or contradict despite frequent local failures in care provision. However, to what extent the NHS can maintain widespread consumer confidence and brand reputation remains to be seen as funding and staffing issues continue to dominate the political agenda.

To summarise the final research question, most service users from case A and B wanted to be involved in the decision making process, but there was considerable difference of opinion regarding the level of participation considered desirable or necessary. The concept of service user as 'joint provider' or 'co-producer' of care helped to reinforce the value of individual opinion and some service providers demonstrated a high level of personal autonomy and competence re: self-management of their health. At the same time, others were less motivated or confident regarding shared decision making because they lacked knowledge (and felt that their contribution was unnecessary) and/or because they demonstrated a high level of trust and confidence in professional expertise and experience. Similarly, most service users believed that people should take responsibility for their health, but some also felt that health professionals had a responsibility to draw attention to poor health choices/behaviour etc., rather than defer responsibility to the individual on the basis that it is their right to choose. These differing perspectives are reflected in the typologies discussed in sections 7.12-7.14. Service users from both cases were also divided regarding whether increased choice and participation would lead to better service provision. Some agreed that

it would, whilst others expressed concern that too much influence/authority may lead to demanding and self-interested behaviour.

7.11 Case study propositions

Having discussed the evidence in relation to the research questions and consumer values regarding healthcare services it is possible to revisit the case study propositions formulated in chapter 3:

- The case study will show that Government policy (since the 1980s) has actively encouraged consumer behaviour amongst healthcare service users and that this behaviour is becoming the norm
- The case study will show that the relationship between service users and providers is dynamic and evolving but that offering service users greater choice may not be sustainable

The first statement is partially correct in that healthcare policy has clearly shaped and guided the standards and values of NHS organisations and the service providers that work for them. This is reflected in the way in which service providers engage with service users and encourage choice, shared decision making, co-production of care etc. For example, an e-mail sent by the senior manager to staff at the MIUs in case A and B emphasises the value placed on customer service by the organisation:

“A full days customer service training will be held on 7th April (bad day I know, but comes down to room availability) and will be provided by an external speaker...It would be nice to have a cross section of staff from the MIU’s” (24/02/2015).

Conversely, service users seem largely unaware of the consumer/customer agenda outlined by successive Governments and implemented by NHS organisations on their behalf. A number of older service users at both cases explained how they had noticed a less patriarchal and more collaborative approach from service providers when interacting with service users (over the years). This was

valued and considered a progressive step by these service users but only one (SU09A) identified policy (the *Patient's Charter*) as of significance regarding this dynamic.

In one sense then, it is true to say that consumer values are 'becoming the norm' since NHS organisations must continue to ensure that service users are able to make choices about their healthcare options etc. in accordance with policy directives. On the other hand, not all healthcare service users want to participate in the decision making process and prefer healthcare professionals to advise and guide their care/treatment options to a greater or lesser degree (as outlined by the typologies below). Indeed, very few of the service users interviewed in case A or B considered themselves customers of healthcare in the true sense of the word (i.e. there is no difference between NHS services and those provided by any other service industry) despite the fact and many described how they valued excellent customer service and were prepared to seek-out healthcare from the most convenient provider. There is an apparent contradiction therefore, between many service users' behaviours and values when accessing healthcare services and their philosophical conception of their 'role' or designation as patient/service user/etc. The most likely explanation for this phenomenon is the high level of respect and trust all interview participants (service user and provider) had for the NHS as an institution that represents the principles of fairness and equality. Part of the reason for this view is that attitudes are learned and developed over a period of time. Those relevant to consumer behaviour are typically formed as a result of direct experience with the product or service, word of mouth or exposure to direct marketing (Schiffman et al, 2012). Probably the most important factor regarding the respect and appreciation that the NHS continues to enjoy is personal and vicarious experience as discussed in section 8.10.

It is also interesting to note that when (non-UK citizen) SU04B was asked whether they viewed themselves as a customer healthcare they replied:

"No. I think in [home EU country] I did because health care is privatised. But here it's not...I don't think people treat you differently so I guess it's just the knowledge of the fact that it's a

[word unclear] *so you automatically more-or-less have a right to it. So I don't view myself as a customer here"* (24-year-old female, customer service).

In this sense then, the proposition that consumer behaviour 'is becoming the norm' is less accurate since although many service users demonstrate consumer modes of behaviour when accessing healthcare (encouraged by Governmental and organisational initiatives), there is still widespread resistance to the idea that healthcare should be viewed in purely transactional terms. The second case study proposition is probably closer to the truth in that the relationship between service users and providers is 'dynamic' and constantly evolving in relation to the way in which NHS services are organised and offered, on the one hand; and how consumer culture continues to shape and direct modes of behaviour and interaction across society as a whole, on the other.

It was observed in chapter 2 that there has been a conceptual shift in social attitudes as traditional market (and marketing) principles have been applied to service-orientated institutions such as healthcare. My study provides examples of the way in which people interact with one another and their environment has changed, and continues to change, in response to social, economic, cultural and technological drivers. For example, a number of service providers observed that some healthcare service users employed the same 'types of assertive behaviour' that they used when communicating with more traditional customer service providers (e.g. retail). Consequently, although many service users seem to value and wish to retain the sense of equity and collectivity that the NHS 'brand' entails, there is also a widespread desire to see services that are more convenient, accessible and customer focused, in keeping with other aspects of consumer society.

This shift in perspective is encouraged by advances in Web 2.0 enabled technology that allows people to describe and review their experience in real time (Carter and Martin, 2016). As a result, there seems to be a 'mutual adaptation' between service users and providers as consumer culture raises expectation regarding the provision of healthcare (and other) services and directs healthcare policy to produce new ways of thinking and working for healthcare professionals. Both strands

influence and encourage one another as service users and providers adopt fluid modes of behaviour to negotiate this dynamic landscape. For example, SP07A commented:

“I don’t know if we are aware that we do it and it might be a way of trying to allay anxieties about being in a hospital setting. This is just another...service that you need but it happens to be healthcare so don’t be alarmed...I’m not sure if it is a positive thing or not really. I think it probably is. I think if you use it to your advantage then I think it probably is but I think the concern is that everything will fuse and merge and become muddled and healthcare will just become another commodity...I suppose we are looking at it with early 21st century eyes. Maybe in fifty years’ time people won’t look at it in quite the same way” (ENP with 7 years’ experience).

Similarly, when asked if they encouraged service users to make decisions about their healthcare, SP10A replied:

“Only if I detect that they want that as part of the partnership that I’m trying to develop. Some people, if you give them too many options, choices, believe that you don’t know what you’re doing. What they’re articulating is that they’re not used to the idea of choice and therefore they want to be directed...I have to read the patient and decide on whether or not it is somebody who would engage in the idea of choice” (ENP with 11 years’ experience).

Whilst many service users benefit from participating in the decision making process, and taking greater responsibility for their care and management, not all are able or wish to do so.

The final part of the second proposition suggests that offering service users greater choice may not be sustainable. This is difficult to predict since some choices are sustainable whilst others require further funding and/or change to current working practice. For example, the senior manager explained the practical difficulties of accommodating requests to return for outpatient and clinic appointments at particular times:

“They expect to be able to do their day’s work and then come to MIU at their convenience. They pick up on certain things in the media and the television as well. Mr Cameron now obviously wants seven days a week, 24-hour health care available. They’ve heard that headline...You have to say ‘we try but...if we bring you back to clinic [at 19.30] and I need a physio they haven’t gone 24-hours yet’. So it is not always that simple” (senior manager with 19 years’ experience as an ENP).

It was observed in chapter 2 that although many service users want to be more involved in individual decisions about their treatment and care, there is little evidence that they want increased choice of healthcare providers except where local services are poor (see 2.30-31). What they do seem to want however, is better and more convenient access to services. The study by Hunter et al (2013) and the PA and RCEM report (2015) examining patient perspectives when accessing A&E services identified that, for many, the decision to attend urgent care providers was a combination of confidence in the service provided and convenience to attend at a time of their choosing. The data from this study demonstrates how MIUs offer access to primary and secondary care services and seem well placed to fulfil both of these criteria through the introduction of co-located GP services and ENP clinics. According to Monitor (2014) the aim of creating walk-in centres that provide these type of services is to be more responsive to peoples ‘busy lifestyles’ and to offer them ‘more choice’ (p.4). However, this will not be possible without largescale capital investment and that seems highly unlikely given current levels of funding and planned cuts across the NHS in England (Bloch-Budzier, 2016; Dorsett and O’Mahony, 2016).

7.12 Typologies and motivation

As noted in the preceding sections, the broad range of views and positions demonstrated and articulated by service users and providers in relation to healthcare consumption seem, in part at least, to be the result of social values and practises that have developed in response to consumer society and culture as well as previous experience of healthcare services. Through careful analysis of

the data, it is possible to identify five different healthcare consumer typologies: Passive, Reluctant, Pragmatic, Fully-engaged and Assertive (see below). Once these categories were confirmed, the data were re-evaluated and reconsidered to ensure that these constructs account for all instances of the phenomenon involved (Shenton, 2004). Although they represent stable attitudes regarding healthcare consumption patterns, service users may move forwards or backwards through the different categories, in a sequential or non-sequential fashion, depending on their experience and engagement with consumer society and healthcare services. For example, service users from both cases described how they had gained and lost confidence when interacting with healthcare professionals and managing their own healthcare at different stages of their life. SU09A described how they had become more confident as they had got older:

"I would probably be on the weak side but yeah I'm not frightened [to challenge]. As you get older you get more rebellious and, as you've seen, old people start to argue about everything. So I think it is an age thing rather than a natural ability...as a young man, no, the confidence isn't there" (70-year-old male, retired engineer).

Whereas SU12A described how they had lost confidence communicating with health professionals over time:

"I think the younger ones question it far more. I mean obviously now I think I do to a certain extent but perhaps I haven't. I definitely have not always been like that...I suppose it's like an insecurity thing isn't it" (71-year-old female, retired cook).

Service users' ability and motivation to research, co-produce and manage their healthcare also determines their level of engagement as does their trust in healthcare professionals, local healthcare providers and the NHS as a whole. The Wanless Report (2002) identified that 'fully-engaged' service users had the potential to deliver substantial savings to the NHS, but it is difficult to predict how many service users will become - and remain - 'fully-engaged' throughout their lifetime. Another important consideration regarding healthcare decision making is urgency of need, since healthcare is

not a typical market commodity which is not consumed for its own sake. Most healthcare service users are what Beresford (2009) describes as 'involuntary consumers' (p.206) who are encouraged or compelled to seek out healthcare services by 'internal' motivators such as physiological or psychological pain and discomfort (Evans et al, 2009). 'External' motivators, on the other hand, focus on the appeal or desirability of products/services and may eventually become internal motivators in the form of preferences following instrumental or vicarious learning (e.g. previous experience or word-of-mouth).

In healthcare, motivation might be influenced by the location of provider, convenience issues, access issues (permeability), customer service and environmental considerations. In simple terms therefore, internal motivation may be understood in this context as a 'need' (medical attention) whereas external motivation represents 'want' (the desirability or appeal of a particular provider where choice is available). The data demonstrates that a large number of service users attended case A and B largely because of external motivators. However, in some instances, external motivators seem to have been transformed into internal motivators and, in case B in particular, service users often presented with potentially life-threatening 'needs' since they trusted staff to make the correct clinical decision on their behalf. This is largely because they had developed a high level of confidence in the care provided at the MIU in case B as a result of previous experience and customer service considerations. Service users valued the convenience of attending case A and B but, in the case of the latter, they also did so because they provided highly personalised care. Owens (2012) concludes that personalised health care 'may be conceived to combine the qualities of convenience, independence and intimacy' (p.30) and it is interesting to note that convenience is regarded as an important consideration by all five healthcare consumer typologies outlined below.

7.13 Five healthcare consumer typologies

As noted in section 3.27, relatively early in the data analysis process I became aware of patterns within the data that suggested there may be at least five potential healthcare consumer typologies.

This was a serendipitous discovery since I had not considered the possibility that the data may reveal common preferences and characteristics that would help to explain healthcare consumer activity and behaviour in case A and B. It is important not to ignore or overlook unexpected or unsolicited findings or perspectives that occur as the research process develops and unfolds since they may provide further insight, as in this case, or enable exploration of an existing idea or position to its fullest extent. Serendipity has played an important role in many discoveries in science, social science, technology and the arts (Rosenman, 1988; Van Andel, 1992, 1994). However, just because something is discovered by 'chance' doesn't mean that the phenomenon being investigated is behaving erratically or unpredictably. Instead, it means that the researcher has made an unexpected discovery due to the methodology and data collection instruments they have put in place (Cramptom, 2017). According to Simard and Laberge (2015) competencies associated with serendipity include alertness, flexibility and an open mind in order to adapt to new experiences and discoveries in the field. The formulation of healthcare consumer typologies during this study represents 'added value' over and above what I originally planned to achieve. However, they complement and inform the original research questions providing greater depth and insight regarding motivation, confidence and engagement. The five healthcare consumer typologies identified and collated from the data are as follows: Passive, Reluctant, Pragmatic, Fully-engaged and Assertive.

i) Passive consumers of healthcare

Service users in this typology demonstrate a high level of confidence in the care and treatment provided by healthcare professionals and the NHS. They are content to be guided and advised by healthcare professionals and are generally deferential and non-questioning during interactions. They tend to lack confidence and/or knowledge and their level of engagement is generally low. They are unlikely to research health related matters using the internet since they prefer to talk to a

healthcare professional and it can also increase anxiety. However, they may seek out alternative healthcare provision if it is more convenient.

Five service user interview participants from case A, and two from case B, fulfilled the criteria for this typology (see appendix 14). Representative data includes the following:

"I'm not an expert so I don't really know what's going to happen, I don't really understand. So I needed her advice...It's an authority thing I think. Doctors and nurses are the ones that look after you, the higher authority, they treat you to make you better" (SU07A, 18-year-old female, student).

"You get to a situation sometimes where a doctor will say well you know "what do you want me to do?" and I feel like saying "I've come to you. You're the doctor" ...They are afraid of getting things wrong perhaps. But to my mind it's, you need to be, well you go for a consultation and that's what you expect isn't it" (SU12A, 71-year-old female, retired cook).

"I'd just want them to say 'you've got this or that' and then, you know, just give me the tablets or if not then just treat me there and then and then I'd go home" (SU21A, 20-year-old male, student).

"I think there is a lot of scare mongering on the internet. People look up and see symptoms and they think they've got that. I'd rather just go and find out from somebody that knows what they are talking about" (SU02B, 39-year-old male, carer).

“I don’t understand that kind of thing [healthcare] you know what I mean. I can’t really understand that side of it. I’m not clued up” (SU03B, 36-year-old male, carpenter).

ii) Reluctant consumers of healthcare

Service users in this typology demonstrate a high level of confidence in the care and treatment provided by healthcare professionals and the NHS but will reluctantly question/challenge professional opinion/operational process to achieve their aims if necessary. They are generally uncomfortable/lacking in confidence in this role and are more likely to advocate on behalf of a family member/other rather than themselves. Knowledge tends to be limited and engagement is typically low. They may seek out alternative provision if it is more convenient and may research their health using the internet.

Three service user interview participants from case A, and four from case B, fulfilled the criteria for this typology (appendix 14). All of them demonstrate reluctance to make decisions regarding their own care on the basis that healthcare professionals are more knowledgeable. However, they may advocate on others behalf or research their healthcare/seek information to a limited extent.

Representative data includes the following:

“To me, being asked my opinion depends on the scenario. If she [GP] was asking my opinion on how I thought [child] was, as his mother I could answer that. But if it came down to his medical condition I can’t have an opinion on that, I’m not medically trained and I wouldn’t presume to have an opinion...So I am more than happy to defer to the person who has more knowledge than me...I’m happy to give my opinion but I don’t expect, she’s a GP and I’m not” (SU13A, 39-year-old female, administrator). (SU13A, 39-year-old female, administrator).

“If I am accompanying someone like my mum or my son who has got [illness] I need to be involved because they live with me and so I’m responsible in the end for administering medication and their ongoing health. If it’s me, I’m ok. I’m not a sort of a stressed patient. I’m quite accepting of what they say. I don’t really make a fuss or question their judgements. I possibly wouldn’t question their judgement on anybody anyway but I would prefer to know exactly what’s happening” (SU20A, 67-year-old female, retired IT engineer).

“I think if the medical decisions are about what they’re having to do, no. I think they should have the say so because they are the professionals, they are the experts and I’m not. But I do like to be informed continually about what they’re doing just so I know what’s going on...I trust medical staff because that’s their profession. They know what they are talking about” (SU14B, 41-year-old female, tree surgeon).

“I know that I’m not a professional, because I know that a pain here or an ache there can mean dozens of things, I usually look it up and then tell myself ‘I might as well go to the GP’” (SU04B, 24-year-old female, customer service).

“I need someone who is qualified to do the decision making and I go along with it. But I have actually found that I’ve had to do that. I’ve had to look things up and come to my own conclusions about things and that’s got me down the road” (SU11B, 61-year-old male, retired).

iii) Pragmatic consumers of healthcare

Service users in this typology want to make choices about their healthcare in partnership with healthcare professionals. They are content to be guided by professional recommendation but will question/challenge professional opinion/operational process if they feel they are not receiving the services/care they require. Typically they are knowledgeable regarding healthcare options and they will opt to use an alternative provider if it is more convenient. Engagement is typically proactive and they are likely to research healthcare issues using the internet.

Six service user interview participants from case A, and five from case B, fulfilled the criteria for this typology (appendix 14). Representative data includes the following:

“...I think what we should be doing is educating about our own health and promoting good health at a much younger age. Because then that becomes engrained and people are more likely to continue that through adulthood and so, therefore, their need for use of these services may be much less. From the perspective of gaining information about conditions and things like that it should be left to the professionals who have studied for goodness knows how many years. You know, to offer a diagnosis” (SU02A, 50-year-old male, support worker).

“It’s nice to know what’s going on and what you can have. Sometimes, if you’re not careful, you’ll just sit there and go “I’ll take these pills, I’ll take these pills”. You need to have some interaction otherwise you end up just taking pills, you know...You have to take the happy medium and at the end of the day [service users] have points of view they can put forward but you have to work within the system...Because you’re the experts you know, you’re the people that have to deal with 20 people turning up at once and stuff like that” (SU14A 60-year-old male, retired stock manager).

“I went online and looked up and got everything I could. And I had such a good understanding of it...I learnt so much about that condition. And I copied everything and put it in a file. I fully understand that and obviously if there were any other occurrences they told me just to go straight in to [Hospital 2]. With the leg I didn't and with these things [I am] totally confused. There was too much information for somebody who is not a full medical person” (SU09A, 70-year-old male, retired engineer).

“I want to know what's going on and obviously if you get, for example, a set of two options that you know what the pros and cons are or what the desired outcome would be of each one so you can make an informed decision as well or you can support the healthcare [professional's] decision” (SU09B 25-year-old female, teaching assistant).

“People are only human and anyone can overlook or oversee something and they might think they got it right but they might not know themselves and if you're not prepared to speak out and say 'I want a second opinion' or 'can you really look at that' a lot of people probably wouldn't. They would just go 'oh, OK then, thank you very much, goodbye'. But I wouldn't. I would be like 'I'm not happy with that. I want someone else to have a look at it” (SU10B, 25-year-old male, unemployed).

“I can appreciate that I won't understand everything that they're talking about, you know all the technicalities that they're talking about, but I am the person that they're talking about and I think it is only right that I should be involved as much as I can” (SU12B, 48-year-old female, unemployed).

iv) Fully-engaged consumers of healthcare

Service users in this typology are knowledgeable regarding healthcare services/options (through experience or research) and have a strong sense of what they are entitled to receive regarding treatment and care. They are confident and willing to question/challenge medical opinion/operational process and/or make a complaint. However, they will also negotiate in order to achieve their aims. Engagement is high/proactive and they research healthcare issues using the internet. They are able to employ relevant evidence to support their point of view and will seek out alternative provision if it is more convenient.

This typology is named after the 'fully-engaged' service user identified by Derek Wanless (2002) and discussed in chapter 2 and above. Wanless estimated that high levels of individual engagement with the NHS could deliver substantial financial savings. In this context, the designation simply identifies that these service users demonstrate high levels of individual engagement with their healthcare production and management that may/may not result in financial savings as they accept greater responsibility and control. Five service user interview participants from case A, and seven from case B, fulfilled the criteria for this typology (appendix 14). Representative data includes the following:

I'm quite intelligent and I want to understand the process and I want to understand what is going on...I suppose it's your...perceived view before you arrive of the healthcare staff and what you're expecting from them" (SU08A, 54-year-old female, lecturer).

"I like to feel that they are listening to me and not just dismissing it as nothing. It's better to be safe than sorry...I would like an influence. I would like to say what I want them to do...I think I'm just that sort of person. I like to have my own way a little bit. And I know if you don't ask you don't get. So that's one of my key things. I also know that, to an extent, they'll

listen to me. Well I feel like that anyway which is why I'm happy to ask. But I know other people are going to leave it and say "well, they are the doctor. I don't really want to question them". But, as I said, if you ask get you don't get" (SU11A, 20-year-old female, student).

"I suppose I'm lucky in a way because I do ask questions and some people haven't got the confidence because they think the nurse knows best or the doctor knows best and they won't discuss it with the doctor. They'll come out and say "he's told me to take these, what are they for?" "I don't know". But I won't. I like to know what they are for and what's going on with me" (SU17A 53-year-old female, unemployed).

"Well if there is a discussion you know what they're thinking and they know what you're thinking. If they just make a diagnosis and don't say anything and then just say that's what we're going to do then you don't really know their thought process or how they got there. Quite often I think you need to make choices about who you might see...I think some [healthcare professionals] have got more expertise than others. I take what they say with a pinch of salt and then I want a second opinion" (SU05B, 62-year-old male, retired managing director)

"I think to be involved and to feel that you are taken seriously and you're viewed as a credible individual with a mind of their own is important. So yes, I would expect to have the opportunity to be involved and I would value that...I would expect to have a hand in those decisions. Obviously, they need to be informed decisions. But yes, I would expect to be able to take some of those decisions and have options myself without being told what was best for me necessarily" (SU13B, 53-year-old male, civil servant).

“I was straight on the internet and thought ‘why is he suddenly doing this?’ and that reassured me because straight away it said [surgical procedure] is quite normal on its own and quite often the surgeons will [describes procedure]...To ask is but a moment’s shame but not to ask is a lifelong shame. Not to ask is to live in ignorance” (SU19B, 70-year-old male, guest house manager).

v) Assertive consumers of healthcare

Service users in this typology have a very strong sense of their consumer rights and entitlements. They may possess or demonstrate unrealistic expectations regarding service provision and are disappointed if their expectations are not fulfilled. Knowledge regarding healthcare options/management may not be accurate or fully understood and they are often distrustful of professional opinion. They are confident and willing to question/challenge medical opinion/operational process and/or make a complaint in order to achieve their aims. They will seek out alternative provision if it is more convenient and are likely to research healthcare issues using the internet.

Only two service user interview participants from case A fulfilled the criteria for this typology (appendix 14). This seems to support the view expressed by service providers that only a small minority of service users demonstrate highly assertive behaviour and/or unrealistic expectations regarding healthcare provision. However, this is a very small sample and evidence from service provider interviews and participant observation data contributed to the construction of this typology (as elsewhere). Representative data includes the following:

"...say you go into a restaurant to order food and your food is cold, you say something about it. I come here for healthcare and if I do not think my health has been taken care of then I'm going to complain. It's exactly the same" (SU04A, 22-year-old female, student).

"I'd say I won't be told. I want someone to explain to me why it is what it is and not something else...You can't tell me how to live my life. In four weeks' time or whatever I could say 'no, I don't want to do this anymore and what are you going to do about it? I'm going to go back to normal. What are you going to do? There is nothing you can do about it. It's not what you want. It's what I want'" (SU18A, 52-year-old female, driver).

"There was a case the week before last actually and this man wanted a chest x-ray. So I said OK, are there any injuries to your ribs? No, he had a three or four week history of a chest infection, two lots of antibiotics by his doctor. He didn't think it was getting any better and thought he had pleurisy...So he was demanding [a chest x-ray] and it got very heated and in the end, I was still trying to book him in at the time, and he just upped and left and the language was foul. Because that's what he wanted. He couldn't understand. I'm saying "if I feel you need a chest x-ray then I need to refer you on to A&E but that wasn't [what he wanted]" (SP04B, ENP with 6 years' experience).

The patient complained that he had been waiting longer than another service user and should therefore be seen next. He did not accept the explanation provided and acted in a belligerent manner. He had been seen at MIU the previous week but did not feel his injury had made sufficient progress. He was seen by another ENP who confirmed the initial diagnosis and reiterated the importance of continuing the treatment advised/provided.

However, since the injury remained painful, she referred the patient to a specialist team at another hospital who offered to review the injury that afternoon. When advised of the same-day appointment, the patient declined because he was too busy that afternoon and asked for the appointment to be moved to another day. The earliest he could be accommodated (because of the clinic schedule and weekend) was 4 days later which the patient agreed to despite having insisted on the urgency of his need (FN: Dec.04, 2014).

A service user presented at the MIU in case B with a history of non-specific illness. During the consultation it transpired that the primary reason they had attended was to request a new limb support since the one that they wore was old and dirty. The ENP provided a new support but declined the service user's appeal for further 'spare' supports because of limited stock. However, they advised the service user that they were welcome to return in the future when the new support was no longer fit-for-purpose. The service user became verbally aggressive and stated their dissatisfaction with the service provided in case B and by the NHS in general (FN: Apr.22, 2015).

One common feature demonstrated by all five categories is willingness to seek out alternative provision if it is more convenient. Speed of service at a convenient time, is an important indicator of service user satisfaction that is encouraged by healthcare policy and legislation (DH, 2013; Monitor, 2014) as well as by local healthcare providers through the FFT etc. Service providers at both cases also identified that the idea that services should be tailored to individual need is further reinforced by consumer society, the media and political rhetoric. For example, SP02B draws attention to the view that services should be provided quickly and should always be striving to be better and more efficient:

"I think there are probably numerous different factors but I think it is general expectation in society, a perception that things; we are just in general a more demanding society really.

Take the internet for example, I want the world's fastest broadband speed. A few years ago we'd never even heard of the World Wide Web and now...it's got to be 56 megabytes a second...It's just everything. I think our general perception of everything is faster, bigger, greater, better, come on, yesterday because that's just society isn't it. And I think it just incorporates everything. So I don't think it's specific necessarily to the NHS. It's just general perception of the world as a competitive place. And it's becoming more so all the time and therefore you can't sort of go to work being competitive and come to the NHS and not be like that. I don't think there is that separation. It's just a global way of thinking isn't it, very demanding" (ENP with 1 years' experience - previously paramedic).

Overall, most service user interview participants correspond to the Pragmatic or Fully-engaged typology (appendix 14). Age is fairly evenly distributed amongst the different typologies (with the exception of Assertive since it is such a small group) and does not seem to predict attitudes to healthcare consumption (appendix 15). Similarly, academic qualifications are fairly evenly distributed throughout the Reluctant, Pragmatic and Fully-engaged typologies. However, the latter demonstrates a higher incidence of degree and masters level qualifications than the others. At the other end of the spectrum, the Passive typology does not exhibit any qualifications above A level and most are GCE/GCSE or below. This seems to suggest that those who have been educated to a higher level are less likely to adopt a passive position when accessing healthcare services or advice. However, the sample is small and it is important to recognise that those with qualifications at GCE/GCSE or below are well represented in the Pragmatic and Fully-engaged typologies. Regarding occupation, the Fully-engaged typology is populated by a high number of service users with professional or managerial type positions (before or after retirement). It is interesting to note that although SU17A was unemployed when interviewed, they had previously worked as a healthcare assistant which may explain why they exhibit a high level of engagement regarding healthcare

decision making etc. Similarly, although SU20B works as a lorry driver he is also a retired police officer who previously occupied a senior managerial position. This provides some support for the idea that social and cultural capital has a positive impact regarding individual decision making and choice. However, it is also important to remember that the sample is small and it is difficult to draw firm conclusions from this data set alone.

7.14 Contradictory typology

According to Yin (1993, p.45) good research design should identify the critical evidence (interviews, documentation, observations etc.) that will support the major hypotheses of the study, including 'potentially contrary evidence' that may support rival hypothesis. Consequently, it is important to note that one service user (SU16B) demonstrated a number of seemingly contradictory views and behaviours that made it difficult to assign them to a particular category. For example, SU16B explained how they had tried to make an appointment to see their practice nurse (regarding a long standing issue) but had been advised to attend an emergency care provider since there were no appointments available. SU16B had clearly attempted to seek care from the most appropriate care provider and, when it was not available, they had chosen to attend case B. The principle reason for this decision seems to be a mixture of convenience and experience and SU16B explained how, in the past, they had attended Hospitals 1, 2, 3, 4 and 5 for a variety of care needs.

"You've picked a good person [regarding] how this place compares, in answer to your question...I always find that I'm dealt with extremely courteously here and there never seems to be an enormous wait. You are never sort of hanging around...The care and the ability of the staff that I've seen here to put a patient at ease has always outshone the major hospitals...by some distance" (46 year-old male, unemployed transport manager).

When asked if this had influenced their decision to return they replied:

“I don’t like to come to hospitals. I don’t think ‘oh I can’t wait to go back there again’. I don’t think like that. If you imply by the question if I had a problem and I was in [case A town] for instance would I rather come here, back to [case B town] to see the A&E here or go and pop into [case A] I would rather come here. But it depends on the nature of the problem obviously. If it’s an emergency, then you need to go to the closest place don’t you?”.

SU16B seems to suggest that they would be prepared to travel eighteen miles from case A town to case B town (providing their complaint was not an emergency) since they preferred the quality of service provided there. This type of behaviour is broadly concordant with the senior managers’ assertion that, for some, seeking healthcare is analogous to returning to a ‘favourite supermarket’ (see 8.5). SU16B goes on to explain that he is confident to challenge medical opinion if needs be and that he wants to be fully involved in the decision making process:

“There is a train of thought that would say these are professionals who know what they are doing. They’ve been doing these jobs for a very, very long time and we have no reason not to trust their judgement because they deal with these situations every day. It’s what they do. However, I’m the kind of person who wants to know why. I like details”.

This type of self-confident and hands-on approach to healthcare is consistent with the Fully-engaged, Pragmatic and possibly Assertive consumer typologies but later in the interview SU16B appears to contradict this view. When asked if he has ever researched his health using the internet he replied:

“I think it is a silly thing to do. Professionals know what they’re talking about. They are the people to talk to. But I have looked at things. I just kept looking and yeah I’ve had that that that that and you think it can’t possibly all be right can it. I have looked things up but the bottom line is it really truthfully a silly thing to do. Go and talk to a professional...So not having that expertise it is really stupid to do so and I think that people who are of that kind of

ilk and try to self-diagnose make a grave mistake. A big error. Make themselves worse if they are not careful”.

Although this statement refers principally to self-diagnosis it does not seem to reflect the more independent-minded views expressed above. Similarly, when asked if he considered himself an expert patient, SU16B remarked:

“No. Have I had an unfortunate, drawn-out and quite lengthy experience of being in hospitals as a patient then yes. But an expert? Goodness me. What’s an expert patient?”.

Finally, when asked if he considered himself a customer of healthcare SU16B replied:

“No. definitely not. I’m quite old school and I don’t particularly like to find myself in hospital for any reason unless it’s absolutely necessary. But a customer, goodness gracious no. No. I’ll tell you why. Our National Health system is the envy of the entire world, no matter what press it gets. I don’t think there is any doubt about that. And the reason that I don’t feel like I’m a customer is from the day you start working and paying your taxes we’re contributing towards it. It’s ours, it belongs to us and why should I feel like a customer, it’s a right”.

These (and other) contradictions and inconsistencies expressed by SU16B, seem to encapsulate in microcosm the broader role-conflict expressed by other interview participants regarding engagement with healthcare services/professionals. However, whereas they were able to articulate a clear typological position (at that point in time at least), SU16B seems confused regarding his values and principles regarding healthcare. Part of the reason for this might be that during the course of the interview he referred to a number of historic and long term medical conditions as well as the care he received/has received in case B. He may, therefore, have been articulating and amalgamating different opinions from different periods of his healthcare history or it may be that he was still formulating a clear position from a highly complex and evolving medical history. In either case, he might best be regarded as a contradictory or transitional typology since his views

incorporate elements from all five constructs in a fluid and often unpredictable fashion. The remaining 39 service users were re-evaluated and reconsidered once the initial categories had been completed to confirm that the constructs to which they had been assigned accounted for all instances of the views/behaviour they demonstrated.

7.15 What do the findings/typologies add?

A small number of international studies/papers have assessed how service user choice and co-production of care has influenced the relationship between service users and providers but there is no recent research on this topic from the UK. The 2015 study by the PA and RCEM examined patient perspectives when accessing A&E services to receive primary care which included discussion of service user motivation regarding convenience and the 'brand' strength of A&E. However, this did not consider how consumer society/culture have influenced and inspired some of these attitudes and modes of behaviour, or how healthcare policy encourages service users to seek out the most convenient care provider. Similarly, although Hunter et al (2013) provide valuable insight regarding how service users with long terms conditions chose which healthcare provider to access during a crisis, they do not evaluate social and policy drivers that may have contributed to the decision making process. Consequently, whilst other studies have identified convenience and trust as important considerations when service users make decisions about healthcare provision, there is little evidence to indicate how policy, and other factors, contribute to this process and what effect this has had on expectation of care and service delivery. My study builds upon the findings from *Creating Citizen-Consumers* (Clarke et al, 2007) in order to explore the relationship between consumer attitudes and behaviour, and healthcare management and delivery. It also evaluates the extent to which consumer attitudes to healthcare have changed and evolved since Clarke et al published their findings a decade ago.

For example, both studies found that the majority of healthcare service users rejected the terms 'consumer' and 'customer' in favour of 'patient'. There was also agreement that the majority of

service users do not focus purely on their own needs but on how the service (and the NHS as a whole) functions for other users. Lastly, service providers and managers in both studies expressed concern that consumer principles risked creating health inequalities as service organisations struggled to manage demand efficiently and equitably. However, there were also a number of important differences between the two studies. Firstly, whereas service providers in Clarke et al's study rejected the terms 'customer' or 'consumer' of healthcare, service providers from case B, and the senior manager, seemed much more receptive, and in some instances favourable, towards this conception of service user identity. Service providers from cases A and B also recognised that public expectation regarding service delivery would continue to change and evolve in response to increasingly competitive market principles and consumer drivers such as technology. Although they collectively acknowledged that this represented a significant challenge regarding professional conceptions of best practice, many of them also believed that there were advantages to be gained, particularly in terms of service user satisfaction, by embracing a more customer focused model of interaction. This was particularly evident in case B where the MIU had successfully managed to adapt to the needs of its community and provide an almost bespoke service. However, this success was offset by rising attendances and increased workload which threatened their ability to continue to deliver a high quality service without an increase in staff etc.

Finally, and perhaps most significantly, the service users in Clarke et al's study considered the language of choice and shopping inappropriate regarding healthcare. In cases A and B, service users were much more receptive to the potential benefits that choice offered and some drew direct comparisons between healthcare and their experiences with other service providers including retail, dining and other hospitality industries. One of the reasons for this apparent change in perspective is almost certainly the increasing use of Web 2.0 technology since Clarke et al's study was completed in May 2005. This has encouraged the active production and sharing of healthcare (and other) data by service users and marks the transformation of the internet from a static source of information to a much more versatile form of communication. Choice has become increasingly ubiquitous in

everyday life and, as the senior manager observes, seeking healthcare has become analogous for some with returning to a 'favourite supermarket' (see 8.5). Similarly, SP10A commented regarding accessibility or 'permeability' issues:

"...18-34 [year olds] will tend to come to A&E and emergency care rather than trying to get a negotiated GP appointment. I think they see healthcare as...a consumer item. So they shop, they come here" (ENP with 11 years' experience).

Consequently, despite the assertion in chapter 2 (section 2.17) that using healthcare services is 'not the same as shopping', it is probably fair to say that, in some circumstances at least, it is *more like* shopping than it has ever been.

Another important difference between my study and Clarke et al's is the methodology and the sample size. Clarke et al interviewed 24 managers, 23 front-line staff and 10 service users across three public services: social care, policing and primary healthcare. They also undertook 6 service user focus groups. However, the majority of their data was obtained from a questionnaire with 50 questionnaires being sent to staff and service users (of each service) respectively at both research sites (600 in total). The return rate for healthcare staff and service users is unknown but, overall, it works out as 55.9% return rate for staff and 35.3% for service users. During the course of my study, I interviewed a total of 40 healthcare service users, 16 healthcare professionals/care workers and one senior manager. I also undertook a total of 28 shifts in both cases as a participant observer (Table 20). I chose to use semi-structured interview to capture service user voice for a number of reasons. Firstly, it helps to ensure that service users' recollection of the care/treatment/service they have received in case A or B is immediate and fresh in their memory. Secondly, it allows direct comparison with service provider views (and observed behaviour) regarding the experience and events they describe in situ. I also wanted to triangulate this source of information with the participant observation (and FFT) data in order to maximise the credibility of the findings.

The healthcare consumer typologies outlined above offer valuable insight into the complex way healthcare service users and providers are reinventing how healthcare services are accessed and delivered in an urgent care context. Service user and provider views help to identify the different qualities, characteristics and behaviours that make up each typological category and although not exhaustive (as demonstrated by the 'contradictory' type) they help to explain motivation and expectation regarding healthcare services in England. The typologies take into account service users' willingness to employ technology to research and/or self-manage their complaint; whether they feel confident to question/challenge/provide relevant evidence during consultation with healthcare professionals or whether they adopt a more deferential approach; and whether they have a sense of their rights/entitlements as a consumer of healthcare services. Different levels of levels of engagement, knowledge and confidence help to predict service users' willingness and ability to manage and make decisions regarding their healthcare. Most service users at case A and B described how they wanted to be involved in the decision making process but there was also considerable difference of opinion at both cases regarding the level of participation considered necessary or desirable. Other consumer typologies have been formulated in the past but none relate to healthcare consumer activity in the UK/NHS.

7.16 Limitations of the study

The chief limitation of this study is transferability (generalisability). The selection of multiple cases was part of the initial research design and the study took place at two MIUs situated in the south of England. Although the cases were located in different parts of the county, and contrasted demographically and economically, there was a great deal of ethnic homogeneity that may not be representative elsewhere in the UK. Cultural homogeneity is more difficult to assess since most UK citizens are exposed to consumer culture in some form or other. However, some cultural groups may reject, or at least demonstrate resistance to, consumer ideals since they are incongruent with other beliefs and attitudes. Consequently, their views regarding healthcare services may not be framed in

a same context as other members of the population. Although the sample size is appropriate for a case study project of this nature, further research at other geographical locations in the UK would help to confirm or disconfirm the findings. This is reinforced by the paucity of UK research in this area which makes comparison and objectivity difficult to achieve at the present time.

Another issue that should be acknowledged is the possibility of selection and sampling bias.

Although the interview participants were selected at random intervals throughout the day, over a period of time at each case, most were satisfied (to a greater or lesser extent) with the care they received at the point of delivery. This almost certainly reflects a degree of selection bias in that many of them were treated relatively quickly (a source of satisfaction) and therefore had the time and inclination to discuss their care, views etc. The unfavourable and critical comments provided by the FFT survey provide a degree of insight regarding service user dissatisfaction and frustration.

However, it is important to note that the majority of FFT responses are from case A (1394). This almost certainly reflects the fact that the MIU in case A is a larger department than in case B and is open 24-hours a day whereas case B has limited opening hours. It may also reflect the time of year that data collection took place in each case. In the former, it included the busy Christmas period (November to January) when attendance is typically highest and waiting times tend to be longer. Consequently, whilst the FFT data represents a valuable source of comparative data, it is not entirely dependable on its own.

A further source of potential sampling bias, in relation to the secondary research questions, is the absence from the sample/data of those who choose to self-manage their complaints and do not present for care. As SP08A remarked when asked whether people researching their health on the internet create more work:

“I think sometimes it does but, as I said before, it is difficult for me to judge when it hasn’t because people don’t ring me up and say ‘oh, I’ve just Google diagnosed myself so I won’t be coming to see you today’” (ENP with 1 years’ experience).

The final limitation with the study is the fact that focus groups were not used to explore service user and provider attitudes in more detail. The group interaction may have enabled participants to explore and clarify views that are less accessible in one-to-one interviews. However, practical considerations dictated that this was not possible during this study. Overall, the study was constrained by the fact that only two cases could be studied by the single investigator for limited period of time and in a limited geographical area.

7.17 Conclusion

There is no escaping the fact that in the UK we live in a consumer society, and belong to a consumer culture, that directly and indirectly influences how we view ourselves and others. The growth and consolidation of consumer society has transformed the way in which we use and access services and resources on an everyday basis, as business modes of behaviour continue to shape and define social norms. Consumer society is constructed upon two foundational principles: choice and competition. The ability to choose one product or service provider over another fosters competition based upon price and quality. The threat of exit from the marketplace if consumers choose alternative products or providers is intended to ensure quality remains high in relation to price. Since the 1980's, successive Governments have argued that increasing individual choice results in better value for money for the customer and improves the overall quality of service provision. This principle has been rigorously applied to public sector services and the opportunity to choose one healthcare provider over another is intended to foster competition and contestability based upon quality of service provision rather than price. Healthcare consumers are encouraged to use choice (and the threat of exit) to apply pressure on providers to ensure that services are personalised and responsive to their needs. At the same time, new providers entering the market are intended to ensure that current providers maintain standards of care or risk exiting the market

It seems clear from the data that the way in which service users access healthcare and interact with service providers has changed since the introduction of market reforms to the NHS in the 1980's.

However, it is not clear to what extent the policy reforms themselves have influenced these attitudes and how much is due to social and cultural changes associated with the introduction and development of consumer modes of thinking and behaving. This is difficult to quantify since healthcare policy is informed-by, and reflects, broader social, economic and political issues (Sturgeon, 2013). The relationship between the individual and the state has been transformed, over the last thirty-years-or-so, as neoliberal policies, characterized by free market competition and economic deregulation, have become firmly established as social norms. In consumer culture, more-and-more aspects of human life are made available through market mechanisms. This includes public sector services that have become increasingly subject to the same consumer drivers that can be identified elsewhere in society. This has fostered a number of positive outcomes and older service users from case A and B described how the NHS had become less paternalistic and more customer focused as greater participation and joint decision making have been introduced and encouraged. Almost all service users from both cases stated that they wanted to be involved in the decision making process regarding their healthcare management. However, there was also considerable variation of opinion regarding the level of participation considered necessary or desirable as indicated by the five proposed healthcare consumer typologies.

Although very few service users at either case identified themselves as 'customers' or 'consumers' of healthcare per se, there was also general consensus that high standards of customer service were both important and desirable in a healthcare context. Similarly, regardless of whether service providers from case A and B believed that service users *should* be viewed as 'customers' or 'consumers' of healthcare, they consistently demonstrated modes of behaviour that *treated* them as such. This should come as no surprise and, on the one hand, it represents professional adaptation to policy and social drivers that encourage this view and, on the other, professional commitment to deliver personalised care. That is to say, both nursing and medicine have continued to evolve and develop as they have acquired new skills and responsibilities, often encompassing a broader range of practice and accountability.

The processes described above have increasingly incorporated and integrated the existing business model that emphasises the role and value of the customer to the NHS at a local and national level. At the same time, doctors and nurses maintain their professional commitment to the 'patient/service-user/customer' and strive - wherever possible - to provide personalised care and advice. This professional commitment to the individual persists regardless of socio-political or ideological context. Confidence in the NHS as a whole, and healthcare professionals' ability to prioritise care on service users' behalf, remains high but most service users are prepared to challenge medical opinion if necessary and seek out alternative provision if it is more convenient or offers better customer service.

Service users are also making increasing use of the internet to research healthcare options/ management strategies and using Web 2.0 (as well as NHS consumer surveys such as the FFT) to express their views regarding service provision. This is consistent with market principles first outlined in *Working for Patients* (DH, 1989) to empower healthcare consumers to drive-up standards in care by exercising choice and voice to apply pressure on healthcare providers to ensure services are personalised and responsive to their needs. There is some evidence that this has been successful in case A and B and data reveals high levels of satisfaction with service provision and increased attendance at both MIUs. In case B, this is encouraged by inconsistent standards of primary care provision in the local area. However, although service users are motivated to use case A and B because they provide a high standard of customer service and convenience, this also leads to greater workload pressures since there is no capacity to increase staff numbers to accommodate increased demand for services. The result is longer waiting times, less personalised care and reduced customer satisfaction as expectations are not met and negative disconfirmation occurs. According to service providers from both cases, the principle reason for customer dissatisfaction and complaint is service user expectation regarding waiting time and the type of care available.

Overall, service providers from cases A and B seemed motivated to develop a more customer focused approach as a result of initiatives implemented by their organisation in response to policy proposals to encourage a more participatory and patient focused approach to healthcare delivery. Although the introduction of market reforms to the NHS has not delivered many of the improvements that were promised - and in some circumstances may have proved detrimental in terms of equity and availability of services (Sturgeon 2014ab) - it has provided some benefits for service users in terms of encouraging engagement and customer focus. It is not possible to simply reverse decades of market-orientated policy, and consumer values seem firmly entrenched in healthcare working practice and organisational philosophy. However, it is important that politicians and healthcare providers manage expectations when making promises to the public regarding choice, responsiveness, accessibility and flexibility of NHS service provision whilst continuing to provide a high degree of partnership working and individualised care in keeping with the five consumer typologies.

7.18 Recommendations from the study

The first recommendation from this research to the Hospital Trust would be to provide primary care services embedded at all urgent care providers in the area (during the day and out-of-hours).

Although this may further 'encourage' some service users to access urgent care facilities to assess/treat primary care complaints it also streamlines those who can be treated by a GP or referred to an appropriate specialist. The evidence from the UK and elsewhere suggests that service users will continue to access urgent care providers with primary care complaints if it is more convenient for them to do so, even when alternative provision is offered/available. Whilst rising patient numbers at A&E/MIUs is a cause for concern, this (and other) research confirms that service users are presenting for rational and predictable reasons. These include decisions based upon access, trust and quality of care criteria in a similar way to other consumer choices. It is highly likely then that service users will continue to 'shop around' for the most convenient healthcare provider particularly

if they work long hours, commute or find that opportunities to seek healthcare are limited by other factors. This is exacerbated by the FFT survey which delivers a 'mixed-message' regarding recommendation to others on the basis of convenience and customer service rather than identifying the most appropriate service provider.

There remains a contradiction, therefore, between encouraging choice and convenience for the individual patient, and ensuring services and resources are employed in the most efficient manner.

One way to discourage patients from attending MIUs with primary care complaints, is for primary care providers to address service provision issues (where necessary) and incorporate greater flexibility regarding access. However, co-located primary care, working alongside ENPs, also seems to offer benefits for local communities and closer working between primary and secondary care practitioners should continue to be encouraged. ENPs in particular seem to offer a valuable stepping-stone between primary and secondary care services and greater utilisation of the clinic model (adopted in case B) might provide a means to incorporate greater flexibility, and improve patient satisfaction, at both settings. It is appreciated that this recommendation is not cost-neutral and may be difficult to achieve whilst the Hospital Trust attempts to make financial savings.

Consequently, further integration between primary and secondary care services should be a priority for central Government regarding future policy and may involve a change to the way money is currently allocated.

The second recommendation to the Hospital Trust is to provide clear and unambiguous advice regarding referral and redirection. Currently, there is a great deal of confusion regarding the types of services offered at different sites. Part of the reason for this is that services have been relocated, centralised and devolved over a period of time (in response to internal and external drivers) leading to uncertainty regarding service provision. For example, the Hospital Trust website identifies that it offers certain services at a number of different sites (e.g. ENT, maxillo-facial, ophthalmology etc.) but it isn't always clear that some of these teams are based at one hospital (e.g. Hospital 3) and only

provide limited services at the other sites (e.g. booked clinic appointments and surgery on certain days). This can lead to frustration when service users are informed that they have been referred to a specialist team (as a new patient/emergency) but must travel to another hospital (often immediately) to be assessed. Ironically, it may actually be quicker to be referred from case A or B to a specialist at Hospital 3 (including c.35 minutes' travel time) than attend Hospital 3 A&E which typically has a much longer waiting time for initial assessment/referral. However, this could be partly remedied by the introduction of co-located primary care services within A&E at Hospitals 2 and 3. At any rate, better communication with service users (and providers) regarding this type of information would help to minimise frustration (and dissatisfied FFT feedback) regarding referral and redirection from other sites. This information should be provided (and updated) on their website and made explicit when considering sign-posting in and outside the clinical environment. The recommendations to the Hospital Trust outlined above will be communicated in two ways. Firstly, the ENP senior manager (and other senior members of staff) have received a copy of an article, published from the data, that outlines the benefits offered by co-located primary care services in urgent care settings (Sturgeon, 2017). Secondly, they will shortly receive a copy of the research report (currently being compiled) that outlines all of the recommendations provided.

The third recommendation, to Higher Education Institutions and other organisations providing professional training, is to acknowledge (if they are not doing so already) the changing and evolving relationship between service users and healthcare providers to ensure healthcare professionals are able to combine professional and customer service values in an effective manner. This will help to prepare healthcare professionals to recognise and understand the different ways in which service users interact with service providers based upon their expectations of service provision and their willingness and ability to participate in consultative labour and to employ negotiation and challenge to achieve their aims. The five healthcare consumer typologies provide insight regarding the differing levels of engagement, knowledge and confidence exhibited by service users when making decisions and/or managing their healthcare. Most service users in both MIUs described how they

wanted to be involved in the decision making process but there was also considerable difference of opinion at both cases regarding the level of participation considered necessary or desirable. This recommendation will be disseminated

Few healthcare professionals would argue with the idea of empowering service users to make choices but simply providing a menu of available options without appropriate explanation is unacceptable. This is particularly important as patients are increasingly expected to take greater- and-greater responsibility for healthcare decision-making and the risks that it might entail. As SP10A commented, when asked if they encouraged patients to make decisions regarding their healthcare:

“Only if I detect that they want that as part of the partnership that I’m trying to develop...What they’re articulating is that they’re not used to the idea of choice and therefore they want to be directed...I have to read the patient and decide on whether or not it is somebody who would engage in the idea of choice” (ENP with 11 years’ experience).

The data suggests that service users may move forwards or backwards through the different typologies in relation to their level of engagement, in a sequential or non-sequential fashion, depending on their confidence, knowledge and experience regarding healthcare services and consumer society at different points in their lives. It is important to be aware, therefore, that some service users, in some circumstances, may want and benefit from a more paternalistic relationship with their healthcare provider. The challenge for the service provider is to recognise when this is/not the case and tailor their communication and interaction accordingly. This recommendation will be followed-up with a Research and Knowledge Exchange (RKE) workshop presentation to the Faculty of Health and Wellbeing at Canterbury Christ Church University. I have also incorporated this and other findings into the Professional Development module learning resources for the School of Nursing.

The fourth and final recommendation is that further research on this topic is undertaken at different geographical locations and in different clinical environments (e.g. primary and other secondary care

centres) to capture the voice of a wider range of service users and healthcare professionals. This will help to confirm/contest the findings from this study and also test and evaluate the applicability and usefulness of the five healthcare consumer typologies in other healthcare contexts. It would also be useful to repeat the study either locally or elsewhere to see if the findings were replicated or whether consumer attitudes and behaviour have continued to evolve and move-on. Although interview and participant observation are often combined in case study and ethnographic research, there are very few examples of this approach in the healthcare studies discussed in chapter 2. One of the reasons for the apparent under-representation of this method/data collection instruments may be because it is time consuming to undertake and because of ethical concerns regarding covert observation. The inclusion of participant observation in this study certainly proved extremely contentious when seeking NHS ethics approval and a number of additional assurances (principally regarding informed consent) had to be provided before the committee agreed that the study could proceed.

7.19 Personal reflection

The participant observer role was both challenging and rewarding in equal measure. On the one hand, it allowed me to contribute to the care and treatment of those presenting for care in case A and B (although anyone I was directly involved with was ineligible as a research participant to avoid leading behaviour and bias). Supernumerary status ensured that my presence in both cases did not inconvenience service users by delaying consultation, care or treatment. It also provided me with an opportunity to interact with service users and make a practical contribution to their care and wellbeing. This was often thought-provoking and required me to reflect on my role as a nurse educator and healthcare researcher. It was also important to ensure that participants received a 'fair return' for their time and insights even if they were not treated by me directly (Spradley, 1980).

At the same time, the participant observer role could be extremely challenging for a number of reasons. Firstly, it was physically and mentally demanding as I combined, and tried to balance,

working as an ENP (providing high-quality, person-centred care) with identifying potential interview participants and recording field notes when I observed unsolicited examples of consumer behaviour etc. Secondly, there were practical lessons to learn and my initial attempts to solicit interview participants were often unsuccessful due to lack of confidence or poor use of interpersonal skills. However, as I familiarised myself with the ENP role, and my interpersonal skills improved, this became easier and more natural. This partially explains why the number of shifts I worked in case A is higher than case B since I had to establish myself as a member of the team and as a researcher in the field. However, I also tended to work longer shifts in case B since it was further from my place of work/home which made it sensible to maximise engagement/research activity from a time-management point of view.

The third challenge was the temptation to over-familiarise with my ENP colleagues and one of them commented that it seemed (to them) as if I was 'taking a holiday in [my] old life'. Consequently, it was essential to continually examine and question my position as ENP and researcher in order to maintain the outsider perspective as discussed in chapter 3. Although it was not possible to achieve total objectivity and detachment during the data collection period, it was important to maintain a high degree of mindfulness and reflexivity regarding my own behaviour etc. to avoid bias, leading behaviour and simply squandering data collection opportunities by becoming too immersed in practice.

The participant observer role provided valuable insights that were simply not possible from interview or survey response alone. However, it is neither a passive nor a neutral role and it required a great deal of effort and commitment to ensure that field notes were regularly recorded and that the observations were accurate and reliable. One of the most frustrating aspects of the role was having to ignore evidence of consumer-motivated behaviour etc. when it occurred during consultation and treatment with 'my' service users. I was often confident that I had not intentionally/unintentionally spoken words, or exhibited behaviour, that could be construed as

leading or encouraging. However, it was essential that this data was not recorded, no matter how strong/rich, for the reasons outlined above. It was also difficult not to discuss the research objectives with ENP colleagues who were genuinely interested - at first at least - in the project. Fortunately, such is the nature of the NHS, that there were plenty of other operational and political issues that provided welcome distraction.

If I were undertaking a participant observer approach in the future, I would ensure that I allowed more time to 'bed-in' at the case or research site. I was fortunate that I already had some prior knowledge of the working environment and staff; and yet I still felt uncomfortable and self-conscious during the first shifts/weeks. In retrospect, I should have delayed recruiting service user interview participants until a little later in case A since some of the data is a quite thin compared to later interviews. I would also feel more confident defending the use of participant observation at NHS REC review if faced with the same queries and concerns as previously. From a personal point of view, the experience I have gained from this research study has proved beneficial not only for my teaching but also for my professional development as a novice researcher and member of staff in the Faculty of Health and Wellbeing. It has also given me the confidence to seek out new research opportunities in the wider academic community.

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APPENDIX 1

Literature search results (from title, abstract, key words and text): CINAHL

	Search terms and Boolean operators	Results
1	consumer AND health	5713
2	customer AND healthcare	482
3	consumer OR customer AND healthcare	8821
4	consumer AND customer AND health	47
5	consumer AND customer AND healthcare	8
6	consumer OR customer AND health AND choice	8807
7	consumer AND health AND customer AND choice	4
8	customer AND healthcare AND choice	1
9	consumer AND healthcare AND choice	28
10	consumer AND nurse-practitioner	65
11	customer AND nurse-practitioner	1
12	consumer AND minor injury unit	217
13	customer AND minor injury unit	14
14	consumer AND emergency care	60
15	customer AND emergency care	4
16	emergency care AND decision making	148
17	consumer AND emergency care AND nurse practitioner	5
18	customer AND emergency care AND nurse practitioner	136
19	consumer AND healthcare AND nurse practitioner	9
20	customer AND healthcare AND nurse practitioner	51
21	consumer AND healthcare AND choice AND nurse practitioner	1065
22	customer AND healthcare AND choice AND nurse practitioner	59

RESEARCH PROJECT 2014-15

A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units

My name is David Sturgeon and I am a Senior Lecturer at Canterbury Christ Church University. I am undertaking a study to look at consumer attitudes to healthcare at this and other Minor Injury Units.

Part of the research will involve observing staff and service user interaction during consultation and treatment. You may also be invited to participate in a short interview. If you decide not to be interviewed it will not affect your treatment at this facility today or in the future.

No observations will be made without consent and patients must opt-in to the study. Please read the patient information sheet provided for more information. If you have any further questions, please ask at reception and I will see you shortly.

A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units



We invite you to take part in a research study

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve
- Please take time to read the following information carefully
- Discuss it with friends or relatives if you wish
- You are free to decide whether or not to take part in this study
- Ask us if there is anything that is not clear or if you would like more information

Do I have to take part?

- No, your participation is entirely voluntary
- We would like you to consent to take part in this study because we believe that you can make an important contribution to the research
- If you do not wish to take part in this research it will not affect the care you receive today/in the future or the time you have to wait for treatment

Important things that you need to know

- Part of the research will involve observing patient interactions with staff during their time at the Minor Injury Unit
- No personal or medical information will be recorded during these observations
- No observations will be made without consent and patients must opt-in to the study
- You may also be invited to participate in a short interview
- If so, you will receive a written letter of invitation and a copy of the consent form

Contents

- We invite you to take part in a research study
- Do I have to take part?
- Important things you need to know
- Purpose of the research
- Why have I been chosen to take part?
- How many patients will be involved?
- Interview
- Confidentiality
- Benefits
- Risks
- Complaints
- After the research has finished
- How to contact us
- Summary time line

How to contact us

If you have any questions about this study please talk to/contact:
Mr David Sturgeon on
01227 767700 ext: 3135
david.sturgeon@canterbury.ac.uk
or
Dr Stephen O'Connor on
01227 782627
stephen.oconnor@canterbury.ac.uk

APPENDIX 3a

Purpose of the research

- Since the 1980's all Governments have introduced changes to the National Health Service (NHS) to try and make it more responsive to patient's needs
- We want to see how these changes have influenced patient's decision making when accessing health care services and interacting with health care professionals

Why have I been chosen to take part?

- Department of Health policy has consistently encouraged researchers to involve patients in assessing the care and treatment they receive from NHS service providers
- We believe it is important to include patients as partners in this research project
- Your experiences today will help us to understand the outcome of Government policy and how services can be improved

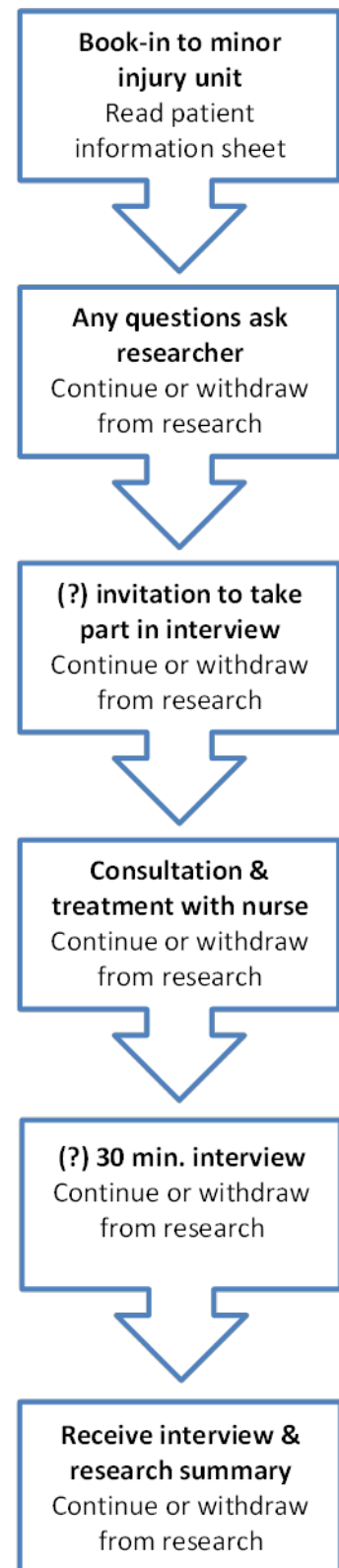
How many patients will be involved?

- The research will take place over a 9 month period at 2 locations
- Observations will be made of participating patients and staff during this time but not all of these will be included in the final report
- Approximately 20 patients from each location will also be asked to take part in a short interview

Interview

- If you consent to be interviewed, it will take place following treatment or at a time convenient to you
- The interview will last about 30 minutes
- No one else will be present unless you would like a friend, relative or chaperone to accompany you
- If you do not wish to answer any of the questions you may say so and the interviewer will move on to the next question
- You may stop the interview at any time or withdraw consent at a later date
- If any untoward incident should occur during the interview or information indicating that poor clinical practice has occurred come to light, the interview will be stopped and the appropriate NHS safeguarding procedures followed
- With your permission, the interview will be audiotaped to ensure accuracy and ease of analysis at a later date, but you have the right to request that this is not done if you wish

Summary time-line



Confidentially

- No information recorded during this research will be attributed to you by name
 - All information is confidential and only the principle investigator (Mr David Sturgeon) and the research supervisor (Dr Stephen O'Connor) will have access to it
 - All information will be stored in a secure place at Canterbury Christ Church University
 - You will be offered a written copy of your interview and a summary of the research findings to review
 - The research findings may be published as a journal article, conference paper or book chapter but all patient information will be anonymised
-

Benefits

- There will be no direct benefit to you but your involvement in this research is likely to provide insights for future policy development and training
-

Risks

- There is a risk that you may share personal information by chance or that you may feel uncomfortable talking about some of the topics
 - You do not have to answer any questions that make you feel uncomfortable and you can stop the interview at any time
-

What to do if you have a problem or complaint

- If you have a problem or complaint about the research or the research process please contact Professor Douglas MacInnes (Centre for Health and Social Care Research) on:
Tel: **01634 894412**
E-mail: douglas.macinnes@canterbury.ac.uk
-

After the research has finished

- If you have any queries, concerns or require any further information once the research has finished please do not hesitate to contact us using the telephone numbers/e-mail addresses provided on page 1

A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units

We invite you to take part in an interview

- Before you decide whether to take part, it is important for you to understand why the interview is being done and what it will involve
- Please take time to read the following information carefully
- Discuss it with friends or relatives if you wish
- Ask us if there is anything that is not clear or if you would like more information

Do I have to take part?

- No, your participation is entirely voluntary
- We would like you to consent to take part in this study because we believe that you can make an important contribution to the research
- You are free to decide whether or not you wish to be interviewed and may withdraw your consent at any time without this having any impact on the care you receive today/in the future or the time you wait for treatment

Important things that you need to know

- If you consent to be interviewed it will take place following treatment or at a time convenient to you
- The interview will last about 30 minutes
- No one else will be present unless you would like a friend, relative or chaperone to accompany you
- If you do not wish to answer any of the questions you may say so and the interviewer will move on to the next question
- You may stop the interview at any time or withdraw consent at a later date
- If any untoward incident should occur during the interview or information indicating that poor clinical practice has occurred come to light, the interview will be stopped and the appropriate NHS safeguarding procedures followed
- With your permission, the interview will be audiotaped to ensure accuracy and ease of analysis at a later date, but you have the right to request that this is not done if you wish

Contents

- We invite you to take part in an interview
- Do I have to take part?
- Important things you need to know
- Purpose of the research
- Why interview patients?
- Consent
- Confidentiality
- Benefits & reimbursements
- Risks
- How to contact us
- Summary timeline

How to contact us

If you have any questions about this study please talk to/contact:
Mr David Sturgeon on
01227 767700 ext: 3135
david.sturgeon@canterbury.ac.uk
or
Dr Stephen O'Connor on
01227 782627
stephen.oconnor@canterbury.ac.uk

APPENDIX 3b

Purpose of the research

- Since the 1980's all Governments have introduced changes to the National Health Service (NHS) to try and make it more responsive to patient's needs
 - We want to see how these changes have influenced patient's decision making when accessing health care services and interacting with health care professionals
-

Why interview patients?

- Department of Health policy has consistently encouraged researchers to involve patients in assessing the care and treatment they receive from NHS service providers
 - We believe it is important to include patients as partners in this research project
 - Interviews give you an opportunity to explain why you have chosen to attend this facility and how you rate the care and treatment you have received
 - Interviews give us an opportunity to capture your views and compare them to those of other patients
-

Consent

- You will be asked to provide temporary (provisional) consent to be interviewed once you have booked-in to the unit
 - This is because we want you to have time to fully consider whether you want to take part
 - You will be asked to confirm that you are still happy to continue with the interview after your treatment has been completed
-

Confidentiality

- The information you provide will remain private and will be stored in a secure place at Canterbury Christ Church University
 - No information recorded during this interview will be attributed to you by name and all recording will be anonymised
 - You will be offered a written copy of your interview and a summary of the research findings to check and review for accuracy if you wish
 - The research findings may be published as a journal article, conference paper or book chapter but all patient information will be anonymised
-

Benefits & reimbursements

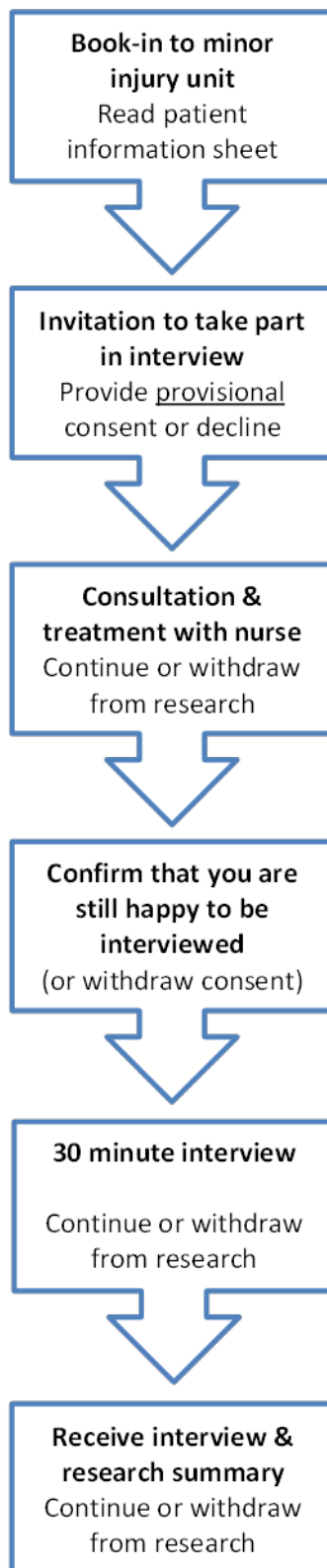
- There will be no direct benefit to you but your involvement in this interview is likely to provide insights for future policy development and training
-

Risks

- There is a risk that you may share personal information by chance or that you may feel uncomfortable talking about some of the topics
- You do not have to answer any questions that make you feel uncomfortable and you can stop the interview at any time

APPENDIX 3b

Summary time-line



A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units

We invite you to take part in a research study

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve
- Please take time to read the following information carefully
- Discuss it with a colleague, friend or relative if you wish
- Ask us if there is anything that is not clear or if you would like more information

Do I have to take part?

- No, your participation is entirely voluntary
- We would like you to consent to take part in this study because we believe that you can make an important contribution to the research
- You are free to decide whether or not to take part in this research and may withdraw your consent at any time with no negative repercussions or consequences

Important things that you need to know

- As part of this research I (David Sturgeon) will be working as a nurse practitioner at your place of work
- My shifts will be clearly recorded on the off-duty
- Part of the research will involve observing patient and staff interaction
- No personal or medical information will be recorded during these observations
- No observations will be made without consent and staff (and patients) must opt-in to the study
- If you are happy to participate you will also be invited to take part in a short interview
- A written letter of invitation and a copy of the consent form will be provided before the research commences

Contents

- We invite you to take part in a research study
- Do I have to take part?
- Important things you need to know
- Purpose of the research
- Why have I been chosen to take part?
- How many staff will be involved
- Interview
- Confidentiality
- Benefits
- Risks
- Complaints
- After the research has finished
- How to contact us
- Summary time line

How to contact us

If you have any questions about this study please talk to/contact:
Mr David Sturgeon on
01227 767700 ext: 3135
david.sturgeon@canterbury.ac.uk
or
Dr Stephen O'Connor on
01227 782627
stephen.oconnor@canterbury.ac.uk

APPENDIX 4a

Purpose of the research

- Since the 1980's all Governments have introduced changes to the National Health Service (NHS) to try and make it more responsive to patient's needs
- We want to see how these changes have influenced patient's decision making when accessing health care services and interacting with health care professionals

Why have I been chosen to take part?

- Department of Health policy has consistently encouraged researchers to involve patients and staff when assessing the care provided by the NHS
- We believe it is important to include staff as partners in this research project
- Your experiences and views will help us to understand the outcome of Government policy and how services can be improved

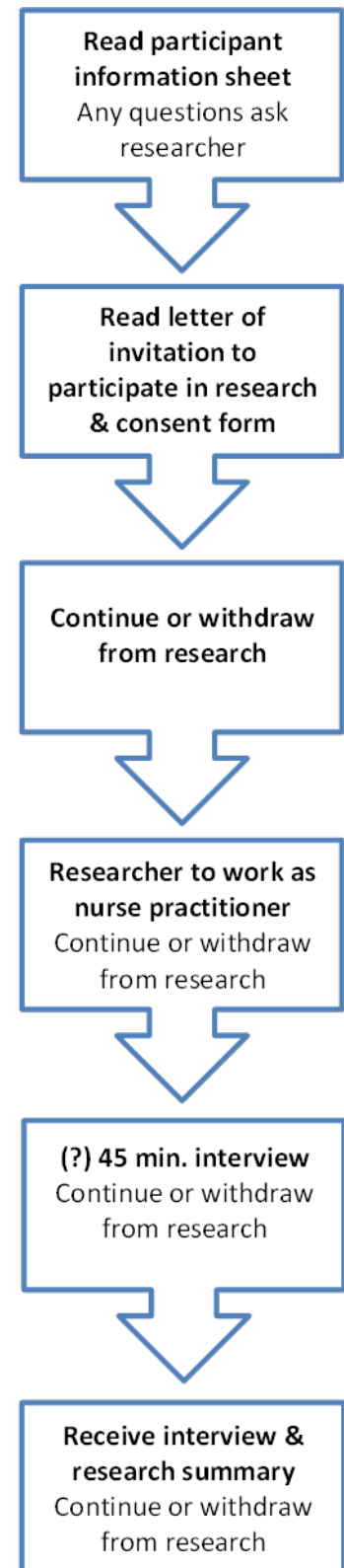
How many staff will be involved?

- The research will take place over a 9 month period at 2 locations
- Observations will be made of participating patients and staff during this time but not all of these will be included in the final report
- Approximately 10 members of staff from each location will also be asked to take part in a short interview

Interview

- If you consent to be interviewed it will take place at a time convenient to you
- The interview will last for about 45 minutes
- No one else will be present unless you would like a friend, relative or chaperone to accompany you
- If you do not wish to answer any of the questions you may say so and the interviewer will move on to the next question
- You may stop the interview at any time or withdraw consent at a later date
- Should any untoward information be disclosed, normal NHS safeguarding procedures will be followed
- With your permission, the interview will be audiotaped to ensure accuracy and ease of analysis at a later date, but you have the right to request that this is not done if you wish

Summary time-line



APPENDIX 4a

Confidentially

- No information recorded during this research will be attributed to you by name
 - All information is confidential and only the principle investigator (Mr David Sturgeon) and the research supervisor (Dr Stephen O'Connor) will have access to it
 - All information will be stored in a secure place at Canterbury Christ Church University
 - You will be offered a written copy of your interview and a summary of the research findings to review
 - The research findings may be published as a journal article, conference paper or book chapter but all participant information will be anonymised
-

Benefits

- There will be no direct benefit to you but your involvement in this research is likely to provide insights for future policy development and training
-

Risks

- There is a risk that you may share personal information by chance or that you may feel uncomfortable talking about some of the topics
 - You do not have to answer any questions that make you feel uncomfortable and you can stop the interview at any time
-

What to do if you have a problem or complaint

- If you have a problem or complaint about the research or the research process please contact Professor Douglas MacInnes (Centre for Health and Social Care Research) on:
Tel: **01634 894412**
E-mail: douglas.macinnes@canterbury.ac.uk
-

After the research has finished

- If you have any queries, concerns or require any further information once the research has finished please do not hesitate to contact us using the telephone numbers/e-mail addresses provided on page 1

A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units

We invite you to take part in an interview

- Before you decide whether to take part, it is important for you to understand why the interview is being done and what it will involve
- Please take time to read the following information carefully
- Discuss it with a colleague, friend or relative if you wish
- Ask us if there is anything that is not clear or if you would like more information

Do I have to take part?

- No, your participation is entirely voluntary
- We would like you to consent to take part in this study because we believe that you can make an important contribution to the research
- You are free to decide whether or not you wish to be interviewed and may withdraw your consent at any time with no negative repercussions or consequences

Important things that you need to know

- If you consent to be interviewed it will take place at a time convenient to/agreed by you
- The interview will last about 45 minutes
- No one else will be present unless you would like a friend, relative or chaperone to accompany you
- If you do not wish to answer any of the questions you may say so and the interviewer will move on to the next question
- You may stop the interview at any time or withdraw consent at a later date
- Should any untoward information be disclosed, normal NHS safeguarding procedures will be followed
- With your permission, the interview will be audiotaped to ensure accuracy and ease of analysis at a later date, but you have the right to request that this is not done if you wish

Contents

- We invite you to take part in an interview
- Do I have to take part?
- Important things you need to know
- Purpose of the research
- Why interview staff?
- Consent
- Confidentiality
- Benefits & reimbursements
- Risks
- How to contact us
- Summary timeline

How to contact us

If you have any questions about this study please talk to/contact:
Mr David Sturgeon on
01227 767700 ext: 3135
david.sturgeon@canterbury.ac.uk
or
Dr Stephen O'Connor on
01227 782627
stephen.oconnor@canterbury.ac.uk

APPENDIX 4b

Purpose of the research

- Since the 1980's all Governments have introduced changes to the National Health Service (NHS) to try and make it more responsive to patient's needs
 - We want to see how these changes have influenced patient's decision making when accessing health care services and interacting with health care professionals
-

Why interview staff?

- We believe it is important to include both patients and staff as partners in this research project
 - Interviews give you an opportunity to explain your views on health policy and your working environment
 - Interviews give us an opportunity to capture your views and compare them to those of other staff and patients
-

Consent

- Interviews will take place at a time agreed by you towards the end of the observation process
 - This is to give you time to change your mind if you wish to do so
 - We want you to have time to fully consider whether you want to take part
-

Confidentiality

- The information collected from this interview will be kept private and stored in a secure place at Canterbury Christ Church University
 - No information recorded during this interview will be attributed to you by name
 - You will be offered a written copy of your interview and a summary of the research findings to check and review
 - The research findings may be published as a journal article, conference paper or book chapter but all participant information will be anonymised
-

Benefits & reimbursements

- There will be no direct benefit to you but your involvement in this interview is likely to provide insights for future policy development and training
-

Risks

- There is a risk that you may share personal information by chance or that you may feel uncomfortable talking about some of the topics
- You do not have to answer any questions that make you feel uncomfortable and you can stop the interview at any time

Summary time-line



APPENDIX 5



David Sturgeon
Dept. of Nursing and Applied Clinical Studies
Faculty of Health
Canterbury Christ Church University
Canterbury
CT1 1QU

Tel: 01227 767700 ext: 3135
david.sturgeon@canterbury.ac.uk

Research Ethics Committee reference: 14/LO/0908
EKHUFT R&D reference: 2014/NURSING/04

March 2015

Dear ENP

Re: PhD research proposal: *A case study exploration of the impact of consumer values for health care provision in Minor Injuries Units*

My name is David Sturgeon and I work for Canterbury Christ Church University as a Senior Lecturer in the Faculty of Health and Social Care. I am undertaking research on people's attitudes to choice and decision making when accessing health care services in a Minor Injury Unit setting. Part of this research will involve voluntary individual interviews with patients and staff, and observation of the way in which patient choice and involvement in decision are promoted in staff/patient interaction during the course of the working day. I would like to invite you to be part of this research. You do not have to decide immediately whether or not you will participate, and even if you agree to take part you may withdraw your consent at any time. Before you decide, please feel free to talk to me, or anyone else you feel comfortable with, about the research. The information sheet and consent form explain how the research will be carried out. If there are any words or terms that you are unfamiliar with I am happy to explain them when we meet or feel free to contact me at the above address, by e-mail or telephone.

Yours sincerely

DAVID STURGEON

v.3 July 2014

APPENDIX 6

Demographic information:

Gender:

Age:

Nationality:

Highest educational qualification: GCSE/O level, A level, Degree, Masters, Doctorate

Questions:

(1) How far (in miles) do you live from this unit?

(2) Have you used this unit before? If yes, on approximately how many occasions?

(3) Why did you decide to use this unit today?

(4) Which of the following words best describes how you view yourself in relationship to health services? They are presented alphabetically.

- Citizen
- Client
- Consumer
- Customer
- Member of the Public
- Patient
- Service User
- Other (specify)

(5) How was your experience today?

(6) Do you think that people want to make decisions about their health care?

(7) Do you think that encouraging people to have more say in the decision making process will lead to better services?

APPENDIX 6

- (8) Were you offered an opportunity to make decisions about your healthcare and treatment during the consultation?
- (9) Do you think that some people are better than others at communicating with health professionals?
- (10) Do you research your health on internet?
- (11) Do you feel confident to challenge medical opinion if necessary?
- (12) Do you think there are any similarities between healthcare and the hospitality industry in terms of customer experience or is it a different experience?
- (13) How could your experience have been made better today?
- (14) Do you think the NHS is doing a good job?

APPENDIX 7

Demographic information:

Age:

Position:

Number of years working in MIU:

Questions:

- (1) Do you think that you service users should be offered an opportunity to make decisions about their health and treatment during clinical consultation?

- (2) Do you think that service users want to make decisions about their health care?

- (3) Do you actively encourage service users to participate in the decision making process, wait to see what level of participation they seem comfortable with or discourage it in general?

- (4) In general, what sort of decisions do service users make during a consultation?

Possible prompts
<ul style="list-style-type: none">• clinical• type of treatment• choice of time/location for follow-up/outpatient appointment (if appropriate)

- (5) Do you always agree with their contribution or decision?

- (6) Do you think that encouraging users to have more say in the decision making process will lead to better services?

- (7) How often do service users challenge your opinion?

- (8) Do you think that some people are better than others at communicating with health professionals?

APPENDIX 7

(9) Do you think service users are becoming MORE assertive regarding their rights to choice (e.g. as outlined in the NHS Constitution)?

(10) Do you think service users are becoming more knowledgeable about health and illness?

Possible follow up question:

- | |
|---|
| <ul style="list-style-type: none">• If so, why do you think this is and where do you think they are getting their information from? (TV/advertising, internet, leaflets, social media, school etc)• Is the Government correct to encourage 'expert patients'? |
|---|

(11) How much is it the service user's responsibility to ensure that they remain healthy and self-manage where possible?

(12) Do you think that service users should be viewed as customers whilst in MIU?

(13) Why do you think service users choose to access the services provided by this institution rather than an alternative provider such as a GP, A&E or alternate MIU?

(14) Which of the following words best describes how you view **service users** who attend this MIU?
They are presented alphabetically.

- Citizen
- Client
- Consumer
- Customer
- Member of the Public
- Patient
- Service User
- Other (specify)

Follow up question:

- | |
|--|
| <ul style="list-style-type: none">• Which of the words best describes how you view yourself in relationship to health services? |
|--|

(15) How do you think the service you provide could be made better for (a) service users (b) staff

APPENDIX 8

Position:

Questions:

- (1) Do you think service users are becoming more knowledgeable about health and illness?

- (2) If so, why do you think this is and where do you think they are getting their information from?
(TV/advertising, internet, leaflets, social media, school etc)

- (3) Do you think it is the service user's responsibility to ensure that they remain healthy and self-manage where possible?

- (4) Have you seen an increase or decrease in the number of service users accessing your MIU services or has it remained relatively constant?

Possible follow up question:

- | |
|---|
| <ul style="list-style-type: none">• Why do you think this is? |
|---|

- (5) Do you think that people want to contribute more actively in the decision making process about their health care?

Possible prompt/follow-up question:
--

- | |
|---|
| <ul style="list-style-type: none">• What sort of decisions do you think it is reasonable for them to make?• should they be offered an opportunity to make decisions during clinical consultation as well as about provider etc |
|---|

APPENDIX 8

- (6) Do you think that encouraging service users to have more say in the decision making process will lead to better services?

Possible follow-up question:

- | |
|---|
| <ul style="list-style-type: none">• If so, how? |
|---|

- (7) Do you think that some people are better than others at communicating with health professionals?

Possible follow-up questions:

- | |
|--|
| <ul style="list-style-type: none">• If so, how?• Is there a danger that if you are able to 'shout louder' you will be advantaged or receive a better service? |
|--|

- (8) Do you think the Government is correct to encourage 'expert patients'?

Possible follow-up question:

- | |
|---|
| <ul style="list-style-type: none">• If yes/no, why? |
|---|

- (9) Do you think service users are becoming more assertive regarding their right to choose?

- (10) Do you think that the government is correct to publish rights and pledges for service users (e.g. the NHS Constitution)?

Possible follow-up question:

- | |
|---|
| <ul style="list-style-type: none">• If yes/no, why?• Is there a danger that 'over-promising' will lead to disappointment/further complaints? |
|---|

APPENDIX 8

(11) Does offering greater choice to service users have implications for your organisation in terms of cost?

Possible follow-up question:

- | |
|---|
| <ul style="list-style-type: none">• Do you think more knowledgeable service users will save money in the long term? |
|---|

(12) Why do you think service users choose to access the services provided by this MIU (Buckland or KCH) rather than an alternative provider (e.g. GP, A&E or alternate MIU)?

(13) Which of the following words best describes how you view **service users** who attend this MIU?
They are presented alphabetically.

- Citizen
- Client
- Consumer
- Customer
- Member of the Public
- Patient
- Service User
- Other

Follow up question:

- | |
|--|
| <ul style="list-style-type: none">• Which of the words best describes how you view yourself in relationship to health services? |
|--|

(14) How do you think the MIU service you provide could be made better for (a) service users (b) staff.

APPENDIX 9

Principle inclusion criteria for study

- Adults aged 18-100 years
- Service users at Minor Injury Unit (excepting those identified in exclusion criteria)
- Nursing staff at Minor Injury Unit
- Nonqualified nursing staff at Minor Injury Unit (e.g. technician or health care assistant)
- Non clinical staff at Minor Injury Unit (e.g. reception staff)
- Senior or management staff at Minor Injury Unit/Hospitals University NHS Foundation Trust

Principle exclusion criteria for study

- Service user under the age of 18
- Service user known to researcher
- Service user who does not speak English
- Service user presenting with mental health complaint
- Service user with learning disability who is unaccompanied by an adult able to provide consent on their behalf
- Service user with impaired cognition such as head injury
- Service user with dementia or progressive neurological disorder/disease who is unaccompanied by an adult able to provide consent on their behalf
- Service user who has been drinking alcohol or using illegal drugs/banned substances

APPENDIX 10



Certificate of Informed Consent for Doctoral Research 2014-15
***'A case study exploration of the impact of consumer values
for health care provision in Minor Injuries Units'***

The Researcher: My name is David Sturgeon and I work for Canterbury Christ Church University as a Senior Lecturer in the Faculty of Health.

The Research: The purpose of this study is to investigate people's attitudes when accessing health care services. It will consider whether changes to the National Health Service over the last thirty years have also changed the way in which people access health care services and interact with health care professionals. The study is qualitative in nature which simply means that the evidence collected from interviews (and observation) will be studied in terms of its 'quality' rather than simply the number of people who said (or did) one thing or another.

The Process: Your participation in this study will involve an interview with an estimated length of 30 minutes. You will be asked a series of questions about your decision making process and attitudes when accessing health care services and interacting with health care professionals. The interview will be digitally recorded for later analysis.

Confidentiality: Your name and any identifying information will not be associated with any part of the written report of the research. All of your information and interview responses will be kept confidential and stored in a locked place or secure computer in a locked office. The researcher will not share your individual responses with anyone other than the research supervisor (Dr Stephen O'Connor).

Research Subjects Understanding (please tick):

- I agree to participate in this study that I understand will be submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Canterbury Christ Church University
- I understand that my participation is voluntary
- I understand that all data collected will be limited to this use: publication in an academic journal, presentation at an academic conference or book chapter
- I understand that I will not be identified by name in the final product
- I am aware that all records will be kept confidential in the secure possession of the researcher
- I acknowledge that the contact information of the researcher have been made available to me along with a duplicate copy of this consent form
- I understand that I may withdraw from the study at any time with no adverse repercussions

If you have any questions or concerns, please contact the researcher David Sturgeon at the following e-mail address: david.sturgeon@canterbury.ac.uk or by telephone at: 01227 767700 ext: 3135.

By signing below I acknowledge that I have read and understand the above information. I am aware that I can discontinue my participation in the study at any time.

Full Name: _____

Signature: _____ **Date:** _____ v.3 April 2014



Certificate of Informed Consent for Doctoral Research 2014-15
*'A case study exploration of the impact of consumer values
 for health care provision in Minor Injuries Units'*

The Researcher: My name is David Sturgeon and I work for Canterbury Christ Church University as a Senior Lecturer in the Faculty of Health.

The Research: The purpose of this study is to investigate people’s attitudes when accessing health care services. It will consider whether changes to the National Health Service over the last thirty years have also changed the way in which people access health care services and interact with health care professionals. The study is qualitative in nature which simply means that the evidence collected from interviews (and observation) will be studied in terms of its ‘quality’ rather than simply the number of people who said (or did) one thing or another.

The Process: Your participation in this study will involve an interview with an estimated length of 45 minutes. You will be asked a series of questions about your/others attitudes to health and the provision of healthcare services. The interview will be digitally recorded for later analysis.

Confidentiality: Your name and any identifying information will not be associated with any part of the written report of the research. All of your information and interview responses will be kept confidential and stored in a locked place or secure computer in a locked office. The researcher will not share your individual responses with anyone other than the research supervisor (Dr Stephen O’Connor).

Research Subjects Understanding (please tick):

- I agree to participate in this study that I understand will be submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Canterbury Christ Church University
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By signing below I acknowledge that I have read and understand the above information. I am aware that I can discontinue my participation in the study at any time.

Full Name: _____

Signature: _____ **Date:** _____ v.3 April 2014

APPENDIX 12

Response rate to FFT survey at Case A and B (October 2014 - May 2015)

Case A

Ex. Likely	Likely	Neither Likely/ Unlikely	Unlikely	Ex. Unlikely	Don't Know	Dates	Responses
318	110	17	15	32	7	01 - 31 Oct 2014	499
348	102	25	13	20	14	01 - 30 Nov 2014	522
27	7	-	-	2	-	29 Dec 2014 - 05 Jan 2015	36
31	12	1	2	2	1	05 - 12 Jan 2015	49
40	10	3	1	3	2	12 - 19 Jan 2015	59
33	8	1	1	2	1	19 - 26 Jan	46
49	13	3	4	2	1	26 - 02 Feb 2015	72
39	12	5	3	-	-	02 - 09 Feb 2015	59
33	10	4	1	3	1	16 - 23 Feb 2015	52
918	284	59	40	66	27	01 Oct 2014 - 23 Feb 2015	1394
65.85%	20.37%	4.23%	2.86%	4.73%	1.93%		100%

Total %:

Recommend (FFT1&2) = 86.22%

Not recommended (FFT4/5) = 7.59%

Neither 4.23+ / don't know (FFT3/6) = 6.16%

APPENDIX 12

Case B

Ex. Likely	Likely	Neither Likely/ Unlikely	Unlikely	Ex. Unlikely	Don't Know	Dates	Responses
10	1	-	2	-	-	23 Feb - 02 Mar 2015	13
24	6	-	2	1	-	09 - 16 Mar	33
24	11	1	-	-	-	30 Mar - 05 Apr 2015	36
25	3	1	2	-	1	06 - 12 Apr 2015	32
25	2	2	2	-	-	13 - 19 Apr 2015	31
32	11	-	1	-	-	04 - 10 May	44
140	34	4	9	1	1	23 Feb - 10 May 2015	189
74.07%	17.98%	2.11%	4.76%	0.52%	0.52%		100%

Total %

Recommend (FFT1&2) = 92.05%

Not recommended (FFT4/5) = 5.28 %

Neither/don't know (FFT3/6) = 2.63%

APPENDIX 13

Incidence of themes in FFT comments rated 1/'extremely likely' and 2/'likely' to recommend service at case A and B

Friendly/ Helpful/Polite	Speed/Time	Efficient	Professionalism
Case A = 167 Case B = 38 Total = 205	Case A = 163 Case B = 27 Total = 189	Case A = 57 Case B = 6 Total = 63	Case A = 39 Case B = 4 Total = 43
Caring/Kind/ Compassionate	Listen/Explained/ Communicated	Locality	Environment/ Cleanliness
Case A = 30 Case B = 6 Total = 36	Case A = 22 Case B = 1 Total = 23	Case A = 9 Case B = 2 Total = 11	Case A = 6 Case B = 2 Total = 8
Knowledgeable	Expectation	Respect/Dignity	Organised
Case A = 6 Case B = 1 Total = 7	Case A = 4 Case B = 0 Total = 4	Case A = 3 Case B = 0 Total = 3	Case A = 2 Case B = 0 Total = 2

Total for case A and B:

Friendliness/helpfulness	205
Speed	189
Efficiency/helpfulness	63
Professionalism	43
Caring/kindness	36
Listening/communicating	23
Locality	11
Cleanliness/environment	8
Knowledgeable	7
Got outcome they wanted	4
Respect/dignity	3
Organised	2

APPENDIX 14

Service user interview participant typological groupings

1. Passive

Case A:

SU01A (86-year-old female, retired)
SU03A (69-year-old female, retired)
SU07A (18-year-old, female, student)
SU12A (71-year-old female, retired cook)
SU21A (20-year-old male, student)

Case B:

SU02B (39-year-old male, carer)
SU03B (36-year-old male, carpenter)

2. Reluctant

Case A:

SU13A (39-year-old female, administrator)
SU15A (30-year-old female, mother)
SU20A (67-year-old female, retired IT engineer)

Case B:

SU01B (41-year-old female, tree-surgeon)
SU04B (24-year-old female, customer serv.)
SU11B (61-year-old male, retired)
SU14B (55-year-old male, carer)

3. Pragmatic

Case A:

SU02A (50-year-old male, support worker)
SU05A (32-year-old male, undertaker)
SU06A (66-year-old male, retired)
SU09A (70-year-old male, retired engineer)
SU14A (60-year-old male, retired stock manag.)
SU19A (73-year-old female, retired nurse)

Case B:

SU09B (25-year-old female, teach. assist.)
SU10B (25-year-old male, unemployed)
SU12B (48-year-old female, unemployed)
SU17B (29-year-old male, mechanic)
SU18B (20-year-old male, team-leader)

APPENDIX 14

Service user interview participant typological groupings

4. Fully-engaged

Case A:

SU08A (54-year-old female, lecturer)

SU10A (63-year-old female, teacher)

SU11A (20-year-old female, student)

SU17A (53-year-old female, unemployed)

SU22A (29-year-old female, theatre comp. dir.)

Case B:

SU05B (62-year-old male, retired man. dir.)

SU06B (81-year-old male, retired)

SU07B (70-year-old female, retired loc. gov.)

SU13B (53-year-old male, civil servant)

SU15B (39-year-old female, nurse)

SU19B (70-year-old male, guest house manager)

SU20B (60 year-old male, lorry driver)

5. Assertive

Case A:

SU04A (22-year-old female, student)

SU18A (52-year-old female, driver)

Contradictory

Case B:

SU16B (47-year-old male, unemployed transport manager)

APPENDIX 15

Service user interview participant demographic data and typological grouping (case A)

	Gender	Age	Nationality	Occupation	Qualification (highest)	Typology
SU 1	F	86	Br	Retired	N/A	Passive
SU 2	M	50	Br	Support worker	A levels	Pragmatic
SU 3	F	69	Br	Retired	N/A	Passive
SU 4	F	22	Br	Student	A levels	Assertive
SU 5	M	32	Br	Undertaker	GCSE/NVQ	Pragmatic
SU 6	M	66	Br	Retired	Masters	Pragmatic
SU 7	F	18	Br	Student	A levels	Passive
SU 8	F	54	Br	Lecturer	Masters	Fully-engaged
SU 9	M	70	Br	Retired engineer	Diploma	Pragmatic
SU 10	F	63	Br	Teacher	GCE	Fully-engaged
SU 11	F	20	Br	Student	A levels	Fully-engaged
SU 12	F	71	Br	Retired cook	N/A	Passive
SU 13	F	39	Br	Administrator	Degree	Reluctant
SU 14	M	60	Br	Retired stock manager	N/A	Pragmatic
SU 15	F	30	Br	Mother	Level 2 in Child Care	Reluctant
SU 16	Removed from study					
SU 17	F	53	Br	Unemployed healthcare assistant	N/A	Fully-engaged
SU 18	F	52	Br	Driver	College	Assertive
SU 19	F	73	Br	Retired nurse	Dip/RGN	Pragmatic
SU 20	F	67	Br	Retired IT engineer	GCE C&G	Reluctant
SU 21	M	20	Congolese	Student	GCSE	Passive
SU 22	F	29	Br	Theatre company director	Masters	Fully-engaged

APPENDIX 15

Service user interview participant demographic data and typological grouping (case B)

	Gender	Age	Nationality	Occupation	Qualification (highest)	Typology
SU 1	F	41	Br	Tree surgeon	GCE	Reluctant
SU 2	M	39	Br	Carer	GCSE	Passive
SU 3	M	36	Br	Carpenter	NVQ	Passive
SU 4	F	24	Dutch	Customer Service	A levels	Reluctant
SU 5	M	62	Br	Retired (managing director)	Degree	Fully-engaged
SU 6	M	81	Br	Retired	N/A	Fully-engaged
SU 7	F	70	Br	Retired (local government)	Post-grad	Fully-engaged
SU 8	Removed from study					
SU 9	F	25	Br	Teaching assistant	A levels	Pragmatic
SU 10	M	25	Br	Unemployed	N/A	Pragmatic
SU 11	M	61	Br	Retired (engineer)	Secondary	Reluctant
SU 12	F	48	Br	Unemployed	GCE	Pragmatic
SU 13	M	53	Br	Civil servant	GCE	Fully-engaged
SU 14	M	55	Br	Carer	GCE	Passive
SU 15	F	39	Br	Nurse	Degree	Fully-engaged
SU 16	M	47	Br	Unemployed (transport manager)	Certificate	Contradictory
SU 17	M	29	Br	Mechanic	N/A	Pragmatic
SU 18	M	20	Br	Team leader	GCSE	Pragmatic
SU 19	M	70	Br	Guest house manager	C&G	Fully-engaged
SU 20	M	60	Br	Lorry driver (retired from police)	A levels	Fully-engaged