UNDERSTANDING DIMENSIONALITY IN HEALTH CARE

S. Margaret Hyde
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Department of Marketing, Operations and Digital Business in Manchester Metropolitan University Business School

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ABSTRACT

In recent years, the quality of non-clinical elements of health care has been challenged in the UK. While dimensions such as the environment, communications, reliability, access, etc., all contribute to making patients feel more at ease during a time when they are at their most vulnerable, they often fall short of what they should be. This paper supports the shift towards greater emphasis on understanding the functional elements of health services in an effort to improve patient experience and outcomes. While there is an abundance of literature discussing the evaluation of service quality, much of this focuses on the SERVQUAL model and, although there is increasing debate about its relevance across sectors, no alternative has been offered. This paper argues that the model lacks substance as a tool to evaluate quality in the complex environment of health care.

The study embraced multiple methods to acquire a greater understanding of service quality constructs within the health care sector. It was carried out in three phases. The first comprised critical incident interviews with service users, which highlighted both successes and failings in their care. This was followed by staff interviews and focus groups representing a cross section of the public, providing an insight into how different groups perceive quality. The data was used in the design of a detailed questionnaire which attracted in excess of 1,000 responses. Factor analysis was then used to develop a framework of key elements relevant both to hospital settings and to those services provided in the community such as general practice.

The findings provide a four-factor model comprising: trust, access, a caring approach and professionalism, three of which are comprised primarily of human interactions. These findings suggest that although the original SERVQUAL ten-item model does have some relevance, with the adapted five-item model being far too simplistic, neither fully addresses the needs of a sector as unique and high contact as health care. The results point the way for further research to develop a detailed model to evaluate service quality in health care settings.

Key words: quality, health, service, SERVQUAL, dimensionality

DECLARATION

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification at this or any other university or institute of learning.

Signed

Susan Margaret Hyde

Date

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INTRODUCTION

Recent years have seen considerable debate over the quality of non-clinical elements of health care in the UK. Publications such as the Francis Report, Keogh Report and a review by The Right Honourable Ann Clwyd MP, all published in 2013, have highlighted major flaws in the delivery of health care. Dimensions such as the environment, communications, reliability, access, etc. all contribute to making patients feel more at ease during a time when they are at their most vulnerable. Unfortunately, these often fall short of what they should be. Health care is a major influencer in modern society both in the developed and developing world, where it contributes not only to quality of life but also to the growth of economies. It is something that every individual has an interest in. While it may be perceived as a human right, the notion of quality of service provision within the sector remains elusive. Although medical science continues to see huge developments there is little evidence to suggest similar advances in the 'caring' elements of the sector.

This thesis sets out to gain a greater understanding of the nature of service quality contextualised within the health care sector.

1.1 AIM

To develop a construct of service quality in health care.

1.2 RESEARCH OBJECTIVES

1. Review extant models and measures of service quality.
2. Identify and evaluate existing service quality approaches in health care.
3. Understand the meaning of quality to health care users and managers.
4. Propose a construct of service quality relevant to health care in the UK.

1.3 DRIVERS FOR RESEARCH

1.3.1 Existing Literature Relating to Service Quality in Health Care

A trawl of contemporary academic theory found little in the way of agreement as to priorities placed on elements in service quality specific to health care. Similarly, there remains no conclusive understanding about what quality means to service users or how it might be measured. Not since 1985, when the SERVQUAL model (Parasuraman et al., 1985, pg. 22) was developed in the marketing discipline, has there been any notable advance in this area of study.

1.3.2 Current Practice

A review of current practices adopted within the National Health Service (NHS) suggests little coherence of approach in the assessment of services, particularly at a micro or local level. While national surveys are carried out annually to assess patient satisfaction with primary care (GPs and community services) as well as hospital care, there is a lack of ownership to these. Meanwhile, the use of questionnaires, which is in common practice at local level, does little in the way of offering meaningful data for managers to use in service design at a strategic level. Systems are required to augment national measures by reflecting local requirements (Francis, 2013).

At the core of service evaluation lies the Care Quality Commission (CQC), an independent body whose remit is to assess, inspect and register health and social care services. Originally this body relied on data from annual surveys comprising self-completion dashboards to provide detailed management and statistical information, a process inherited from its predecessor, the Healthcare Commission. Significantly, the then chair of the CQC, Baroness Young, went on record as stating that their organisation inherited a rating system not fit for purpose (BBC, 2009). Since then the Commission has remodelled the process, augmenting the quantitative data with feedback from external stakeholders as well as staff and patients. However, it became headline news in 2013 when questions were asked as to what extent it used its authority in responding to service failures, and accusations were made that it had been less than candid in reporting hospitals for providing poor care. Concern still existed about the extent to which it uses its authority in responding to service failures.

More recently, findings from the Inquiry into Mid Staffordshire NHS Foundation Trust demonstrated major flaws within the whole framework of regulation of service quality and its monitoring that contributed to suffering for hundreds of patients (Francis, 2013).

1.3.3 Government Policy

Over the years there has been an abundance of policies published by the Government, starting with the Griffiths Report in 1983, which focused on restructuring management of the NHS to involve clinicians more in decision-making (Griffiths, 1983a). It introduced the concept of obtaining perceptions of the public through market research but did not go as far as involving them in service design. Without exception these policies have emphasised the importance of patient involvement and patients being a part of the service provision. The most recent of these papers, Equity and Excellence – Liberating the NHS (2010), states that the NHS "scores relatively poorly on being responsive to the patients it serves ... Too often, patients are expected to fit around services, rather than services around patients" (Department of Health, 2010, pg. 8). The paper goes on to say that "current outcome measures, patient experience surveys and national clinic audits are not used widely enough" (Department of Health, 2010, pg. 14). It aims to address this by greater validity, data collection and use of measurement tools. It does not, however, say how it will achieve this other than in terms of clinical outcomes and actually asserts that it will seek ideas on how to achieve this, further endorsing the relevance of this study.

Controversial in nature, these massive changes came into being on 1st April 2013. They have brought with them some of the most far-reaching modernisation to the NHS since its inception in 1948 and central to this is the intention to encourage competition and patient choice. It also opens the door for more services to be provided by the private sector, albeit on behalf of the NHS. With such far-reaching changes, it is not be unreasonable to expect this to force a step change in attitudes towards service quality.

1.3.4 A Recognised Need for Improvement

There is recognition even at international level that a need exists for improvement in service quality. “Even where health systems are well developed and resourced, there is clear evidence that quality remains a serious concern, with expected outcomes not predictably achieved and with wide variations in standards of health-care within and between health-care systems” (Bengoa and Kawar, 2006, pg. 3). Expenditure on health care in developed countries has doubled in the last 30 years. Nevertheless, those countries with highest expenditure are not always those which reap the most success (Leatherman, 2004).

Meanwhile, in the UK, the Francis Inquiry into Mid Stafford NHS Foundation Trust highlighted extremes of poor service and the serious consequences that can occur. Of special note: the report stated that such breakdowns in service quality are not restricted to isolated trusts (Francis, 2013).

1.4 THESIS STRUCTURE

This thesis first discusses the dynamic nature of UK health care in the early part of the 21st century, going on to consider the nature and the operational evaluation of the service quality construct within the sector. A review of extant literature debates contemporary theory about the nature of service quality and its evaluation. In doing so it provides a critique of SERVQUAL, considering its relevance within health care.

The methodology provides a description of a three-phase study embracing critical incidents, interviews and focus groups, the feedback from which is used to inform the qualitative stage of the study, which takes the form of a detailed questionnaire that attracted responses representing a wide cross section of the UK population, the results of which are used to provide a construct of service quality.

The closing chapters explain the relevance of the findings in a managerial and operational context as well as from an academic perspective.

CHAPTER 2

CONTEXT

2.1 INTRODUCTION

The role of health services in society should not be underestimated. Although the NHS faces tough financial challenges, its contribution to the health and well-being of society has a significant input to the national economy. This chapter considers the changing face of health care in the UK and examines the far-reaching measures used, with varying levels of success, in an attempt to evaluate service quality in this dynamic and complex sector.

2.2 THE CHANGING ECONOMY

The health service is never far from the headlines in the UK and, as one of the largest employers in the world, it has a major place in the UK economy. Out of 5.7 million people employed in the public service sector in this country (Office for National Statistics, 2011), more than one million are employed by the NHS and still more within private health care, which has an annual value of £5 billion per annum (Office of Fair Trading, 2011). The size of the sector reflects the growth of services in general, and represent three quarters of the gross domestic product (GDP) in the UK. Although the UK remains the sixth-largest manufacturer of goods globally (according to the value of output) the sector accounts for only 10% of the gross domestic product), while the remaining 15% of GDP is attributed to agriculture (Trading Economics, 2013). This change in emphasis is a global phenomenon; even in China, which has become known as the industrial might of the world and where the government has based its rapid economic growth on ‘making things’, there is evidence of a change in direction, with services forecast to catch up with manufacturing output (*The Economist*, 2013).

The contribution services make to overall UK GDP is significant, not only through the investment the sector brings into the country, but also through the infrastructure it provides as a backdrop to industry. Manufacturers cannot be successful without access to services such as banking, insurance, telecommunications or transport systems. As some of the most competitive in the world, UK business services contribute greatly to UK exports, accounting for over 20% of output and one in eight jobs (Sissons, 2011). Across Europe, approximately 75% of the workforce is employed in the service sector, where it makes a significant contribution to long-term investment as well as enhanced transfer of knowledge, which together create opportunities for greater innovation. The sector is the lifeblood of the global economy (European Union, 2012).

Split between private and public, the services sector is in a particularly dynamic phase, with growth in the former alongside the scaling down of the latter. Again, this is a global phenomenon, rather than being restricted to the UK. Nevertheless, the public sector remains an inherent part of economies globally, providing essential services such as education, health services, social care and welfare. It also provides a structure supporting the private sector, not least in its role as a major purchaser of goods and services and via an increasing trend towards public/private sector partnerships. In the UK, privatisation of utility companies, along with deregulation, which has opened up new opportunities for private organisations, and increased outsourcing have all contributed towards a trajectory which is seeing a changing balance between public and private sectors. Despite this, the UK still maintains a workforce of almost six million across central and local government, public corporations and the civil service that accounts for 53.4% of GDP as opposed to just 40% in 1997 (OECD, 2013) and employs 5.7 million people (ONS, 2013).
Although there is a growing trend towards the provision of public services by the private sector, this does not diminish the importance and scope of public services provided, which remain vital to both society and the economy, not least within health care.

2.3 SIZE OF HEALTH SECTOR

The NHS is one of the three largest employers in the world, employing approximately 1.3 million people (representing almost 1 in 23 of the working population in the UK). The workforce comprises employees across a wide spectrum and a myriad of disciplines. These include doctors, nurses, allied health professionals (e.g. occupational therapists, physiotherapists, dieticians, etc.), dentists, pharmacists, managers, clerical staff, psychologists and informatics experts, to name a few, all of whom may be working across a variety of departments, specialties or even organisations.

Services can be provided from home, the community (general practice, district nursing, walk-in centres, support groups), local general hospitals and, for more specialist care, tertiary hospitals such as heart centres, children's hospitals and cancer units. Most recent figures show that more than 1 million people access NHS services every 36 hours (NHS Choices, 2012).

Although the number of those directly employed by the NHS has fallen in recent years, with 2011 seeing the biggest fall in ten years, there are still almost 250,000 more employed by the NHS than a decade ago (Health and Social Care Information Centre, 2012).

These statistics illustrate the sheer scale and complexity of a sector which faces a wealth of challenges at political, managerial and operational levels.

2.4 THE CHANGING HEALTH SECTOR

Apart from the contribution health care makes to quality of life for the individual and to society as a whole, it brings with it a significant influence on the economy, since productivity relies on input from human capital, making good health essential to reduce sickness levels. While traditionally it has been recognised that investment must be made through education, contemporary theory increasingly recognises the need for investment in health care in order to maximise growth (Suhrcke et al., 2005).

The NHS was launched soon after World War II in 1948 and since then has been an intrinsic part of UK society. It was designed to provide health care from 'cradle to grave' and over the 66 years since its inception has, arguably, been seen as an exemplar of how health care could be delivered, being free at the point of delivery. However, it faces growing pressures as medicine advances and becomes increasingly expensive as well as facing the demands of an increasingly aged population.

These pressures have manifested themselves through rising concerns about the quality of service provided. Early 2013 saw the publication of the Francis Report into serious failings at Mid Staffordshire NHS Foundation Trust, which was by far the most serious, but not the only, example of a trust shown to be wanting in the care of its patients. In June, major concerns were brought to light about the CQC following their inquiry into the University of Morecambe Bay Hospitals University Trust, after complaints were received about the deaths of several babies. A whistle-blower accused the CQC of covering up failings at the hospital. A subsequent report by independent auditors found "poor governance at" and "questionable decision making by" the regulatory body (Grant Thornton, 2013, pg. 6). It also attributed some blame to the North West Strategic Health Authority and North Lancashire and Cumbria Primary Care Trust, both of which had some responsibility for monitoring and performance management of the Trust.

There is much that is good about patient care. The 2012 annual patient survey carried out by the CQC reported that 92% perceived their experience as being at or above the average score of 5 out of 10 (Care Quality Commission, 2012). Nonetheless, there remain pockets where improvements are necessary.

Governments have not been short of rhetoric concerning the importance of service quality, dignity and respect as well as, increasingly, the concept of public involvement in service design and delivery (Table 2.1). The Department of Health claims that increasing patient power will make services better through greater public involvement, choice and a wider range of providers.

The most significant changes to the NHS since its inception came into being on 1st April 2013 with the aim of giving local people more say in the care they receive and

clinicians more autonomy to improve the quality of service (Department of Health, 2013(a)). Mike Farrar, the chief executive of the NHS Confederation, described the changes as a “refocusing of what the health service is there for”, saying the NHS of the future “will need to move from a medicinal service with a care dimension to a care service with a medicinal dimension”.

Figure 2.1 illustrates the new and complex structure of health and social care in England. GP commissioning consortia are now responsible for purchasing services from providers on behalf of the patient and are accountable to the NHS Commissioning Board, which in turn oversees the delivery of improved outcomes for patients and a fair and comprehensive service throughout the country. Services will continue to be monitored through Monitor and the CQC, while at both national and local levels HealthWatch groups represent the views and interests of service users across both health and social care.

Figure 2.1 The Health and Social Care System from April 2013

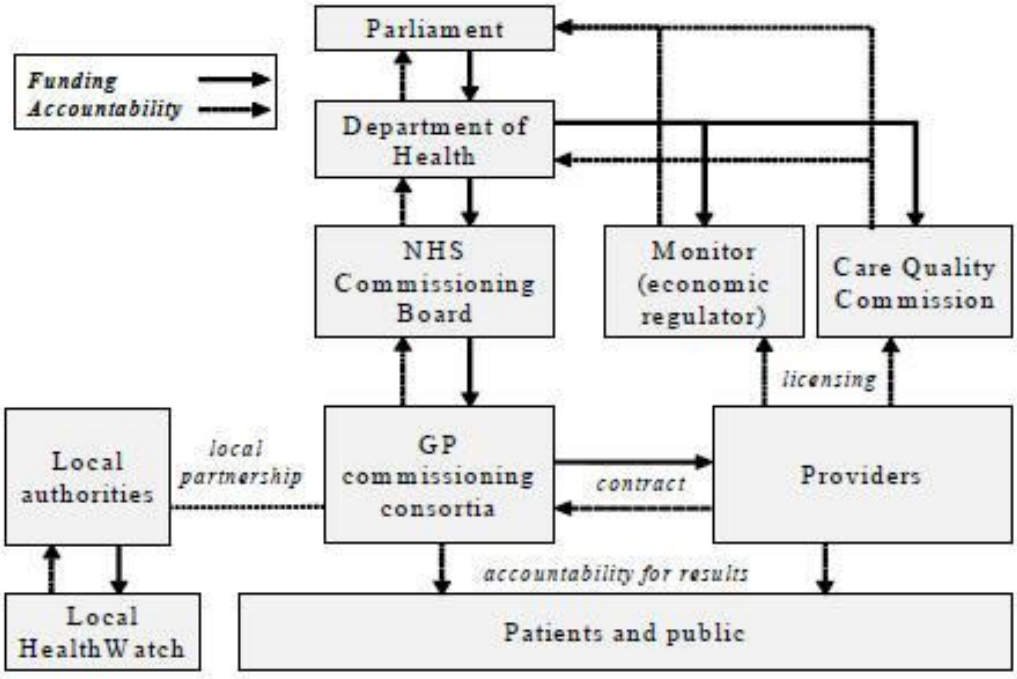


Table 2.1 Key Government Policies on the NHS

POLICY	KEY ISSUES
NHS Constitution (Department of Health, 2013(b))	The Constitution "establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively." (NHS Constitution, 2010, pg 2)
Health and Social Care Act (Department of Health, 2012)	The 2010 White Paper culminated in this Act, the focus of which is to introduce clinically led commissioning of services and greater choice and voice for patients. It has created local HealthWatch committees with the remit to inform and advise on patient views.
Equity and Excellence: Liberating the NHS (Department of Health, 2010)	The main objective of this White Paper sets out the ways in which the coalition government will free the NHS from central bureaucracy to increase local control. It puts patients will be at the heart of everything. It places emphasis on giving them choice and control, helped by easy access to the information. Patients will be in charge of making decisions about their care while doctors and nurses will be empowered to use their professional judgment about what is right for patients. Health care will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients"
High Quality Care for All (Department of Health, 2008b)	Aims to tackle variations in the quality of care and give patients more information and choice.
Better information, better choices, better health (Department of Health, 2008a)	Sets out to improve information to give patients the power and confidence to engage as partners with their health service. It includes ensuring information is available to disadvantaged and marginalised groups, accrediting information providers so the information can be trusted, and extending access to information in a range of media for everyone.
World Class Commissioning (Department of Health, 2007)	World Class Commissioning sets out the priorities of the NHS to ensure that commissioning of services gives the highest quality and value for money. It promotes innovation in commissioning and seeks to create cost-efficiency and productivity as well as ensuring quality. Again it states the intention to put the patient at the heart of decision-making.
Our health, our care, our say 2007 (Health, 2006)	This White Paper focuses on four key themes: • better prevention for improved health and well-being; • giving people greater choice and control over the care they receive; • providing rapid and convenient access to high-quality, cost-effective care closer to home; and • support for people with long-term conditions.
Creating a Patient-led NHS (Department of Health, 2005)	This document was published to push forward the NHS Improvement Plan following consultation with approximately 100,000 members of the public. The aim was to move towards a patient-led system. "We therefore need to develop even better systems for 'feeding back', learning lessons and adapting our approach while maintaining the

	overall direction." (Department of Health, 2005, pg. 2)
NHS Improvement Plan (Department of Health, 2004)	This promised more choice of hospital for patients, improved information and increased emphasis on prevention.
The NHS Plan (Department of Health, 2000)	The NHS Plan recognised that the NHS was a "1940s system operating in a 21st century world … For the first time patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works" (Department of Health, 2000, pg 1). The Plan required local health economies to consult patients on services, conduct surveys and forums to enable services to be more patient-centred, employ patient advocates, ensure patients are copied into all correspondence relating to their care and guarantee that where an operation is cancelled it will be carried out within 28 days.
The new NHS: modern, dependable (Department of Health, 1997(a))	The objective was to shift the focus towards guaranteeing "excellence" for all patients and for this to become the driving force for decision-making at all levels. It also took account of the loss of public confidence and in an attempt to win this back the NHS was to become accountable to patients, open to the public and shaped by their views.
Patients' Charter (Department of Health, 1997(b))	This charter aimed to provide a guarantee of satisfaction for service users by stating what they could expect in terms of performance.
Working for Patients (Department of Health, 1989)	As far back as 1989, policy was around patient choice, ensuring best value for money, independence for NHS Trusts and splitting the purchaser and provider roles. The purpose was to put the needs of the patient first. The objectives and policies have changed little over the succeeding 20 years.
Griffiths Report (Griffiths, 1983b)	This report promoted the need for the NHS to be more accountable to the public by addressing concerns that there was no measurement to demonstrate whether the needs of patients were being met.

(Compiled by the author)

2.5 SERVICE QUALITY IN HEALTH CARE

"The NHS has been said to be awash with data but short on information" (Dr Foster, 2012). This statement is perhaps reflected in the fact that the quality of health care in the UK continues to attract considerable concern despite a backdrop of national initiatives and a plethora of national measures designed to improve quality. Nevertheless, as the Chair of one major hospital trust believes, “National surveys are a waste of time”. The Secretary of State concurred in his response to the Francis Inquiry given to the House of Commons when he said, “there is a serious gap in the provision of clear, comprehensive and trusted information on the quality of care. ... the disjointed system of regulation and inspection smothered the NHS, collecting too much information but producing too little intelligence” (Hunt, 2013) .

The problematic nature of service quality in health care is reflected in a piece of research conducted by the King’s Fund in this area. Storytelling techniques were used to ascertain patient perceptions of quality. The results suggested varying levels of satisfaction which did not correlate with the data from a survey which was carried out at a similar time and which showed a far more positive picture than the findings from the qualitative study (Goodrich and Cornwell, 2008). The authors recommended:

- As a starting point, the effective measurement of service quality in a complex environment such as health care should be mindful of a number of issues: the achievement of targets often does not represent quality (Raleigh and Foot, 2010).
- There needs to be a common understanding of the language in order to act on findings.
- It should be meaningful to the client (patient or family).
- It should be meaningful to local staff.
- There must be ownership at both Board and ward level.
- It should consider the expectations of patients.
- The long-term notion of quality should be considered against that of satisfaction, a short-term impression of a customer based on one point of contact.

(Goodrich and Cornwell, 2008)

The King’s Fund has since produced a paper setting out advice on how to conduct surveys in a hospital setting. It offers useful pragmatic advice on research techniques and asks what quality is and why it should be measured, and advises what indicators

should be measured and how different methods of data collection might be conducted (Raleigh and Foot, 2010).

While many attempts are made to measure ‘quality’ in health care, they are often complex in nature, and many of them have been based on performance and political issues such as targets rather than service quality (Goodrich and Cornwell, 2008). A former regional director of the CQC expressed concern that the frequent changes to mandatory monitoring instruments in recent years provide little in the way of continuity and presents challenges to managers as they familiarise themselves with new intricate processes to follow .

Nevertheless, a genuine will to improve service quality in health care exists, although it is a dynamic field which experiences continual revisions to statutory requirements in the UK.

2.5.1 NHS Constitution

The NHS Constitution is a 15-page document which sets out the principles and values of the NHS, along with the rights of patients, public and staff. It lays down the pledges to which the NHS is committed, as well as the responsibilities of the public, patients and staff so that the health service can operate fairly and effectively (Department of Health, 2013(b)). It is supported by a handbook which explains in detail how the Constitution is applied and what it means to each stakeholder.

The Constitution is underpinned by seven basic principles:

1. The NHS provides a comprehensive service available to all.
2. Access to NHS services is based on clinical need, not the individual’s ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The NHS aspires to put patients at the heart of everything it does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public and communities that it serves.

(Department of Health, 2013(b))

2.5.2 The Mandate – A Mandate from the Government to the NHS Commissioning Board

In parallel to the new commissioning arrangements within the NHS from April 2013, the government has set a mandate which states where improvements in service must be sought:

- Providing safe care.
- Helping people live longer.
- Making sure people experience better care.
- Helping people recover from episodes of ill health or injury.
- Helping people manage their ongoing physical or mental health conditions.

(Department of Health, 2012)

2.5.3 Monitoring of Service Quality

The monitoring of NHS services is enshrined at a multitude of levels. It is a constantly changing environment but at April 2013 elements include:

i. Dr Foster.
ii. CQC.
iii. Patient surveys on behalf of the Department of Health.
iv. Quality Outcomes Framework used to assess general practice on behalf of the Department of Health.
v. Monitor.
vi. Local HealthWatch committees.
vii. Friends and Family Test.
viii. Trust-level intelligence.
ix. Patient Opinion.
x. Ombudsman's Office, which considers those complaints which have not been resolved at local level.
xi. Scrutinising complaints.

In addition, the King's Fund charity lobbies for improved health care.

i. Dr Foster – Performance Based

Dr Foster is an independent organisation which is endorsed by the Department of Health and works in partnership with Imperial College London. It provides comparative records for every hospital in the country as well as online tools for the public to complete. The data is taken to compile guides which allow prospective patients to make informed decisions on which hospital they wish to attend.

Hospital Record Cards

Record cards provide comparative records for every hospital in the country. Using a 'traffic light' system, they register the achievement of hospitals in each of six categories and the reader can instantly see if the performance of a hospital exceeds expectation (green), is in line with expectation (amber) or is below expectation (red). The criteria measured are:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or injury.
- Ensuring people have a positive experience of care.
- Ensuring hospital staff inform patients or carers who to contact if they are worried about their condition or treatment after discharge from hospital.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

(Foster, 2009)

Performance rather than quality based, each of these is broken down into a number of items and the results are benchmarked with national trends.

ii. CQC – Performance and Quality Based

The CQC was established in 2009, creating integrated regulation for health and social care in England, a process that had formerly been delegated to the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. Its aim is to "ensure better care for everyone in hospital, in a care home and at home" (Care Quality Commission, 2013).

All NHS trusts are required to register with the CQC, which in turn monitors their performance through both qualitative and quantitative means. Data from annual self-completion assessments is augmented by data from visits, surveys, MPs, local authorities, LINks (Local Involvement Networks) and local HealthWatch committees, feedback from Patient Advice Liaison Services (PALS) and comments from the public, and these all contribute to annual reports. In addition, the CQC carries out spot checks on an annual basis.

The Commission has the power to remove registration from any trust (mental health, social care, primary care or acute settings) failing to comply with essential standards, in which case teams can be brought in to ensure performance is brought up to the required standards. Nevertheless there have been concerns that the organisation is 'toothless' after reports of poor care following visits.

All health care organisations are judged against a number of essential standards, which they claim are based on the type of care provided rather than systems and processes.

1. Patients can expect to be involved and told what is happening at every stage of their care:

- *a.* They will be involved in discussions about care and treatment, and privacy, dignity and independence will be respected.
- *b.* Patients will be asked for their consent before receiving an examination, care, treatment or support.

2. Patients can expect care, treatment and support which meets their needs:

- *a.* Personal needs will be assessed to ensure that care is given that is safe and supports the patient's rights.
- *b.* Food and drink will be provided to meet dietary needs.
- *c.* Safe and co-ordinated care will be given where more than one care provider is involved or if a patient is moved between services.

3. Patients can expect to be safe:

- *a.* They will be protected from abuse and human rights will be respected.
- *b.* They will be cared for in a clean environment and protected from infection.
- *c.* Medicines will be provided safely and when needed.
- *d.* Care will be given in a safe and accessible place to help recovery.
- *e.* Patients will not be harmed by unsafe or unsuitable equipment.

4. Patients can expect to be cared for by qualified staff:

   a. Health and welfare needs are met by properly qualified staff.
   b. There will be sufficient staff to meet health and welfare needs and keep patients safe.
   c. Staff will be well managed and have the chance to develop their skills.

5. Patients can expect their hospital to constantly check the quality of its services:

   a. The health care provider will continuously monitor the quality of services to make sure patients are safe.
   b. Complaints will be listened to and acted on properly.
   c. Personal records will be accurate and kept safe and confidential.

   (Care Quality Commission, 2013)

While the CQC claims that it focuses on quality of service and outcomes rather than systems and processes, the dimensions are limited in some aspects of overall patient experience, particularly around the complexities of communications and around empathy.

iii. Patient Surveys on Behalf of the Department of Health (DoH) – Performance and Quality Based

Patient surveys were imported from the United States where they were developed over 20 years ago Their rigour was underpinned by research to determine priorities that the public placed on service elements. Since 1997, hospitals in the UK have been required to carry out a survey annually. The CQC determines the core questions of these surveys and, although these can be augmented at local level, this opportunity is treated with caution since the core questionnaire is unduly long with 78 questions (Appendix 1) for the inpatient survey and 62 for the GP survey (Appendix 2). Unfortunately, more recently there has been a tendency to incorporate questions of a political essence in the inpatient survey, where questions about waiting times, cleanliness and mixed-sex wards (Goodrich and Cornwell, 2008) are included. These go against the spirit of the original framework.

NHS/CQC Inpatient Survey

The first-level elements of the patient survey for adult inpatients are:

- Admission to hospital – *communications; dignity; access.*
- Hospital and ward – *tangibles; safety; food.*
- Staff – *staff; communications; safety; reliability, trust.*
- Care and treatment – *reliability; communications; access; involvement.*
- Operations and procedures – *communications.*
- Laving hospital – reliability; *communications.*
- Overall – *dignity; staff.*

The document comprises multiple-choice questions where the respondent is asked to tick the most appropriate statement (Appendix 4). The questions are simple to answer and cover both processes and their evaluation of the caring (non technical) nature of the experience.

GP Patient Survey

- Access – frequency of visits, how appointment is booked, who do you see – *access.*
- Making appointments – what type of appointment, same day or advanced, ease of getting appointment, length of wait to get appointment, convenience, action taken if appointment not available, overall experience – *access.*
- Waiting times at surgery – *access.*
- Last visit to the doctor or nurse – *empathy, access, involvement, trust, communications, overall experience.*
- Planned care – does patient have care plan and were they involved in its design – *involvement.*
- Out of hours services – *ease of access, trust.*
- Dentistry – *access, overall experience.*
- Questions about the profile of the respondent.

(Ipsos MORI, 2013)

The notes in italics for both the Inpatient Survey and the GP Patient Survey represent the dimensions included in each section

One of the major challenges with the questionnaires is the definition of experience as opposed to satisfaction (Coulter et al., 2009; Goodrich and Cornwell, 2008; Richards and Coulter, 2007). A patient merely registering dissatisfaction with an element is not given the opportunity to identify what they were unhappy about; more information about the experience is required. As an annual process the survey can be deemed to be longitudinal and annual

trends can be extracted for each trust, providing an insight into the longer-term service quality construct rather than the transitory nature of customer satisfaction. The process also allows trusts to benchmark themselves against others. Nevertheless, unless the data is acted upon at board level it is meaningless. They are a national requirement, rather than having local ownership, and a danger exists that actions are not always based on the longer-term but are a knee-jerk reaction to the current year's results. Vigilance is also recommended when drilling down to understand the data more accurately since there is evidence to suggest that respondents tend to register an overall positivity towards the service they receive. Studies have indicated that even where a patient has perceived their care as excellent they have often experienced a number of problems, especially in respect of professional services (Goodrich and Cornwell, 2008). Allowing respondents to explain where dissatisfaction lies may help overcome this flaw, although more research is required in relation to this specific survey.

iv. Quality Outcomes Framework – Performance Based

This process is voluntary and is used to assess general practice on behalf of the Department of Health. It is carried out by panels of clinicians and laypeople who visit each general practice on an annual basis and provides the basis for an incentive programme for GP practices which are scored on:

- Clinical care – with 87 indicators across 20 common illnesses such as coronary heart disease, hypertension, etc. (661 points).
- Organisation – comprising 45 indicators across: management of records and information; patient communication; education and training; quality and productivity; practice management and medicines management (262 points).
- Patient experience – length of consultations (33 points).
- Additional services – which includes indicators across four services: cervical screening, child health surveillance, maternity services and contraception (44 points).

(NHS Information Centre, 2011)

v. Monitor – Performance Based

Monitor has a responsibility to scrutinise the performance of foundation trusts around business, risk and governance. Since April 2013, it has also had a

remit to prevent anti-competitive behaviour and to support commissioning boards in maintaining service continuity. The nature of how they scrutinise services is through self-regulation and self-reporting on the part of trust boards.

v. HealthWatch – Quality-Based

While HealthWatch is not a regulatory body such as Monitor or the CQC, HealthWatch committees are statutory bodies with a remit to collect evidence of shortfalls in service at both national and local levels and to ensure that these are acted upon. They have the authority to visit providers at any time and can provide information and advice to inform commissioning decisions.

vii. Friends and Family Test – Quality-Based

The Friends and Family Test is a key requirement in the Mandate (para 5.1). Within 48 hours of a patient being discharged they will be invited to state how likely it is they would recommend a ward or department to friends and family by means of a Likert-type scale ranging from ‘extremely likely’ to’ extremely unlikely’. Follow-up questions will give them opportunity to explain their response. All responses are gathered to give a cumulative result which is then posted on NHS Choices. Results may also be published in trust annual reports and on individual trust websites.

viii. Trust-Level Intelligence – Quality-Based

All NHS trusts are required to include patient experience and involvement at strategic level, although how extensive this is varies from trust to trust. Examples include:

- a major teaching hospital in the North West where patients and staff work together to identify areas for improvement through user groups set up across the trust. Some actions are then dealt with by relevant departments; others are referred to the Board.

- another North West hospital, which takes a high-level approach led by a non-executive director from the banking sector and involving patient

representatives, matrons and organisational development. Patients were asked to say what was important to them and a model for the promotion of service quality was adopted focusing on the emotional needs of patients.

Other hospitals may track service evaluation merely through feedback from Patient Advice Liaison Service (PALS), which all trusts are required to have, or from trends in complaints. Simple surveys may also be conducted on an ad hoc basis.

ix. Patient Opinion – Quality-Based

Patient Opinion is an independent website, similar in concept to Trip Adviser and recognised by the Department of Health, which allows patients to rate and to comment on the care they have received at hospitals, surgeries and clinics. As at June 2013, 450 organisations were members, with 45,000 patient stories having been published and 51 million public viewings, more than half of the stories being positive, a third mixed and a sixth negative. It is a proponent of a shift away from national surveys, claiming, “the approach to measurement here is evolutionary and there needs to be a move away from the reliance on national surveys with long lead-times and small samples” (Patient Opinion, 2009).

A report published in 2011 brought together comments over the five years since 2006 to report on the patient perspective on service quality. Its findings suggested 40% of respondents expressed concern around one or more of the following: staff attitudes; care and compassion; miscommunication or lack of communication; and responsiveness.

It does provide a forum for feedback to augment the multitude of other sources of data, but its failure to adopt any formal protocol leaves it open to claims that its findings are anecdotal. It also recognises that the patient accounts are purely subjective perceptions rather than fact but that the conclusions should be a focus for improvement.

x. Ombudsman

The role of the Parliamentary and Health Service Ombudsman is to carry out investigations into complaints about public services on behalf of service users. Through this work it is able to generate a picture of service quality and highlight issues of particular concern. While it does not employ formal models in terms of measuring services, it does use data received through investigations to produce reports on contextual issues.

xi. Complaints

Patients have the expectation of, and are frequently given, extremely professional care and treatment by the NHS. But when standards are not as high as might be expected, patients need to have access to a responsive and effective complaints system. If handled properly, complaints can be a valuable source of information for organisations. Unfortunately, there is still considerable room for improvement. Ann Abraham, Health Service Ombudsman for England, stated in her 2010/2011 Review of Complaint Handling that the NHS needed to "listen harder and learn more from complaints":

> "The volume and types of complaints we have received in the last 12 months reveal that progress towards achieving this across the NHS in England is patchy and slow.
>
> "Change will only happen in the NHS if there is a change in the culture, as well as in the procedures and practices. Staff must feel that there is clear guidance on when they will be held to account for errors, and when these will be seen as systemic failings of an organisation. They should receive regular feedback on the volume and nature of the complaints about them and their teams, and anonymous patient feedback should be used to support improvement." (Abraham, 2011, pg. 2)

However, the NHS complaints system sometimes compounds and exacerbates the negative experiences of patients where it fails to deliver timely or appropriate resolutions. In such situations, patients have little choice but to

give up or turn to the legal system. Often the motivation of complainants is often not to seek compensation for failures of care but rather to have their concerns listened to and acted upon in order to reduce the likelihood of similar failings happening again (Department of Health, 2011b).

2.5.4 King's Fund

The King's Fund is a charitable organisation with a remit to promote improvements in health services. They work with other organisations to seek changes in behaviour and attitudes and to develop policy. These include charities, government departments and other agencies with interests in the provision of health care. Their work programme includes projects relating to measuring patients' experiences in hospital (Coulter et al., 2009); patient experience and how this can be improved (Goodrich and Cornwell, 2008); and examining trends from the national survey of the NHS (Richards and Coulter, 2007).

2.5.5 Francis Inquiry

The Francis Inquiry was set up after 1,200 patients died due to a series of major failings at Mid Staffordshire NHS Foundation Trust between January 2004 and March 2009. The Inquiry made 290 recommendations which have resulted in the Government promising a new regulatory model to be led by an independent chief inspector of hospitals whose role will be to assess hospitals at specialty or departmental level. Fundamental to the assessments will be standards of patient experience and care and no hospital will be able to achieve the highest ratings without this. At the time of writing this thesis, the methods and service elements on which measures would be based had not been published.

Also as a result of the Francis Inquiry, a revised NHS Constitution was put out to consultation in March 2013 which featured amendments to a number of areas:

- Patient involvement.
- Feedback.
- Duty of candour.
- End of life care.
- Integrated care.
- Complaints.
- Patient information.

- Staff rights, responsibilities and commitments.
- Dignity, respect and compassion..

Changes in training for nurses were announced in March 2013, placing emphasis on front-line experience prior to their degree. At the same time health care support workers have a code of conduct and minimum training standards (Hunt, 2013).

2.6 In Conclusion

The provision of health care is complex and multifaceted, making it extremely difficult to construct an effective means of measuring service quality at all levels. A multitude of instruments exists and much work continues in an attempt to overcome the problem, but still there remains a lack of continuity or robustness, or a commitment at board level to gather data in a co-ordinated and meaningful manner to inform strategic decisions.

Problematic to these endeavours is the difficulty in defining what service quality actually means and until this is more readily understood the gap will not be filled. More research is required in determining this from the perspective of both service users and providers and ultimately contributing to the development of a diagnostic tool which can be used at local level. Much remains to be done, but the problem is not insurmountable and once some meaningful tool exists, then perhaps boards can be convinced of their own responsibility towards this matter, which is of increasing import as the NHS shifts to its next incarnation, because until this is achieved no framework will achieve its goal.

CHAPTER 3

LITERATURE REVIEW

This chapter reviews literature about the nature of quality and seeks to understand how this is currently measured and managed in the services sector, before discussing more specifically how it is applied to health care. It also offers a critique of SERVQUAL, the most widely recognised model used to measure service quality to determine its relevance across all sectors, and concludes by explaining how this study will contribute to the extant literature to further understanding in the health care sector. It is structured in eight sections, each of which underpins the study as a whole:

1. Quality – defines quality; discusses quality in manufacturing and total quality management.
2. The nature of services – considers the concept of services, looking at the IHIP (intangibility, heterogeneity, inseparability, perishability) framework; service-dominant logic and professional services.
3. What is service quality? – defines service quality and looks at the role of credence. Assesses how extant literature defines service quality.
4. Service evaluation – discusses attitude; customer satisfaction versus service quality and expectations and looks at dimensions.
5. A critique of SERVQUAL – debates in some detail the SERVQUAL model and its relevance across sectors.
6. Dimensionality – identifies the items most often applied to the evaluation of service quality and examines how definitive these are.
7. Service quality in health care – applies the literature to health care and explores its relevance to this unique sector.
8. Applying the literature – explains how the literature will direct the research to develop a tool for the evaluation of service quality in health care.

3.1 QUALITY

3.1.1 A Background to the Quality Construct

The focus of this thesis is to understand the concept of quality in a health care setting. This section introduces what a vague construct it is and considers if it is possible to offer a clear definition. It also looks at how quality has developed from its application in manufacturing, which can be measured in objective terms to a shift towards services where the quality construct is more nebulous, to assess if similar instruments can be applied to both.

The concept of marketing first evolved in the early 20th century and was concerned only with the transaction of goods and their physical distribution. It was present as a discrete unit within larger, bureaucratic organisations (Lusch and Webster, 2011). The notion of service was no more than an aid to the processes involving goods (Vargo and Lusch, 2004) in an economy where business and management research focused on goods alone.

The late 1950s and 1960s saw the beginning of a slow shift away from this paradigm towards the idea of customer benefits and the concept of unique selling points. Quality was to become a key ingredient to succeed in an increasingly competitive marketplace, although even as late as the 1970s the Four Ps (marketing mix) model with its offering of product, price, place and promotion was still being largely applied to goods.

3.1.2 Defining Quality

Meeting and/or exceeding customer expectations (Parasuraman et al., 1985; Gronroos, 1984) is possibly the most accurate and widely accepted definition of quality and grew out of services literature (Reeves and Bednar, 1994), taking over from the previous concept of conformance to specifications which failed to address value or the human element of quality. The word ‘best’ has also been applied, as it is easier to measure and verbalise than ‘value’, which has also been applied. Meanwhile the word ‘excellence’ is often quoted but is seen as too abstract (Reeves and Bednar, 1994).

There is no collective experience of quality; it is a concept that varies between encounters, perceptions of actors, times and/or places. It follows, therefore, that there is no global definition of the construct which can be applied in different circumstances, with each variation having strengths and weaknesses (Reeves and Bednar, 1994).

Although quality is difficult to measure (Lilja and Wiklund, 2006), business leaders and theorists have described a number of imperatives required for quality development which have, in different ways, focused on human behaviour: speed of processes; cost where value for money is not always the cheapest option; competition centred on quality; treating quality seriously (Feigenbaum, 1999) and fact-based decision-making rather than intuition (Feigenbaum, 1999, pg. 285; Peters, 1997).

3.1.3 Measuring and Managing Quality in Manufacturing

3.1.3.1 Total Quality Management

It was in the 1950s that William Deming worked with the Japanese manufacturing industry to develop total quality management (TQM), making a vital contribution to quality and helping the industry to become the world leader. It was based on a simple cycle of plan, do, check and act (Senapati, 2004). The rest of the industrialised world soon followed their lead and adopted the process.

While TQM has not received academic scrutiny it has had far more impact on practice than literature-based input (Silvestro, 2001). It requires everyone in the organisation to be involved in continuous improvement, with the lead being taken from the very top. It must include all integrated activities, to produce goods or services that are fit for purpose, at a reasonable price and timely (Zineldin, 2000). It must also be sustainable (Svensson, 2006) and become a continuous process. (De Feo, 2006). Top-level management have to be able to view things holistically to push forward general improvement, innovation and creativity (Svensson, 2006; Zineldin, 2000).

Specifically, literature cites TQM as including 11 dimensions: customer focus; continuous improvement; teamwork; top management commitment; training; quality systems and policies; supervisory leadership; internal communications; partnerships; measurement/feedback; and culture change (Hing Yee Tsang and Antony, 2001).

Total relationship management (TRM) has evolved alongside TQM and views quality through a wider lens where everyone places continuous improvement at the top of the agenda and focuses on internal and external relationships as well as the processes. (Silvestro, 2001; Zineldin, 2000). Quality can also be encapsulated within the dimensions of the Five Qs model: quality of each of interaction, atmosphere, object, process and infrastructure. All these principles should be as applicable to services as they are to goods.

3.1.3.2 Lean Manufacturing

Lean manufacturing began to evolve in the 1990s and has been described as being about asking the right questions and trying things, or encouraging others to try things (Shook, 2008). They are based on improving productivity and reducing errors. When General Motors adopted lean they reduced the time it took to get a car to market from three or four years to just 18 months (Teresko, 2005). The philosophy is based on reducing waste and improving productivity through building on knowledge, methods and tools over decades of operational experience and research (Byrne et al., 2007).

3.1.3.3 Six Sigma

The principles of lean are often closely associated with Six Sigma which was developed around the same time, also from the manufacturing industry (Pepper and Spedding, 2010; Chakrabarty and Tan, 2007). It has been defined as “A quality improvement program with a goal of reducing the number of defects to as low as 3.4 parts per million opportunities or 0.0003%” (Chakrabarty and Tan, 2007, pg. 195). Again, both lean manufacturing and Six Sigma require total involvement from the whole organisation (Black and Revere, 2006).

More recently Six Sigma has encroached on the services sector and, while initially this has focused on mass services (Silvestro, 2001), there has been a shift towards professional services, in particular health care (Chakrabarty and Tan, 2007; Taner et al., 2007; Senapati, 2004; Woodall, 2001; Gronroos, 1984; Sehwail and DeYong, 2003) where it is based on processes and their improvements (Woodall, 2001). Although health care largely relies on the human element rather than automation (Sehwail and DeYong, 2003), this statistical approach has helped in health care processes such as increasing capacity, reducing avoidable emergency admissions, improving accuracy of clinical coding and others (Taner et al., 2007).

3.1.3.4 ISO 9000

Around the same time that lean manufacturing developed, so did the ISO 9000 system, a form of quality assurance which provides reassurance to the customer that quality is being met, but it has been criticised for being inflexible and depending too much on bureaucracy. Nonetheless the formal policies and processes it exploits to ensure quality (Dumke de Medeiros, 2000) have seen it grow steadily in manufacturing (Karapetrovic, 1999), although its use in service industries is less apparent.

3.1.3.5 Balanced Scorecards

The latter part of the 20th century also saw the introduction of balanced scorecards, which have been cited by the Harvard Business Review as one of the 75 most influential ideas of the 20th century (Kocakulah and Austill, 2007). They are designed to translate vision into action and link objectives and measures; plan and set targets; and enhance learning through feedback. The measures, which are both external for customers and shareholders as well as internal for business processes (Chavan, 2009), have more recently encroached into health care where both nationally and locally set targets are monitored.

3.1.3.6 In Conclusion

Although each of these instruments is process driven, they have become prevalent in many services, particularly in health care. Unfortunately they fail

to address the ‘softer’ issues such as responsiveness, environment, communication, etc., leaving scope for further research.

3.2 THE NATURE OF SERVICES

Since endeavouring to measure something without an understanding of what is being measured is unworkable, the following narrative explores the nature of services, providing a grounding for research into the most appropriate means of evaluating this elusive concept.

The service economy represents almost 80% of the UK economy in terms of GDP, with the public sector representing 60.8% of this figure (Economywatch, 2010). It also accounts for a workforce of 25.6m out of a total UK workforce of 31.26m (Office for National Statistics, 2011). The scope of the service sector is reflected in most developed economies, yet there has been limited work in this field (Lovelock and Gummesson, 2004). This is surprising when the expectations of consumers have changed to an extent where it is no longer acceptable for even manufacturing organisations to rely solely on goods. Sir John Harvey-Jones, former chairman of ICI as far back as the 1980s, said that his company was “providing a chemical service to customers, rather than selling chemical products” (Gronroos, 2007, pg. 22). Service offers an extra dimension to a ‘goods-dominant’ logic whereby it adds value to goods (Lusch et al., 2007). Whether any value exists in a product if there is no service attached to it is questionable, but caution should be taken where service fails to live up to expectations, for example through late delivery or poor advice/instructions (Gronroos, 1997). This will affect the perception of quality in terms of the product.

It was not until the late 1970s that there was a real shift in the direction of commentators’ thinking, when it was beginning to be seen that purely focusing on goods equates to using ‘straitjackets’ in relation to the application of existing theories to services (Gummesson, 1978, pg. 89). While this argument was in the context of professional services, it holds just as true with services generally.

3.2.1 Defining Services

Since the 1970s there have been numerous definitions offered for the meaning of services but with no consensus (Gronroos, 2007; Gummesson, 1987). This debate becomes increasingly problematical in a world where advancing technologies are constantly changing the nature of service transactions.

Literature alludes to “high-touch/high-tech services and discretely/continuously rendered services” (Gronroos, 2007, pg. 57), where high-touch services comprise staff producing the service, as opposed to high-tech services, which rely on technology for automated systems. Discretely provided services are those where continuous service provision is not required, such as car maintenance, while those described as being continuously rendered allow for relationships to build between the customer and provider. These are particularly well-illustrated by professional services such as law, health or finance.

When searching for a definition, the terms ‘services’ and ‘service’ often appear as interchangeable, although some make a distinction between the two where the former is an individual transaction which is offered to the customer (Edvardsson et al., 2005, Zeithaml and Bitner, 2003) and the latter is the performance of the whole organisation (Edvardsson et al., 2005) or industries as a whole (Zeithaml and Bitner, 2003).

In an attempt to find an all-encompassing definition, a study comprising 16 interviews with leading scholars found little evidence that one definition would cover all aspects of services (Edvardsson et al., 2005). This is reflected in the definitions set out in Table 3.1. Many commentators focus on activities which take place between the customer and service provider and which can be broken down into three dimensions: activities; interactions; and solutions to customer problems (Edvardsson et al., 2005). This has been subject to criticism with the contention that the focus of a service should be its function rather than the action (O'Shaughnessy and O'Shaughnessy, 2008).

Table 3.1 Defining the Service Construct

AUTHORS	DEFINITION
(Lewis and Mitchell, 2007), pg. 11	The service encounter is the "interaction between a service organisation and its customer" where every time the customer comes into contact with the organisation (face to face, over the telephone, by letter or by automated means) the firm has an opportunity to create an impression.
(Gronroos, 2007), pg. 22	"A service is a process consisting of a series of more or less intangible activities that normally, but not necessarily always, take place in interactions between the customer and service employees and/or physical resources or goods and/or systems of the service provider, which are provided as solutions to customer problems."
*(Edvardsson et al., 2005), pg. 112	"Goods are things, services are activities."
*(Edvardsson et al., 2005), pg. 112	"A service, in essence, is a performance meant to provide benefit. It can be performed for a customer or by a customer ... Services are used by not owned by the customer."
*(Edvardsson et al., 2005), pg. 112	"Service is the experience created for customers when in contact with a provider ... The experience has two major components: the core quality (food, clothing) and the delivery (quality)."
(Edvardsson et al., 2005)	A service is not a market offering but rather a perspective on the part of the customer about the value that offering brings. Implicit in this is the interactive, experiential and relational nature of the service.
(Vargo and Lusch, 2011), pg. 2	"...the application of specialised competences (knowledge and skills) through deeds processes and performances for the benefit of another entity or the entity itself."
(Zeithaml and Bitner, 2003), pg. 3	"Services are deeds, processes and performances."
(Yang, 2000)	A set of activities that represent the output of a service system which will vary from one firm to another.
(Gummesson, 1987), pg. 22	Services are "something which can be bought and sold but which you cannot drop on your foot".
(Surprenant and Solomon, 1987)	The dual interaction between the customer and service provider.
(Parasuraman et al., 1985)	Services have three unique features – intangibility, heterogeneity and inseparability. (This paper does not identify perishability as a feature.)

* These represent responses in a study into how services are portrayed in service research, which interviewed leading scholars.

(Compiled by the author)

While Gronroos provides what is possibly the most comprehensive definition of service, caution should be applied in using it in a field for which no watertight definition has yet been offered.

There is little doubt that services can be differentiated from products, but debate continues about just how far apart the two are from each other (Moeller, 2010; Edvardsson et al., 2005; Vargo and Lusch, 2004; Lovelock and Gummesson, 2004).

3.2.2 Features of Services

While intangibility, heterogeneity, inseparability and perishability (IHIP) are the features most commonly accepted in determining services, a school of thought exists that questions how robust they actually are. They are not based on empirical research (Lovelock and Gummesson, 2004), and are often seen as being too simplistic with commentators arguing that the features are not unique to services (Moeller, 2010; Vargo and Lusch, 2004; Lovelock and Gummesson, 2004).

3.2.2.1 Intangibility

It is unlikely that any service can claim to be wholly intangible but is far more likely to fall somewhere along a continuum, albeit veering more towards the intangible (Moeller, 2010; Edvardsson et al., 2005; Lovelock and Gummesson, 2004). The tangibles that exist are often in the form of the environment from where they are delivered (such as offices, clinics, salons, restaurants, hotels, etc.), which contributes towards the overall impression of the service to a lesser or greater extent. They can equally refer to knowledge and people, or even memories – for example, on one level, a holiday may be a transient experience, but on another, the memories remain with the holidaymaker potentially for a lifetime (Edvardsson et al., 2005) and so become a tangible asset. To assume services are wholly intangible is, at best, ambiguous, at worst, false.

3.2.2.2 Heterogeneity

Similarly, a dispute lies in the concept of heterogeneity, where sophisticated control procedures and standardisation can reduce any variability in services (Edvardsson et al., 2005). This is likely to be the case in more routine service delivery such as call centres, where high-tech services provide a lack of

individuality (Gronroos, 2006). This impersonal nature of the service often compromises the perception of quality.

It follows that homogeneity remains the antithesis of most services, particularly within the professional sphere where tailoring the service to individual needs is crucial to success. The fact that impersonal contact delivered by call centres has become a modern-day irritation suggests that the provision of 'virtual' remote services is not synonymous with service quality, giving rise to the opportunity for organisations to exploit personal service as a unique selling point, or high-touch (as defined by Gronroos).

3.2.2.3 Inseparability

Traditionally, the consumer is a key player in the delivery of a service where they have a fundamental effect on the quality, although some services are provided in the absence of the customer – delivering goods, laundering and cleaning, etc. – and they become separable (Lovelock and Gummesson, 2004). The advance of communications technology has meant that this notion of inseparability is no longer applicable in some sectors due to web-based communications, for example in the delivery of lectures (Moeller, 2010). Sophisticated technology in communications via social media, which reduces the occurrence of relationships even in continuously rendered services (Gronroos, 2007), is becoming increasingly common and will remain in the ascendency. Even within medicine, the birth of consultations via the Internet and electronic records is having an impact and one which is forecast to become widespread in the near future. That technology has reduced the level of inseparability in some services is beyond doubt. Nevertheless, this does not mean that long-term relationships and continuously rendered services, which require personal involvement, will become anachronistic. Contemporary authors refer to this as co-creation (Vargo and Lusch, 2004) and it justifies reflection in its own right as discussed in section 3.2.4.

3.2.2.4 Perishability

Tangibility and perishability can be closely associated with each other. In the case of a person's memory becoming tangible through their continued

awareness or within their subconsciousness, it follows that it is no longer perishable (although memory does fade over time and as age takes over). Similarly services such as some surgical procedures or education may be deemed as non-perishable.

In general, the perishability of a service will differ from the stance of the provider and that of the consumer, where the provider will see it through its relationship with capacity – for example, vacant rooms in a hotel – as opposed to the consumer who sees it according to its lasting nature in terms of its benefits. It is argued that in order to provide the service and maximise its potential, the organisation requires customer resources and without these the opportunity will perish (Moeller, 2010). These resources fall into three categories:

- The customer themselves, where their person is the focus of the service as in the case of medicine, hair styling.
- Their property, which receives the service – for example, car or house maintenance.
- Their rights, which are protected by lawyers, financial advisors, etc.

(Moeller, 2010)

Goods, on the other hand, can be produced regardless of demand and do not, therefore, rely on customer resources at a given time.

Many services are viewed as transient: when taking a flight, once the plane has landed the service has been completed; or when enjoying dinner in a restaurant, once the dinner has been consumed the actual experience expires, although the memory of the event may not.

3.2.3 Alternative Classifications

Regardless of critics the IHIP model remains the most recognised means of distinguishing services despite attempts to devise alternative classifications such as the FTU framework – facilities, transformation and usage (Moeller, 2010) – as well as a method of categorising types of service (Lovelock, 1983). The authors of both of these have sought to interweave the respective elements with the IHIP features. While the FTU framework largely concurs with IHIP, considerable exceptions can be seen when services are categorised (Lovelock,

1983). Table 3.2 compares how each of the two theories align with the IHIP model.

Table 3.2 Relationships between IHIP Model and Alternative Classifications

CLASSIFICATION		**INTANGIBLE**	**HETEROGENEOUS**	**INSEPARABLE**	**PERISHABLE**
FTU (Moeller, 2010)					
Facilities	Provider: staff, machines, knowledge, skills	Tangible environment and machines, but knowledge and skills intangible	Human involvement makes process heterogeneous, but to varying degrees according to service	Provider and customer resources are both necessary	If resources are not present, the opportunity perishes
	Customer: possessions, self	Intangible service to tangible goods	Human individuality requires heterogeneity in service		
Transformation		Transfer of knowledge and skills are intangible	Human involvement of both the provider and customer make process heterogeneous	Customer is an integral part of transformation and therefore inseparable	If the customer does not activate the service, then the opportunity perishes
Usage		Service is a 'performance', therefore intangible	Varies e.g. 'live' entertainment not heterogeneous	Simultaneous service delivery and usage = inseparability	Simultaneous service delivery and usage = inseparability
Service Categorisation (Lovelock, 1983)		**INTANGIBLE**	**HETEROGENEOUS**	**INSEPARABLE**	**PERISHABLE**
Physical actions to the customer e.g. health care		May be seen as tangible if there is physical or lasting change	Human individuality requires heterogeneity in service	Customer is an integral part of transformation and therefore inseparable.	If the customer does not activate the service, then opportunity perishes
Physical actions to the customer's possessions e.g. cleaning, maintenance		More transient, but may result in tangible transformation	Varies, but can be standardised	Customer not usually part of the process	Perishable
Non-physical actions towards the customer (eg entertainment, education)		Intangible	Varies, but can be standardised	Inseparable if 'live' performance or real-time class. But need not be inseparable	Not if stored in printed or digital form
Non-physical actions directed at customer e.g. processing data – insurance, banking		Intangible	Varies, but can be standardised	Many exceptions. Often customer is not present	Not if stored in printed or digital form

Adapted from (Moeller, 2010) and (Lovelock and Gummesson, 2004)

3.2.4 Co-creation/Service-Dominant Logic

The notion of a service-dominant (S-D) logic which involves the knowledge and skills of parties to provide a service has attracted almost universal acceptance. Underpinning the S-D logic is the supposition that all firms and economies are service-based and it can, therefore, be concluded that marketing should focus on service theory and principles. Ten foundational premises (Table 3.3) are applied to S-D logic, six of which (1, 3, 6, 7, 9 and 10) relate specifically to the concept of co-creation, where the consumer is a fellow actor with the provider of a service in creating value (Vargo and Lusch, 2004). While this leads to the potential for greater heterogeneity it also follows that the higher the levels of contact, the greater the risk of compromising efficiency owing to the inconsistencies between actors (Chase, 1978). This, along with the fact that FP10 asserts that value is always determined by the beneficiary, makes for considerable challenges when measuring value and quality (Table 3.3).

Table 3.3 Foundational Premises of a Service-Dominant Logic

FP1	Service is the fundamental basis of exchange
FP2	Indirect exchange masks the fundamental basis of exchange
FP3	Goods are a distribution mechanism for service provision
FP4	Operant resources are the fundamental source of competitive advantage
FP5	All economies are service economies
FP6	The customer is always a co-creator of value
FP7	The enterprise cannot deliver value but only offer value propositions
FP8	A service-centred view is inherently customer orientated and relational
FP9	All social and economic actors are resource integrators
FP10	Value is always uniquely and phenomenologically determined by the beneficiary

(Vargo and Lusch, 2004, pg. 7)

The main detractors of the theory contend that, because of the heterogeneity of the service sector, to suggest that “all economies are service economies” (Lusch and Vargo, 2011, pg. 1301) is far too broad a statement (O'Shaughnessy and O'Shaughnessy, 2011). The use of the word ‘services’ as opposed to ‘service’ is worthy of note since the word is often used to denote a function rather than the

sector as a whole (O'Shaughnessy and O'Shaughnessy, 2008). Lusch and Vargo use it here in reference to the sector.

Critics of the S-D logic claim that viewing service in such a general manner removes the true richness or depth of a sector that can be dissected into many niche segments. This argument is countermanded by the fact that specialism equals competence, where firms concentrate on expertise that distinguishes them from others to offer expertise in a narrow field. (Lusch and Webster, 2011; Vargo and Lusch, 2004). The censure seems somewhat pedantic in the overall debate since the concept of a service-dominant logic can be applied to all manner of services, not just niche ones as suggested by O'Shaughnessy and O'Shaughnessy 2008..

The S-D logic reflects the Nordic School of thought with a shift away from specialised marketing teams taking responsibility for customer focus to an understanding that the role of every colleague must play a part in the customer offering. They highlight the need for value to be at the heart of all stakeholder activities – including those of the consumer, outside agencies and staff throughout the whole organisation.

The theory refers to operand and operant resources, where the former refers to a resource that has an act done to it while the latter is one which conducts that act (Vargo and Lusch, 2004). Historically the consumer fell into the role of the operand resource but recent years have seen a transition where the consumer has become the operant resource, contributing to value. This is reflected by one definition that goods are "resources that support customers' value generation", while service logic refers to the fact "that the firm facilitates processes that support customers' value creation" (Gronroos, 2006, pg. 324). The word 'facilitates' promotes the notion that the firm merely supports the consumer by providing resources such as goods, information and/or activities required to maximise value, and in doing so can influence the consumer's value creation (Gronroos, 2011) and, ultimately, their perception of quality.

The beginning of the 21st century has seen a shift from research and development departments leading on maximising economic value creation to that of interaction between the customer and provider (Cova et al., 2011). The rationale supporting this

change is laid open to claims that consumers are being exploited; that through interaction firms are able to direct customer attitudes in the direction they want. At the same time their input into service development is taken advantage of for economic gain, enabling the provider to charge premium prices for tailored services. A phenomenon is created where consumers are offering their expertise and enthusiasm at no cost. In fact, greater control is being given to consumers to determine what they deem to be quality provision.

3.2.5 Professional Services

Discrete within the service economy are professional services which have their own distinguishing features, and have become more prominent in the field of marketing partly as a result of deregulation both in the UK and the US. Services, which were previously provided by government agencies, have seen the private sector taking over and with this phenomenon comes competition (Zeithaml and Bitner, 2003), placing increased pressure on them to differentiate themselves through higher levels of quality. In this sector it is the professionals, many of whom are highly skilled and qualified with considerable authority and autonomy, who have control over service design. Professionals tend to be very task orientated and are in danger of having a false impression of the level of quality as perceived by the clients, a group who can feel helpless and intimidated in the relationship (Brown and Swartz, 1989). Professional services can be classified into four types (Table 3.4).

Table 3.4 Classification of Professional Services

	Knowledge intensity	Professionalised workforce	Capital intensity
Classic professional service firms – law and accountancy	High	Yes	Low
Professional campuses – hospitals	High	Yes	High
Neo-professional service firms – management consultants	High		High
Technology developers – biotechnical	High		High

(Von Nordenflycht, 2010)

Traits of services across the sector may vary and it can be difficult to generalise these, although four have been identified: functionalist, power, knowledge and continental (Abbott, 1991):

Functionalists –	The consumer is protected by institutions which offer credibility and guarantees around the skills and ethics of their members.
Power –	Practitioners of respective professional groups also rely on institutes to safeguard exclusivity, thus giving rise to prestige and high rewards.
Knowledge –	Education, intellect, knowledge are explicit requirements.
Continental –	The state has control, although this has become far less significant with deregulation and outsourcing.

While these traits are generally plausible, they may vary according to differing definitions of professional services (Thakor and Kumar, 2000).

The Nordic School argues that professionals provide advice and problem-solving and have their own independent identity (Gummesson, 1978). This fails to consider professionals such as medics who perform acts on the patient. In addition, rather than being independent, many are employed by NHS trusts in the UK, although, even as employees, specialists may retain some of their own identity since their performance is available to patients when exercising their right to choice. Nor does it recognise engineers, architects, or those in a range of other occupations as professionals whose services also extend beyond advice and are more practical (Thakor and Kumar, 2000).

Those characteristics which are reasonably constant in the literature are: knowledge intensity, regulation, autonomy/identity and low capital investment (Lewis and Brown, 2012; Von Nordenflycht, 2010; Vargo and Lusch, 2004; Thakor and Kumar, 2000). While the first three may apply, low capital investment is flawed where premises, professional development and, in some cases, equipment are all required. Possibly the two open to least dispute are knowledge and regulation. Together these bring professional credibility and controlled competition to sectors where it is especially difficult to judge quality because the consumer lacks the expert knowledge to judge technical performance or professional advice and relies on the credibility provided by membership of professional bodies (section 3.6.1.2). However, while

regulation through qualifications, experience and membership of professional institutions provides consumers with a level of assurance, conversely, as has already been cited, it can have the effect of protecting the professionals through restricting competition (Lewis and Brown, 2012).

Professional services have also been conceptualised as having high levels of customer contact and customisation of services. Although this can apply to services in general, the human element is of particular significance in professional services where there are a lot of levels of interaction and co-creation and the service is often bespoke (Lewis and Brown, 2012).

3.2.6. In Conclusion

Services are too complex and dynamic to be constrained by the IHIP model, especially where advancing technology is changing the nature of some services, and especially in terms of inseparability. Nonetheless, there remain many services which retain high levels of contact and are based on long-term relationships, particularly within professional services, and are open to further research to gain greater understanding of sector specific constructs.

3.3 WHAT IS SERVICE QUALITY?

3.3.1 Definition

Following a long period of services being seen as little more than an extension of product marketing, the growth of service economies internationally has led to a groundswell in literature about service quality and satisfaction (Sureshchandar et al., 2002a; Cronin and Taylor, 1994; Teas, 1994; Carman, 1990; Zeithaml et al., 1990; Parasuraman et al., 1985). Nevertheless, services remain theoretically elusive and give rise to ongoing debate among scholars (Robinson, 1999).

As consumers become more educated and knowledgeable their expectations have increased, as has their ability to create or destroy reputations (Douglas and Connor, 2003). Word of mouth is a powerful influencer, as is 24-hour media coverage with its consumer programmes. More recently, sites such as Trip Advisor have appeared and, despite the credibility of some comments being in question (Sweeney, 2011;

Smith, 2011), they are a source consumers increasingly make use of. Service providers who ignore quality leave themselves extremely vulnerable.

Attempts to define service quality have included: "'the degree to which customers' specifications are satisfied', 'a fair exchange of price and value', 'fitness for use', and 'doing it right the first time'" (Pitt and Jeantrout, 1994, pg. 170); and, in reference to public services, "Meeting the requirements and expectations of service users and other stakeholders while keeping costs to a minimum" (Moulin, 2002, pg. 15).

Opinions have covered a broad academic spectrum, with one school arguing that quality is a conformance to specification (Reeves and Bednar, 1994), and others that it is far more person-centric and underpins the service-dominant logic (Vargo and Lusch, 2004). Often it is associated with demonstrating that performance is of an acceptable standard and is assessed against a collection of quantitative performance measures and targets as a means of quality assurance. All too frequently it fails to address the 'softer' human elements which are more difficult to measure, and lacks the drive to address service enhancement where efforts are made to improve quality rather than simply measuring it (Rowley, 2005).

Parasuraman et al. concur with the view that service quality is a construct which remains enigmatic and elusive (Parasuraman et al., 1985). It reflects life in general through social constructivism where the individual builds a perception of it based on their own social values or norms. It is that perception that must be measured. It is also a construct that must be embedded in the whole organisation where management sets the tone and values and ensures they become core to the firm and its staff. This form of institutionalised quality (Berry et al., 1988) presents inherent challenges where personalities and human interaction are key. While some staff may deliver 100% effort in their job, this may fall off when customers become difficult, rules become constraining and efforts are not recognised (Berry et al., 1988).

Service organisations depend on the integrity and competence of their employees in delivering high levels of service quality, and the co-operation between the firm and its staff remains one of the main antecedents of the service performance gap (Chenet et

al., 2000). This can be particularly demanding in professional services where staff are more accustomed to being autonomous (Von Nordenflycht, 2010).

The diverse nature of human characteristics can result in individual moments of truth (when the service delivery takes place) varying in levels of quality. Staff members each have their own personality or approach which may, in turn differ at each point of contact. Similarly the consumer may judge them differently at each encounter. The interaction between the consumer and professional is also vulnerable to variances in effectiveness.

3.3.2 Service Quality in the Public Sector

Of course service quality is key to commercial growth or even the survival of providers in an increasingly competitive marketplace. More recently, the same context has been applied to public service organisations which are similarly facing up to competition and where pressures are becoming increasingly demanding in line with deregulation. Apart from the fact that public services contribute hugely to general quality of life, there is the hard fact that consumer satisfaction in this sector brings votes (Sharp et al., 2000). This has led to increasing scrutiny by independent bodies such as OFSTED, the CQC, Assurance Agency and government departments, as well as public services becoming engulfed in performance management systems (Rowley, 2005). Primarily process driven, these are largely in the tradition of manufacturing where progress is assessed against targets that can be easily and objectively measured.

The public sector is driven by top-down targets and standards which have grown through a loss of faith by political masters and the public (Downe et al., 2010). Despite promises to decentralise, giving local organisations greater autonomy, there has been little respite in central direction and target-setting (Dixon et al., 2012) reflecting priorities of central government rather than those of the consumer or local needs (Andrews et al., 2011) .

The fact that the public sector has become so entrenched in a plethora of targets and performance measures which rely largely on administrative data (Andrews et al., 2011) has led to accusations of a tick-box mentality that is about meeting targets

rather than about a push towards service enhancement (Rowley, 2005). It has become a case of ‘hitting the target and missing the point’ in many scenarios. While targets and performance measures are important in providing an objective means of monitoring performance, they should not be at the expense of other means of assessment and findings should be followed up by actions for improvement.

The multilateral nature of service quality challenges the notion of conformance to specifications as a measure of quality. While some public service activities might be adequately measured and managed by quantitative methods, many are based on high contact and professional relationships where this alone is insufficient. Health care is a particular example of this where requirements can be nebulous, complex and individually tailored to the needs of the patient. Although treatments/procedures are standardised based on clinical evidence, and clinical success rates are recorded against hospitals and specialists, the service-dominant logic and human interaction should also be fundamental in the delivery of care. Section 3.4 furthers the discussion on the technical and human dimensions and their respective contributions towards quality.

3.3.3 In Conclusion

Understanding the concept of quality is key to survival and helps managers to decide where service elements need improving, and if they should maximise performance in one area rather than provide lower levels of service across the board (Kanning and Bergmann, 2009). Although it is vital in a commercial environment it should also be central to public services, most of which are there to promote the well-being of the community (Wright et al., 2011).

The basic assumption made by the literature is that service quality is “whatever the customer perceives it to be” (Gronroos, 2007, pg. 73), so, while the definition of service quality may continue to elude scholars (Robinson, 1999), it does not elude customers who will apply their own individual interpretation to it. Regardless of the plethora of monitoring devices used, service quality is actually on the decline and this is in part due to a lack of understanding of what service means (Lusch et al., 2007). Understanding the nature of sector-specific services underpins this study.

3.4 SERVICE EVALUATION

Alongside the abundance of writing by theorists on the definition of service quality there is an equal amount of debate over the best ways to measure it, but with no apparent conclusion being drawn (Winsted, 2000) other than the claim that “Quality is an elusive and indistinct construct” (Parasuraman et al., 1985, pg. 49) and means different things to different people. It is based on individual perception (Kang, 2006) and imitates the subjectivity of a societal phenomenon where easy access to data that reflects reality is seen as unachievable.

While it is hard to pin down a definition of service quality, one of the few things academics do agree on is that service quality is an attitude (Robinson, 1999; Sureshchandar et al., 2002; Parasuraman et al., 1985; Cronin and Taylor, 1994). Some commentators theorise that perceptions of service quality come from disconfirmation which compares expectations with service performance (Parasuraman et al., 1985). Understanding the role of attitude is important in furthering research into service quality. This section considers both attitude and disconfirmation, putting them into context with service quality and customer satisfaction and their relationship with each other. It assesses the role each plays in order to give direction for the development of an instrument to evaluate service quality.

3.4.1 Conceptualising Customer Satisfaction versus Service Quality

Customer satisfaction and service quality are commonly regarded as similar in concept while remaining two distinct constructs. Some scholars see the former as the evaluation of individual service encounters, while the latter involves a longer-term evaluation of encounters generally (Parasuraman et al., 1985). Others argue that it is service quality that is more specific and which is an antecedent of satisfaction (Oliver, 1993). There remains no conclusive resolution about the hierarchy between the two constructs and whether it is customer service or service quality that comprises the transactional experience and which offers a global attitude (Dehghan and Zenouzi, 2012; Dabholkar, 1995; Iacobucci et al., 1995b; Cronin and Taylor, 1994; Bitner, 1992; Bolton and Drew, 1991; Parasuraman et al., 1988).

Attempts to determine if the two constructs are different and, if so, to draw a causal link between the two constructs have concluded that it very much depends on the situation and whether the evaluation process is pre-, during or post-encounter (Brady and Robertson, 2001a; Dabholkar, 1995). Understanding them can help organisations determine what they need to measure. For example, an individual may recognise a service as high quality but then experience an encounter which is not satisfactory. Will this one encounter affect their perception of the usual high quality delivered by the organisation? Alternatively, is it acceptable for an individual to experience an encounter with a reputation for low-quality service but then come away satisfied because their expectations are lower?

It appears that consumers do not distinguish between the two constructs in terms of evaluating experience against expectation, but they do make distinctions in terms of some attributes where:

Service quality	=	price, backstage processes and expertise
Customer satisfaction	=	timeliness, service recovery and tangibles

Theory suggests that a gap exists where management looks to the first of these while consumers evaluate the second (Iacobucci et al., 1995b).

The fact remains that, if operationalised as one construct, the process of evaluation is reasonably simple, but when viewed as two constructs it becomes more complex but with a greater richness of data generated through a mix of emotion and cognition (Iacobucci et al., 1995b). Each must be balanced against each other. The theory of how attitude is used in evaluation is discussed in greater detail in the next section.

3.4.2 Attitude

Attitude has been conceptualised as forming an opinion or predisposition about something or someone from information we have acquired (Fishbein and Ajzen, 1975). It is a learnt and constant phenomenon and is the evaluation of a service over a period of time which is experienced at multiple levels (Sureshchandar et al., 2002). It results in favourable or unfavourable responses, beliefs or feelings about something (Randhani et al., 2012; Lee et al., 2007) through the rational and

systematic processing of information (Fishbein, 2008). To form an attitude to service quality we evaluate the service over a period of time at multiple levels: core service, human elements of service, non-human elements (processes), the tangibles of the service or servicescape and social responsibility (Sureshchandar et al., 2002a). Arguably the most respected of the theories surrounding attitude is that of the Theory of Reasoned Action which itself comprises three independent theories:

1. Cognitive – the theory of how we gather knowledge both through experience with the object/activity in question and through knowledge acquired from other sources.
2. Affective – the way in which our emotions or beliefs are associated with an object/activity, together with how we strongly or intently we hold those beliefs.
3. Conative – the likelihood or tendency that we will behave in a certain way towards the object/activity, taking into account the complexities of our attitudes.

(Fishbein and Ajzen, 1975)

The process has three distinct and hierarchical stages:

1st Attitudes – the sum of beliefs (generated through the rational and systematic processing of information) and the weighting placed on these beliefs. A person dislikes exercise but the health factors outweigh the discomfort which they experience in taking part (Miller, 2005).

2nd Subjective norms – the influence of more abstract and subjective stimuli such as peer pressure, family influences and other social norms and the weighting an individual places on these. For example, friends are health-conscious and encourage a member of their group to exercise regularly but the same individual has a husband who dislikes exercise. The individual will place weightings against how important they view each opinion as being (Miller, 2005).

3rd Behaviour intentions – the sum of the individual's attitude towards exercise and the influence from subjective norms.

In line with other models it relies on a learning process, either through the acquisition of knowledge or through subjective norms. Where it shifts away from other theory is that it argues that attitude itself is solely based on knowledge and that the more abstract and subjective stimuli associated with subjective norms is external to this. In this it promotes the individual from being a passive recipient to becoming the prominent player where he/she is required to process and evaluate knowledge (Fishbein and Ajzen, 1975).

The evaluation process of service quality is primarily cognitive and is based on prior knowledge or experience (Dabholkar, 1995; Bitner et al., 1990; Parasuraman et al., 1988). Customer satisfaction, however, is based entirely on experience which arouses emotions or feelings about that experience and is, therefore, affective (Woodruff et al., 1983).

The primary means of measuring attitude is through the use of multi-attribute models where any subject (object or action) being assessed comprises numerous attributes which need to be systematically identified prior to being measured independently. For example, potential hotel guests and managers may identify attributes as being: courtesy, comfort, decor, responsiveness to requests, how complaints are handled, cost, etc. Fishbein is, again, accepted as being the most influential author in this field (Johnson, 2002) and identifies three factors:

1. Attributes – the probability that an object has an important attribute.
2. Beliefs – salient beliefs about the object that are considered during evaluation.
3. Importance weights – evaluation of the important attributes.

This approach is operationalised by the equation:

$A_o = B_i + E_i$

Where:

A_o = the overall attitude (A) toward object ($_o$)
B_i = the strength of the belief (B) that object ($_o$) has a particular attribute ($_i$)
E_i = the positive or negative evaluation (E) of the attribute ($_i$)

The belief and evaluation scores are acquired through the use of attitudinal scales such as Likert where numerical values are given to statements (Johnson, 2002).

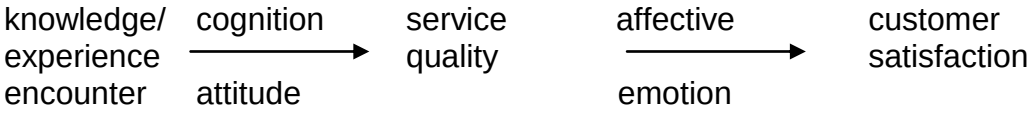
3.4.2.1 Attitude – Customer Service versus Service Quality

Causal links between customer service and service quality are confusing and various factors are taken into account.

- If evaluation is through cognition based on pre-experience of advertising material or word of mouth, the causal link is from service quality to customer service because it is not associated with a single encounter but derives from knowledge acquired prior to the encounter (Brady and

Robertson, 2001a; Dabholkar, 1995). This then generates (affective) emotions which determine customer satisfaction as illustrated in Figure 3.1.

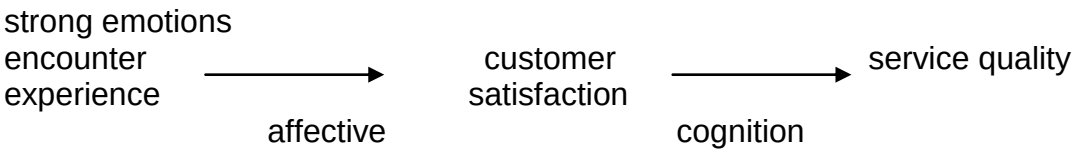
Figure 3.1 Customer Satisfaction – Causal Links



(Figure compiled by the author)

- Where strong emotions result from the experience the causal link is reversed due to their affective nature. If a customer experiences high levels of emotion from the experience of just one dimension, this will influence their cognition of all aspects of the service (Figure 3.2).

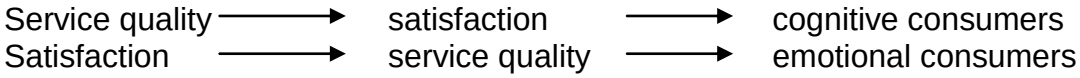
Figure 3.2 Service Quality – Causal Links



(Figure compiled by the author)

- The type of individual can also have an effect on the causal link where more highly emotional people evaluate a service at the affective level and less emotional actors will use cognition to make their judgement (Figure 3.3).

Figure 3.3 Effect of Emotions on Causal Links



(Brady and Robertson, 2001a)

This suggests that a service which is experienced in emotive situations is more likely to lead to an ultimate evaluation of overall service quality as opposed to customer satisfaction.

In cases where the consumer feels no strong emotion, either negative or positive, towards an encounter (Dabholkar, 1995; Woodruff et al., 1983) a zone of indifference exists. Similarly, if essential features (essential aspects) and non-essential ones (service enhancers) (Dabholkar, 1995) are achieved they are often not noticed and fall within this zone. Where the essentials are absent strong emotional reactions occur, shaping the consumer's cognitive evaluation of the service, leading to evaluation of service quality.

Even changes in mood can also have an effect, where very good or bad moods will cause a person to be more affective in their judgments (Dabholkar, 1995).

Understanding the links between service quality and customer satisfaction helps management to identify if focus should be given to the emotionally based customer satisfaction or the cognitive construct of service quality. It is not sufficient to satisfy a consumer during one encounter only. Reputation must be built on service quality and, once created, continual improvement is essential as the higher the perception of quality created, the more demanding consumers become (Douglas and Connor, 2003).

3.4.3 Expectations

The idea of comparing expectations and experience and the influence of attitude in the evaluation of quality was first mooted around 40 years ago (Oliver, 1980). Since then, many researchers have accepted expectations as the major influencers in evaluating customer satisfaction, although some question their effectiveness.

3.4.3.1 Defining Expectations

In their simplest form, expectations are defined as the beliefs an individual has about a product or service pre-purchase (Higgs et al., 2005; Oliver, 1980), or as preferences or desires and beliefs/predictions (Poister and Thomas, 2011).

The theory is very much based on gap models (Swartz and Brown, 1989; Parasuraman et al., 1985), where satisfaction results from how closely products or service processes and outcomes match expectations (Ojasalo, 2001). The most recognised of these is SERVQUAL (Parasuraman et al., 1985) which identifies five gaps against which satisfaction is assimilated, as discussed in section 3.5.

3.4.3.2 Characteristics of Expectations

While the concept of expectations may be easy to define, the characteristics which surround it are far more complex to understand. This section considers three common stumbling blocks which face managers when using the theory in their assessment of customer satisfaction:

i. The standards on which expectations are based.
ii. When expectations are formed.
iii. Expectations of consumer versus those of provider.

i. The Standards on which Expectations are Based

The ways in which expectations are manifested are encapsulated in Table 3.5, which summarises the varied approaches of scholars in the field. It demonstrates the complexities of using the concept as a means of measuring satisfaction and the variety of factors which arise from its use.

Expectations can be based on a number of variables which can be categorised as implicit influencers – those which the customer is not conscious of; those that are self-evident; and explicit influences which are determined by external factors such as advertising, word of mouth, traditional media (Bitner, 1992) and, more recently, social media. There are also different degrees of experience which can affect expectations, such as how often a customer has previously encountered a similar service. Often familiarity leads to expectations becoming implicit and *passive* since the consumer does not process their thoughts (Rosen et

al., 2003). Differentiation has been made between *'will'* (predictive) and *'should'* (desirable) expectations where the former, being less aspirational, are more likely to be met (Boulding et al., 1993). Both implicit and explicit promises can significantly affect the expectations that a consumer believes *will* occur (Devlin et al., 2001) while those that are *desired* are only influenced by word of mouth, and then only marginally (Devlin et al., 2001)**.**

Table 3.5 Standards on which Expectations are Based

AUTHOR	EXPECTATIONS/COMPARISON STANDARDS IDENTIFIED IN THE SERVICE CONTEXT
(Higgs et al., 2005)	*Forecast* are those expectations a consumer has about what they believe will happen *Normative* are consumer beliefs about what should happen *Ideal* refers to the highest performance any provider in a sector can attain *Minimum tolerable* are the expectations associated with the lowest level of performance acceptable *Predictive* refers to what consumers think will occur in their next service encounter
(Boulding et al., 1993)	'*Will*' expectations, referring to what **will** happen in the next service encounter *'Should'* expectations, referring to what **should** happen in the service encounter
(Liljander and Standvik, 1993)	*Ideal standard*, referring to the subjective norm *Industry standard*, referring to the customer's perception of the brands in the market *Relationship standard*, based on the overall experience a customer has of a particular service provider
(Oliver, 1980)	*Ideal* expectations *Predictive* expectations
(Zeithaml et al., 1993)	*Desired service* referring to the level of service the customer hopes to receive *Adequate service*, referring to the level of service the customer will accept *Predicted* service
(Bitner et al., 1990)	Expectations based on pre-attitude and traditional marketing mix
(Bolton and Drew, 1991)	Expectations based on organisational attributes, engineering attributes, personal needs, word of mouth and past experience
(Zeithaml et al., 1990)	Expectations based on word of mouth, personal needs, past experiences and marketing communication
(Tse and Wilton, 1988)	*Equitable* performance – value for money *Ideal* – optimal level of service *Expected* – the most likely to be achieved
(Gronroos, 1984)	Expectations based on market communication, image (including former experiences), word of mouth and customer needs

Adapted from Ojasalo, 2001

Managers must recognise the fact that those expectations attained through experience-based norms often reflect the performance that consumers are aware is provided by competitors in the same sector/industry and are, therefore, realistic (Cadotte et al., 1987).

ii. When Expectations are Formed

Perhaps the most significant challenge to understanding expectations lies in the interactive nature of services, which means that a consumer is able to evaluate the service almost simultaneously with delivery. Often people don't have expectations prior to experience, especially in relation to professional services (Devlin et al., 2001; Yuksel and Yuksel, 2001). Where they do, these expectations can change according to which stage of the process they were originally made at: pre-experience, during the experience or post-experience (Yuksel and Yuksel, 2001) and these are continually modified (Boulding et al., 1993) as the experience increases and new information is received (Licata et al., 2005, Boulding et al., 1993). This change may be due to additional information which helps them to realise what is realistic (Yuksel and Yuksel, 2001). As familiarity increases, customer perceptions of individual dimensions of service quality become cumulative each time the person is exposed to them. These cumulative perceptions can be influenced by expectations as well as the most recent service experience (Boulding et al., 1993). This leads to expectations becoming implicit (Ojasalo, 2001) and a closer correlation between expectation and experience occurs (Yuksel and Yuksel, 2001).

iii. Expectations of Consumer versus those of Provider

Scholars agree that usually customers expect more than they receive (Teas, 1994; Rosen et al., 2003). The only way in which a successful or desired service can be delivered is where both the provider and the client have similar perceptions of service delivery and, where this does not apply, quality managers need to understand why. If the consumer has higher expectations and/or less favourable perceptions of experiences than the provider perceives, the likelihood that lower-

quality service ratings will occur is greater than would be the case if both groups' perceptions were identical (Swartz and Brown, 1989).

While both staff and consumers each remain consistent in their respective expectations, those of consumers are the higher, although there is evidence to suggest that customers' perceptions of service delivery are often higher than those of staff, leading to a smaller gap between expectation and performance than might be anticipated in some cases. One explanation of this may be that staff have a backstage view which allows them to see things through a different, and perhaps more pessimistic, lens. They see the challenges that arise backstage, while front of house; consumers have little or no impression of backstage issues. Nonetheless, where a gap does exist this might be attributed to the fact that consumers judge the service delivery as a whole, whereas individual teams of staff responsible for independent elements might only view it from their own narrow area of activity (Crick and Spencer, 2011). This suggests that, while it is important to assess expectations against perceptions in individual elements, the results should be brought together to give managers a holistic view of gaps.

3.4.3.3 Expectations of Professional Services

Expectation theory is more easily associated with products than services, but the literature that does exist on the latter rarely considers professional services (Ojasalo, 2001). This omission is especially pertinent to this paper.

Often customers do not have a clear picture of what they are expecting, particularly in the case of professional services. They know they need a problem solving, but are not sure in what way, leading to a fuzzy expectation (Ojasalo, 2001), or no expectations at all (Spreng and Olshavsky, 1993). This lack of understanding on the part of the customer potentially means that they are unable to accurately convey what they want and create a situation where these 'fuzzy' expectations are difficult to meet (Ojasalo, 2001). They can, however, be made clearer through the provider and consumer working together to understand what problem needs solving and focusing on the solution (Ojasalo, 2001). This is an important point since, if what the consumer

is being asked to evaluate is of little relevance to them, the results will be meaningless. It is crucial for the dimensions to reflect the needs of the customer, rather than those of the management.

Clients often rely on developing their expectations through regulation, qualifications and functional aspects of service in an effort to evaluate the credibility of the professional services they use.

3.4.4 Disconfirmation

Expectations are central to the theory of disconfirmation where they are used as a reference point by which consumers judge performance. Disconfirmation (negative perceptions) occurs where the goods, processes or outcomes fail to reach expectations; conversely confirmation (or positive disconfirmation) is the result of expectations being met or exceeded (Imrie, 2005; Rosen et al., 2003; Churchill Jr and Surprenant, 1982). Smaller disconfirmation scores (even if they are negative) can be seen as good because consumers see dimensions they are evaluating as of little importance, or see that the provider is doing better than the competition.

The manner in which expectations are determined can be direct where disconfirmation is measured using single scales or through the discrepancy model which subtracts evaluation scores from those of expectations. Although the majority of studies use the difference score (Yuksel and Yuksel, 2001), the former is operationally easier to perform (Youssef et al., 1995).

Unfortunately it is more common for customers to expect more than they receive (Rosen et al., 2003; Teas, 1993). This can often be associated with operational aspects of the offering or external variables such as national targets being set (especially in the public sector), regulation, law and needs of other stakeholders. Alternatively it may be as a result of the temptation for an organisation to focus on what it does well rather than what is needed. Building unreasonable expectations through advertising also has a negative effect. Failing to understand expectations accurately means that they are less likely to be met, creating a quality gap or discrepancy (Andereck et al., 2012; Hsieh and Yuan, 2010; Berry et al., 1988).

3.4.4.1 Problems with Expectation/Disconfirmation Theory

Although expectations form a basis for measuring customer satisfaction, studies have revealed a variety of conceptual and operational problems with expectation/disconfirmation theory (Poister and Thomas, 2011; Higgs et al., 2005; Devlin et al., 2001; Yuksel and Yuksel, 2001; Teas, 1993):

Interpretation – There is ambiguity about the concept of expectations (Kanning and Bergmann, 2009). How they are defined inevitably has an effect on findings – if they are regarded as preferences or what would be ideal for service quality, an individual's perception of satisfaction will differ from those that are seen as a forecast or belief about what the service encounter will be (Poister and Thomas, 2011).

Characteristics of consumers – Often good or bad incidents can have an exaggerated effect on consumers' perceptions of overall service experience (Douglas and Connor, 2003). These incidents are likely to have a stronger impact on disconfirmation-sensitive consumers whose evaluations of a service are more sensitive to their expectations. Lowering their expectations will reduce the impression of dissatisfaction (Kopalle and Lehmann, 2001).

Diagnostic – While disconfirmation can highlight where quality does not meet expectations, it fails to explain why. Where customers are dissatisfied with individual dimensions it is not possible to gauge whether they performed less well, or whether they were the ones that were most important to customers (Rosen et al., 2003).

Moods/emotions – The moods of consumers can affect their evaluation of service delivery against expectation (Dabholkar, 1995), adding a level of uncertainty to the accuracy of the model.

Timing – Problems arise over the role of predictive expectations, which most commentators believe are the primary focus in evaluating service quality. They are also the most likely to change (Oliver and Burke, 1999). Desired expectations are those that people feel they deserve or want, so rarely

change. Predictive expectations, however, are likely to change as the experience progresses and the consumer becomes more familiar with the service and what it is likely to deliver. This factor reinforces the question about how effective expectations are in the evaluation of satisfaction (Oliver, 1980).

Surveys – A question also arises over the effectiveness of surveys where changing expectations can distort the results. If asked to complete a survey for pre- and post-experience, some respondents will inevitably choose to complete the expectation section only after their experience, rather than both before and after the encounter (Devlin et al., 2001; Carman, 1990)

Managing expectations – While little research has been conducted into how expectations can be managed, it is a key factor in maximising customer satisfaction scores (Ojasalo, 2001). There are occasions where customers may know they are not satisfied with the level of service but can't explain in what way they would like to see it improved. This can be a particularly difficult issue with professional services where clients are unable to define a problem effectively (Ojasalo, 2001). While a lack of sufficient information or a poor brief from the customer presents challenges to the provider, service quality cannot be dependent on expert clients (Gronroos, 1990).

Where customers have long-term relationships with the provider, their expectations change according to previous encounters. Satisfaction levels often rise as the relationship continues, the encounters coming together to raise the level of service quality. This then creates a loop where the expectations are boosted, making it increasingly difficult for the organisation to meet them (Pitt and Jeantrout, 1994).

Desires – Meeting expectations is a different concept from that of meeting desires. The expectations a person has of a service with a reputation for low quality would be minimal and satisfaction scores would be relatively high. Desires, however, are unaffected by reputation and satisfaction scored against desires would be significantly lower (Spreng et al., 1996; Spreng and Olshavsky, 1993). This can be overcome where desire is used as an

alternative standard to measure satisfaction against and is rated against the best in class as a pointer to what is possible in the service encounter (Spreng et al., 1996; Spreng and Olshavsky, 1993).

Ceiling/floor effect – A consumer may have particularly high or low expectations for an offering and give the highest or lowest expectation score accordingly. This presents operational challenges where, if expectations are exceeded or are not met, only the same score for satisfaction can be given even though it does not accurately reflect the evaluation (Yuksel and Yuksel, 2001).

Other problems associated with interpreting expectations include:

Service attribute importance – The satisfaction with an experience may be assessed according to the priority the consumer places on the importance of that particular encounter when compared with another.

Equitable performance – The cost in financial terms or other resources (e.g. time) to the consumer might contribute to their assessment of satisfaction.

Ideal performance – Their evaluation might be based on what can be delivered rather than what is delivered.

Minimum tolerable performance – What is the minimum that is acceptable (Teas, 1993)?

3.4.5 In Conclusion

Attitude is hugely influential in service evaluation and its role as a differentiating factor between service quality and customer satisfaction as two independent constructs and their causal links is key in this field of study. While expectations and the disconfirmation model are widely used in evaluating customer satisfaction, its efficacy is called into question both conceptually and operationally and cannot be taken as being watertight (Poister and Thomas, 2011). More work is needed to fully explain the influence of expectations and disconfirmation, particularly in the field of

professional services where expectations can be vague, a fact that is highlighted in the following section.

3.5. A CRITIQUE OF SERVQUAL

Despite literature debating the service quality construct, not since 1985 when the SERVQUAL model was first developed by Parasuraman et al. has any significant contribution been made in this field. Although the model is generally accepted among commentators as being the major contributor to understanding the architecture of service quality, the time is ripe to revisit this.

This discussion comprises three sections. The first of these introduces the concept of SERVQUAL, explaining how it was developed while the second section looks at criticism levelled against the model. In the third section a number of arguments are set out which examine the robustness of research on which the original models, developed in 1985 and 1988 respectively, were based, and goes on to question the strength of their later papers published in 1991 and 1994.

3.5.1 SERVQUAL – A Gap Model (Parasuraman et al., 1985)

Until the development of SERVQUAL in 1985 by Parasuraman et al. the measurement of service quality traditionally came from theory around the marketing of goods, much of it based on the TQM Framework. At the time there was a lack of existing literature on service quality from which to form a conceptual picture of the service quality construct. To overcome this they undertook exploratory research in the form of a series of 12 consumer focus groups and in-depth interviews with 14 senior executives. The aim was to generate a greater understanding of the construct through questions designed to compare what managers see as key to service quality with the perceptions of consumers, and to examine if these can be included in one model (Parasuraman et al., 1985). Their work was conducted within just four service categories: retail banking, credit card, securities brokerage and product repair and maintenance. The research was carried out in the USA (South West, West Coast, the Midwest and the East).

Table 3.6 SERVQUAL Determinants of Service Quality (Ten Dimensions)

DIMENSION	DEFINITION
Reliability	Consistency of performance and dependability. It means that the firm performs the service right the first time. It also means that the firm honours its promises. Specifically, it involves: - Accuracy in billing; - Keeping records correctly; - Performing the service at the designated time.
Responsiveness	Willingness or readiness of employees to provide service. It involves timeliness of service: - Mailing a transaction slip immediately; - Calling the customer back quickly; - Giving prompt service (e.g. setting up appointments quickly).
Competence	Possession of the required skills and knowledge to perform the service. It involves: - Knowledge and skill of the contact personnel; - Knowledge and skill of operational support personnel; - Research capability of the organisation, e.g. securities brokerage firm.
Access	Approachability and ease of contact. It means: - The service is easily accessible by telephone (lines are not busy and they don't put you on hold); - Waiting time to receive service (e.g. at a bank) is not excessive; - Convenience of hours of operation; - Convenient location of service facility.
Courtesy	Politeness, respect, consideration and friendliness of contact personnel (including receptionists, telephone operators, etc.). It includes: - Consideration of the consumer's property (e.g. no muddy shoes on the carpet); - Clean and neat appearance of public contact personnel.
Communication	Keeping customers informed in language they can understand and listening to them. It may mean that the company has to adjust its language for different consumers – increasing the level of sophistication with a well-educated customer and speaking simply and plainly with a novice. It involves: - Explaining the service itself; - Explaining how much the service will cost; - Explaining the trade-offs between service and cost; - Assuring the consumer that a problem will be handled.
Credibility	Trustworthiness, believability, honesty. It involves having the customer's best interests at heart. Contributing to the credibility are: - Company name; - Company reputation; - Personal characteristics of the contact personnel; - The degree of hard sell involved in interactions with the customer.
Security	Freedom from danger, risk or doubt. It involves: - Physical safety. (Will I get mugged at the automatic teller machine?); - Financial security. (Does the company know where my stock certificate is?); - Confidentiality. (Are my dealings with the company private?)
Understanding/ Knowing the customer	Making the effort to understand the customer's needs. It involves: - Learning the customer's specific requirements; - Providing individualised attention; - Recognising the regular customer.
Tangibles	Physical evidence of the service: - Physical facilities; - Appearance of personnel;

	- Tools or equipment used to provide the service; - Physical representations of the service – plastic credit card or a bank statement; - Other customers in the service facility.

(Parasuraman et al., 1985)

Essentially, SERVQUAL is an operational instrument used to measure the service quality construct and is based on assessing the gap between expectation and satisfaction.

It measures five gaps:

1. Management perceptions of customer expectation and actual customer expectation.
2. Management perceptions of customer expectations and company stated service specification.
3. Company stated service specification and service delivery.
4. Company stated service specification and the external communication of this.
5. Customer expectation and customer experience. This gap is influenced by gaps 1-4.

   (Parasuraman et al., 1985)

In measuring the service quality construct the instrument employs the theoretical framework of expectation versus satisfaction. It comprises a set of 22 questions which asks the respondent the extent to which the firm delivering the service should possess each feature, followed by a similar series of 22 questions, this time asking the extent to which the respondent feels the firm possesses each item. It does not, however, ask respondents to state the priority they would place on each item.

It was originally based on ten dimensions (Parasuraman et al., 1985): reliability; responsiveness; competence; access; courtesy; communication; credibility; security; understanding/knowing the customer; and tangibles (Table 3.6).

A later piece of work used factor analysis to refine these. In the first instance, 97 items were generated to represent the ten dimensions and two questionnaires using Likert scales were designed to capture expectations and perceptions respectively. Two hundred respondents – each of whom had used one of the five sectors included

in the research, which this time included appliance repair/maintenance, retail banking, long-distance telephone, securities brokerage and credit cards – were recruited. With almost 200 questions to answer, the process was lengthy and potentially unwieldy, although respondents were trained. Two stages using factor analysis were conducted (the second of these being confirmatory), which ultimately reduced the dimensions to five, although retaining the original 22 items (Parasuraman et al., 1988). Table 3.7 sets these out. The literature doesn't set out all of the original 97 items, which raises the question as to how many were removed that may have had service-specific relevance. Indeed, there is little difference between some of the items.

Table 3.7 SERVQUAL Determinants of Service Quality (Five Dimensions)

DIMENSION	DEFINITION	DIMENSION	DEFINITION
Tangibles:	• up-to-date equipment, • physical facilities visually appealing • staff well dressed and neat • appearance of facilities in keeping with the service	Assurance:	• customers can trust staff • customers feel safe • polite staff • staff get support from firm
Reliability:	• staff should be sympathetic if customer experiences problems • when firm promises something by a certain time it is achieved • dependability • provide service at time they promise • records kept accurately	Empathy:	• staff know what needs of customer are • staff have customer's best interests at heart • staff give personal attention • staff give individual attention • convenient opening hours
Responsiveness:	• prompt service • tell customers when to expect service • willing to help customers • staff not too busy to provide prompt service		

(Parasuraman et al., 1988)

The process SERVQUAL employs to measure quality (measuring the gap between expectation and experience) bases itself on the disconfirmation model which, through comparing delivery and expectations, supplies richer data than measures based merely on performance (Parasuraman et al., 1985).

3.5.2 Service Quality versus Customer Service

SERVQUAL is widely accepted as having made an enormous contribution to theory around the measurement of service quality, with claims that service quality "has become SERVQUAL" (Woodall, 2001, pg. 596). It has, nevertheless, received considerable critical analysis over the years with concerns having centred on a variety of aspects including the use of dimensionality (Buttle, 1996), diagnostic versus predictive usage (Carrillat et al., 2007; McAlexander et al., 1994), its subjectivity, complexity and use of scales (Ladhari, 2009; Buttle, 1996; Cronin and Taylor, 1994), application of the disconfirmation model instead of the conceptualisation of attitude (Buttle, 1996), and generalisation across sectors (Kilbourne et al., 2004; Robinson, 1999). It has, however been utilised in a variety of sectors including retailing (Carman, 1990), dental services, medical services (Quader, 2009) and recreational services (Taylor, 1994). It has also been criticised for its attention towards short-term customer satisfaction rather than the longer-term focus on service quality.

Despite the many words which have been written critiquing the model, a review of extant literature has provided little evidence of alternative models other than examples which have merely been adapted from it. One that does stand out, albeit another adaptation, is SERVPERF (Cronin and Taylor, 1994). SERVPERF comes from the school which queried the concept of consumers measuring quality by comparing experience with expectation, thereby adopting a simpler approach (Cronin and Taylor, 1994). Though based on the same 22 attributes as SERVQUAL the model was more parsimonious, removing expectation and relying on data around performance only. In this, the pragmatic advantage over SERVQUAL cannot be ignored when operationalising the model since only one questionnaire is required (Jain and Gupta, 2004).

Academics have been debating the question over which model is most effective (Table 3.8), but with a general consensus that SERVQUAL is better for diagnostic purposes while SERVPERF is preferable as a predictive tool.

Table 3.8 Comparison between SERVQUAL and SERVPERF Models

AUTHOR	SERVQUAL v. SERVPERF
(Carman, 1990)	The dimensions of SERVQUAL cannot be applied cross industry.
(Ladhari, 2009)	SERVQUAL limitations: scoring, reliability, validity, emphasis on process rather than outcome, hierarchical service quality constructs, reflective scales, use of generic scale for all sectors, applicability for online use and culturally. It can be useful if adapted for specific industry use and it is validated through reliability and validity analysis.
(Rhee and Rha, 2009)	SERVQUAL does not explore the validity of its constructs in the public sector where service issues are more complex and there is a greater diversity of stakeholders.
(Jain and Gupta, 2004)	SERVPERF is simpler to use and explains variations in overall quality service; SERVQUAL is better diagnostically. SERVPERF is preferable for assessing overall service quality; SERVQUAL is superior in identifying quality shortfalls.
(Kilbourne et al., 2004)	The use of SERVQUAL in care homes across the USA identified limitations in the original version Some items were irrelevant. They conclude that SERVQUAL is convenient and reliable in measuring quality across countries, but more work is needed in cross-national reliability in health care.
(Sureshchandar et al., 2002b)	SERVQUAL model overlooks key factors of service quality: the core service, systemisation/standardisation of service delivery (non-human) and social responsibility of the provider.
(Winsted, 2000)	SERVQUAL doesn't ask what consumers want service providers to do; constructs are predetermined; service literature is still confused about the meanings of some of SERVQUAL constructs; it is not as effective as service-specific models.
(Robinson, 1999)	While SERVQUAL has been the preferred method of measuring service quality since the 1980s, too many questions arise concerning its efficacy for it to retain its prime position. Concerns include: generalisability across sectors; the measurement of customer satisfaction rather than service quality; the wording of questions; the relevance of measuring expectation. SERVQUAL has a major impact on business. But there are limitations around validity of constructs; consumers assess quality as perception v. expectations (they do not consider expectations); dimensions are not universal; moments of truth can vary from event to event; use of two questionnaires causes confusion.
(Cronin and Taylor, 1994)	Published SERVPERF model as an alternative to SERVQUAL. Saw the SERVQUAL model as too subjective relying on disconfirmation and the transitory element of customer satisfaction rather than long-term service quality.
(McAlexander et al., 1994)	SERVPERF is superior as a predictive tool and looks at weighting performance items. They question the inclusion of SERVQUAL'S expectations in health care where expectations are high across all dimensions; they also consider it the more useful as a diagnostic tool for managers.

(Compiled by the author)

There is a general consensus among commentators that service quality is a long-term attitude and can be employed to predict behaviour and intention. SERVQUAL ignores this theory. It measures short-term customer satisfaction perceptions based on experience, rather than service quality which can rely on external factors such as advertising, word of mouth or other influencers such as the media rather than just service experience. By ignoring longer-term attitudes, SERVQUAL fails to allow managers to predict a consumer's intention (Cronin and Taylor, 1994). Furthermore, since the SERVQUAL model is based on satisfaction rather than quality it is based on the moment of truth when the exchange of goods or service occurs, which will inevitably vary from encounter to encounter (Cronin and Taylor, 1994; Robinson, 1999). SERVPERF overcomes this and is recognised as far superior in its predictive abilities to SERVQUAL, which is recognised as a diagnostic tool (Jain and Gupta, 2004).

3.5.3 Expectations

The use of expectations in assessing service quality or customer satisfaction is in itself open to question and has been discussed in some detail in section 3.4.3. Some claim that SERVQUAL fails to address either customer satisfaction or service quality as: "Satisfaction judgements are believed to degenerate into overall service quality judgements over time. Expectancy-disconfirmation judgements, however, are distinct from both consumer satisfaction judgements and service quality perceptions" (Cronin and Taylor, 1994, pg. 127). This claim suggests that SERVQUAL fails to address either quality or satisfaction. A later study found that customer expectations are usually higher than the level of service they receive, but that expectations can change with familiarity (Rosen et al., 2003). If expectations change, then it may be assumed that the perceived level of quality also changes, thus affecting the validity of the disconfirmation model to measure service quality. Aside from the expectations of an individual, questions arise over the relevance of experience in a consumer's assessment of a service, suggesting that experience is polysemic in its variety of meanings and that using this alone is too simplistic. Section 3. 4.3 has discussed the difficulties associated with interpreting expectations which, by default, leave SERVQUAL open to uncertainty.

3.5.4 Dimensionality

The original SERVQUAL model was designed through the findings of qualitative research via interviews with both managers and consumers across four sectors: retail banking, credit card services, repair and maintenance of electrical services, and securities brokerage. Whether the five dimensions can be used effectively across all sectors is questioned, with claims that they vary according to the setting (Robinson, 1999; Buttle, 1996). The seven-point Likert scale used also fails to capture the large variability within each of SERVQUAL's five dimensions (Robinson, 1999).

A study of dental practices in the USA compared SERVQUAL and SERVPERF in measuring service quality/customer service. Both models were used in their traditional way before being compared to further studies where the dimensions were weighted according to the priority patients placed on respective service elements. Their findings supported the concept that patients were more concerned with the overall service quality functions than with outcomes. Theory around credence supports these findings in that within, in professional services, the process is more important than the outcome for customers to assess performance. The outcome is assumed to be a given (McAlexander et al., 1994).

The study provided evidence to support the argument that SERVQUAL provides a more effective diagnostic tool than SERVPERF. It does, however, add a cautionary note that numerous empirical studies have shown that lengthy questionnaires are likely to affect response rates and suggests that managers should have clear research objectives when justifying the use of the model.

3.5.5 Chronological Development of the SERVQUAL Model

Amidst the wealth of debate, what is deficient in the literature is the question about the strength of the evidence on which the model is based. Although the work was replicated for validity there remain a number of potential flaws in the development, for which there is little evidence of academic debate – an extraordinary omission for a seminal piece of work such as this. This section looks at four papers published by Parasuraman et al. in 1985, 1988, 1991 and 1994 respectively, each of which describes how the model has been amended over a period of time and critiques the impact on the effectiveness of the model in customer evaluation of services.

3.5.5.1 A Conceptual Model for Service Quality and its Implications for Future Research (Parasuraman et al., 1985)

Sectors – The work was undertaken in a very small cross section of the service sector. While the authors claim these firms represented both high- and low-contact services this is open to some debate. The concept of high contact refers to those services where transactions involve consumers and staff in complex levels of, and often lengthy, professional interactions where the consumer is a key actor in the service delivery, as contextualised by the theory of co-creation (Vargo and Lusch, 2004). An example of such a service may be consultancy on a long-term retainer or carrying out a complex act for another party. Although there has been a dramatic rise in technology, which has reduced levels of interface in some sectors in the 25 years since SERVQUAL, this does not negate the fact that contact would still have been relatively low in each of the sectors included in the research when compared to others. Nor does it accommodate those services that remain high contact, such as health care. The importance of this lies in the fact that involvement, interaction and, ultimately, co-creation lead to increased levels of value and better outcomes for the consumer. In those services with highly complex delivery processes and outcomes, it is dangerous to underestimate the importance of this and, in not targeting sectors with higher-contact services during its development, SERVQUAL fails to acknowledge a key feature of the service quality construct.

Components of services – Through ignoring the features of high-contact services, the SERVQUAL model fails to fully acknowledge the significance of heterogeneity and inseparability from the IHIP model where the interrelations between provider and user are key to the delivery process and where sectors such as professional services require varying levels of tailored services.

Sample – The notion of gaps was identified through working with senior executives and consumers who were familiar with the sectors involved. Nevertheless, the sample of participants used in the work was limited. Fourteen senior executives were interviewed across the four sectors. At less than four per sector this does not provide a statistically robust sample from

which to generalise. Furthermore the omission of front of house staff risks losing rich and valuable data gleaned from their working relationships with consumers. It is they who are the first line of contact for consumers, not executives.

Twelve focus groups were held across the four sectors and while general guidelines were followed in respect of the constituents of each group, no mention is made of the size of the groups. It is assumed that these would represent approximately 100 participants. While this is a respectable sample for qualitative work, there was no follow-up statistical process conducted to validate or generalise the findings in the initial work.

Geographical – The geographical aspect of the work can be open to criticism in its focus on Western USA (although two focus groups were held in the East). Apart from the cultural differences to be found in a country the size of the US, there remains the question over whether the work is transferable not only across sectors, but across international cultural boundaries as well. This may lead to potential discrepancies in the level of expectation and perception.

Dimensions – It is not disputed that dimensionality is a pragmatic way in which to measure service quality. The question lies in the nature of the dimensions. The influence of SERVQUAL is diminished since sector-specific dimensions were omitted from the research, only general dimensions being deemed relevant (Parasuraman et al.,1985). While this factor ensures a more flexible model across services, it misses some key components relevant to specific sector contexts where items are not transferable from one sector to another. Although the original SERVQUAL instrument developed in 1985 comprised ten dimensions, in contrast with the model developed in 1988 which was condensed to five, the dimensions still give rise to concern. They fail to address the true complexities of the service quality construct along with the human elements as illustrated by courtesy, empathy or communication skills such as rapport. These are fundamental to services, especially those that are tailored to individual needs.

Diagnostic versus predictive – There is a debate about whether the measurement of service quality should be predictive or diagnostic. Predictive allows managers to forecast users' future actions and is based on Fishbein's theory around attitude. Since SERVQUAL does not take attitude into account, predictive qualities are absent. SERVQUAL does, however, provide data of a diagnostic nature which assists managers to develop their strategy on quality of service, albeit within the limitations of those dimensions it covers.

While SERVQUAL remains a highly acclaimed model, the study on which it is based lacks robustness as regards whether the dimensions can be translated across sectors in terms of the conflict between customer satisfaction and overall service quality. In this, it opens the door for further research.

3.5.5.2 SERVQUAL: A Multiple-Item Scale for Measuring Consumer Perceptions of Service Quality (Parasuraman et al.,1988)

A later paper published in 1988 by Parasuraman et al. refined the original SERVQUAL model by reducing the dimensions from ten to five, but still retained 22 dimensions. From the original ten-dimension model, 97 items were generated, of which only those seen as transferable across service categories were retained.

Removing items – The results of the data collection and purification of scales resulted in the removal of some items. The initial purification process involved calculating a quality score for each item using the equation Q = P – E where Q represents quality, P = perception and E = expectation. Initial results were inconclusive so, to improve these, those items which had the lowest correlation to the sum of the scores of each of the others within the dimension were removed.

The remaining items were then grouped into five dimensions as opposed to the ten which comprised the original model. Although the ensuing results may be reliable for the sectors within the study, there is again a window of doubt as to whether the removal of some items renders the model less flexible in its use

across sectors that are more complex and have higher levels of contact. There is a risk that some valuable data is ignored.

Reliability of responses – The questionnaire used was extremely complex and although the exercise was not one of general market research, but was one where respondents were screened and given training in completing it, there remained a danger of boredom which may or may not distort the results.

Complexity – Regardless of the reduction in dimensions, the model still remains complex to operationalise, with staff requiring training in its implementation.

Effectiveness – It is advised that SERVQUAL should be used in conjunction with other instruments – alternative surveys, suggestions, complaints, etc. (Parasuraman et al., 1988). In this it should, perhaps, be seen as a supportive instrument. This is in line with literature that maintains questionnaires should be used alongside other methods, either qualitative or quantitative.

Sectors – As with the original model, the refined model of SERVQUAL fails to address concerns about its cross-sector use, the sectors represented in this work being banking, credit cards, repairs/maintenance and securities brokerage, all businesses which arguably epitomise low-contact service.

3.5.5.3 *Refinement and Reassessment of the SERVQUAL Scale (Parasuraman et al., 1991)*

A later piece of work published in 1991 reviewed the dimensionality of SERVQUAL, this time measuring three categories of service: telephone repair, retail banking and insurance. Although they were able to maintain that (with the exception of banking), these differed from the original work. once, again, there is no representation of sectors which deliver more complex services or have higher contact levels between staff and the consumer. Their results found significant interrelationships between responsiveness and assurance/reliability, where the former was seen as a potential antecedent of the latter. Those consumers perceiving a high level of responsiveness

perceived similar levels of assurance and reliability (Parasuraman et al., 1991). 'Tangibles' were subdivided into facilities/equipment and personnel/communications materials. To include communications materials within tangibles is confusing and misses the point of the nuances of the dimension, which should be a high-level construct in its own right that can be deconstructed into many items, among them:

- Listening to the patient/carer.
- Understanding the patient.
- Accent of foreign members of staff.
- Use of plain English.
- Breakdown in communications.
- Contradicting messages from different staff members or organisations.
- Providing correct information.
- Providing sufficient information.
- Communication between staff members.
- Communication between organisations.

(Hyde, 2010)

The wording of items may be adapted, although changes should be relatively minor in order to avoid affecting the integrity of the model. However, there is insufficient evidence to suggest that the five-dimension model is sufficiently robust to endorse SERVQUAL as being applicable in a cross-sector context.

3.5.5.4 Alternative Scales for Measuring Service Quality: A Comparative Assessment Based on Psychometric and Diagnostic Criteria (Parasuraman et al., 1994a)

The debate over dimensions continued in a further paper published in 1994 which looked at the assessment of diagnostic and psychometric criteria (Parasuraman et al., 1994a). The study investigated ways in which expectations might be best incorporated into measuring service quality and was carried out within the banking sector, computing manufacture, retail, car insurance and life insurance. Companies involved had sponsored the study and, again, the question over choice of sectors in terms of complexity and levels of personal contact is raised. They looked at three formats for an adapted SERVQUAL model:

- Three columns which took into account desired, adequate and perceived levels of service.
- Two columns side by side to compare what the authors describe as “adequate service and desired service expectations” (Parasuraman et al., 1994a, pg. 205).
- One column which similarly measures the gap between superiority and adequacy but uses a questionnaire which is split into two sections: one for superiority, the other for adequacy.

The findings concluded that, although more time-consuming, the three-column format was the simplest to complete and was more effective as a diagnostic tool.

They identified opportunities for further research:

- The scope and length of the three-column questionnaire (which was deemed to be preferable) could lead to practical difficulties. Further research into the use of subsections being administered to corresponding subsections of the population was recommended.
- Most existing scales make use of psychometric principles (direct measures). Their study suggested that the three-column questionnaire that used disconfirmation techniques rather than direct psychometric scales was more accurate. Alternative diagnostic techniques to psychometric scales should be investigated.
- Direct measures often exaggerate consumers’ ratings and more research was suggested into why this should be.
- Additional research was needed around the dimensions, as an overlap between responsiveness, assurance and empathy causes ambiguity, and work into the effectiveness or otherwise of the generic use of dimensions across different sectors is also required (Parasuraman et al., 1994b).

3.5.6 In Conclusion

There is no doubt about the importance of SERVQUAL in the debate about service quality. Nevertheless, the original research on which the SERVQUAL model was founded was simplistic and lacked robustness. It was based on four sectors which were limited in their coverage and not at all representative of the wide spectrum that the service industry covers. It was also carried out with a limited population sample, both in size and representation.

The use of services existing on low contact between service personnel and consumers remains consistent throughout their later work as highlighted in this paper. Later papers published by the authors have done little to redress this. It has limitations, not least in the range of dimensions and items it offers. One of the features of services is heterogeneity, thus implying individuality and flexibility. The use of a generic instrument to measure such a complex concept is inappropriate. SERVQUAL had provided an important contribution to the measurement of service quality over the preceding decade, but Robinson claimed that it was unlikely that it would retain its prime position for the next (Robinson, 1999). Although 15 years have passed since Robinson made this claim, there is still little evidence to suggest there are any significant advances.

3.6 DIMENSIONALITY

While debate continues about the pros and cons of the effectiveness of using gap models, disconfirmation and expectation frameworks, one thing they share is that they all rely on the use of dimensions. Understanding these underpins everything else. The following section explores the dimensions identified by literature and their relation to functional and technical elements of service. It also discusses the importance of interactions between consumer and provider. Theorists have come up with numerous variations of these core dimensions (see Table 3.9.) and, while similarities do exist, there is no overall consensus about them, or about whether they can be generalised across sector (Brady and Cronin, 2001). Generally speaking, dimensions comprise a number of sub-dimensions or items which, in turn, may influence more than one dimension, providing a more detailed and better-defined construct. They do not, however, overcome the complexities of use across different sectors.

Table 3.9 Service Quality Dimensions – an Overview

AUTHORS	ELEMENTS	
(Wright et al., 2011)	Service	Interpersonal
(Rhee and Rha, 2009)	Process quality, Outcome quality	Design quality Relationship quality
(Sanchez-Hernandez et al., 2009)	Functional – efficiency Relational – empathy	Tangibles
(Howden and Pressey, 2008)	Know-how (technical expertise) Trust Personal interaction	Service fulfilment Location Direct/indirect costs
(Dagger et al., 2007)	Interpersonal quality – interaction, relationship Technical quality – outcome, expertise Environmental quality – atmosphere, tangibles	Administrative quality – timeliness, operation, support
(Kang, 2006)	Process	Outcome
(Sureshchandar et al., 2002a)	Core service/service product Human element Systematisation of service delivery: non-human element	Tangibles of service – services capes Social responsibility
(Brady and Cronin, 2001)	Outcome Interaction	Environment
(Daley, 2001)	Technical (processes, procedures)	Service (interpersonal)
(Mels et al., 1997)	Intrinsic – reliability responsiveness assurance empathy	Extrinsic – tangibles technical
(Rust and Oliver, 1994)	Customer–employee interaction (function or process quality)	Service environment Outcome (technical quality
(Lehtinen, 1991)	Interactive quality Corporate quality	Physical quality
(Gronroos, 1990)	Technical	Functional
(Parasuraman et al., 1988)	Reliability Responsiveness Assurance	Tangibles Empathy
(Parasuraman et al., 1985; Parasuraman et al., 1988)	Responsiveness Reliability Competence Access Courtesy	Communication Credibility Security Understanding Tangibles
(Lovelock, 1983)	Classification of services: Nature of the service act Relationship between organisation and customer How much room is there for customisation?	Nature of demand and supply for the service How is service delivered?

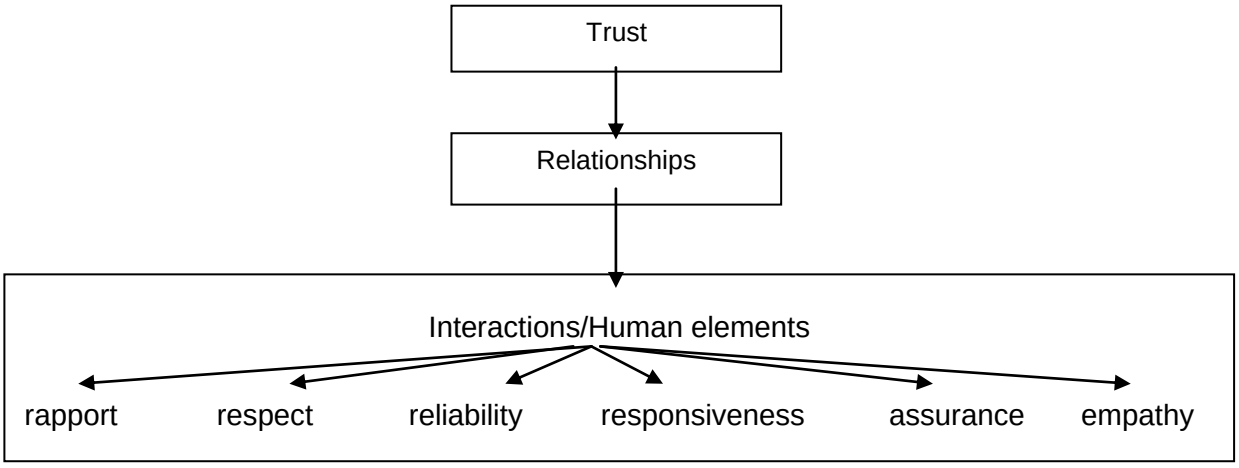
(Compiled by the author)

Some theorists have attempted to categorise dimensions according to the Nordic approach of distinguishing between functional and technical elements as defined by Gronroos or the US school of thought as in SERVQUAL. However, this is an oversimplification where neither fully defines the service quality construct (Brady and Cronin, 2001).

3.6.1 Relationships – Rapport, Respect and Trust

The nature of services makes the proposition of value and quality especially unpredictable. “There are many opportunities for something to go wrong when the service provider and the customer interact, when both parties experience and respond to each other’s mannerisms, attitude, competence, mood, dress, language, and so forth” (Berry et al., 1988, pg. 38). It is impossible to ignore the importance of the human element where the characteristics of service employees, alongside those of consumers, add to the confusion of elements affecting the service quality construct. The nature of services is based on interaction between two parties to create value. Their importance, especially in professional and high-contact services, is clear (Lehtinen, 1991; Sureshchandar et al., 2002) since interactions help build professional relationships which should ultimately lead to trust. Drawing on literature suggests a basic hierarchy of constructs. These will, however, vary according to the nature of the service (Figure 3.4).

Figure 3.4 Hierarchy of Constructs



(Compiled by the author)

3.6.1.1 Respect and Rapport

Of the five dimensions central to SERVQUAL, four of these are based on the human element of service: responsiveness, reliability, assurance and empathy, of which responsiveness and reliability have been seen to be especially crucial (Rhee and Rha, 2009; Angelopoulou et al.; 1998, Berry et al., 1988; Parasuraman et al., 1988).

Missing from the model, however, are rapport and respect, which, although they may be implicit within assurance or empathy (polite staff and understanding/knowing the client), it is argued they are first-order constructs in their own right (Macintosh, 2009) and should be explicit as dimensions since they are key antecedents to trust. Their omission is especially surprising with regard to professional services, where credence and trust are so important. 'Respect' is giving attention to a person and valuing them; understanding the individual; responsibility; an interest in humanity; and acceptance of differences in people beyond tolerance (Abbott, 1991). 'Rapport' goes much further than polite staff and understanding or knowing the client as defined by SERVQUAL. It has been deconstructed to include mutual self-disclosure (shared information and open communications); extras (responses to simple requests for customisation or exemplary behaviours); civility/courtesy (Macintosh, 2009); and interaction (Gremler and Gwinner, 2000). Rapport creates a bond and cohesiveness which, in turn, generates trust. Since is it also seen as including an enjoyable element, it helps consumers relax (Macintosh, 2009), although the use of the word 'comfortable' may be preferable to 'enjoyable' for some services.

To ignore the significance of either respect or rapport leaves the organisation vulnerable to poor relationships with the customer/client, potentially breaking down levels of trust.

3.6.1.2 Credence/Trust

Credence, often referred to as trust, is a construct that should be inherent in all professional services but is one that does not appear as a dimension in its own right in much of the literature. This may be because it is assumed that the

customer has a right to be able to trust the integrity, knowledge, experience, skills and expertise of the professional providing the service. To what extent this assumption is justified can be variable.

Professionals are bound by regulations set by governing bodies such as the UK Law Society, General Medical Council, Royal Colleges, etc., which help in building confidence for customers/clients. Their membership and qualifications are there as indicators of standards and skill which, in turn, help builds trust, a key contributor to the co-creation between consumer and provider in service delivery and outcome. (Macintosh, 2009). Trust is difficult to quantify but has been defined as being able to rely on someone in whom a person has confidence (Moorman et al., 1993), or where a consumer has confidence in the reliability and integrity of a firm that it will deliver on its promise (Eisingerich and Bell, 2008; Howden and Pressey, 2008).

Confidence in expertise is identified as one of the precursors of trust; although it can be difficult to judge without some personal knowledge of the service (Howden and Pressey, 2008; Eisingerich and Bell, 2007), consumers can use cognitive processes to assess this competence (Macintosh, 2009).

A second antecedent of trust revolves around dependability or predictability of staff. Any service organisation is largely dependent on the skills and characteristics of staff and this is particularly the case in professional services where individuals will have varying levels of expertise, skill, knowledge or experience and where personalities play a significant part in relationships with clients.

Familiarity is a third characteristic that has been recognised as an antecedent to trust (Macintosh, 2009). It helps customers to be confident that the provider knows what their needs are and that they are able to meet them. This comes with time and is only applicable to continuously rendered services.

Of course it is far easier to judge the functional dimensions which enhance the experience in the delivery of a service than it is to judge trust or the

technical/professional elements. These can be placed in the context of Maslow's Hierarchy of Needs, where the technical dimensions meet the physiological level and self-actualisation represents the functional processes as they become more peripheral (Woodall, 2001). This fails to recognise that the functional dimensions add to the overall experience and can contribute to the eventual outcome, especially in health care where positive interaction is a major contributor in the overall service delivery.

There is also a view that the functional elements of service influence perceptions of technical elements as customer education increases. If they feel more comfortable with the overall service encounter, consumers find it easier to ask questions and understand the value of their advisor's personal attention when they offer recommendations (Eisingerich and Bell, 2008).

3.6.2 In Conclusion

Two key assumptions can be made from this section:

- It is important to ensure that the dimensions being evaluated are of relevance to the respondent.
- Greater significance should be placed on the human elements of services delivery, especially in professional services.

3.7 SERVICE QUALITY IN HEALTH CARE

As the central focus of this thesis, this section considers the unique features of health care (Suki et al., 2009). It contextualises them within the domain of service quality and theory around their measurement.

UK health care organisations are facing pressures from a variety of directions, one of which is the introduction of competition and increasing use of the private sector, particularly since the changes which came into being in April 2013 which are described in Chapter 2. This new phenomenon is pushing hospitals and community services to take a hard look at the quality of the services they offer and they are facing increasing demands to meet or exceed patient expectations (Dougall et al., 1999). At the same time, contracts within the internal health care market have service

quality at their core. This is a difficult aspiration, especially in an environment where some elements of patient dissatisfaction may be out of their control (Vukmir, 2006), such as the needs of different demographic groups, the involvement of partner agencies, government intervention, etc.

The quality of health care remains a problem (Gummesson, 2001a) and in the UK it is certainly never far from the headlines. The challenges it faces are many and varied: the size and structure of the sector; the multitude of stakeholders involved; an ageing population placing increasing pressures on it; budgets; the 'people factor'; expensive medical advances; and increasing expectations of the public. The World Health Organisation (WHO) defines health care as including all actors, institutions and resources used to improve health (Murray et al., 2001) and encapsulating the multilateral nature of the sector on an international level. It has three main goals which, as aims of the WHO, are implicit for all health care globally. These are:

- Improving people's health.
- Responding to legitimate non-health-related expectations (respect for people and client orientation).
- Fairness in financing.

(Eiriz and Figueiredo, 2005)

It is the second of these aims that this study is interested in.

3.7.1 Service Quality

In the UK, health care has traditionally been seen to be a monopoly, which has led to a danger that responding to patient perceptions of quality is not an imperative. More recently, however, competition through both internal and external markets has been changing this and more interest is being shown in the quality of delivery (Singh, 1990). The NHS is increasingly being seen as patient-led and commoditised (Owusu-Frimpong et al., 2010, pg. 204) and, not unreasonably, patients now expect to be treated as individuals receiving respect and care rather than being seen merely as sets of symptoms (Colosia et al., 2011).

Narratives offered by a management consultant, who has had extensive experience of health care throughout most of his life, equates his experiences to the constructs: threat, fear and anxiety. He states that, at times, each of these feelings has been

immense, particularly during the early years of his life. He alludes to a feeling of threat prior to surgery; fear about the consequences and how the surgery may affect his quality of life; and anxiety from having no idea about what was to come next. Most staff did their job, but that was all. However, three people stood out for the way in which they understood that he was a young patient who was frightened and did all that they could to reduce his fear and make his experience easier, simply by spending time with him, bringing him books or taking him to a window. He concludes that, rather than simply treating bodies, it takes common humanity to provide the best levels of care (Brophy, 2005).

Problems in ensuring consistently high levels of the type of service quality that Brophy alludes to in health care have been condensed into three categories (O'Connor et al., 1988):

- ***Service elusiveness*** – The nature of health care often means that the patient does not know what to expect; it is difficult for them to assimilate in their minds the essence of what the service means and, for this reason, they are more likely to pay attention to the tangible and functional aspects of the service (Berry et al., 1988).
- ***Employee diversity*** – Health care is dependent on a huge diversity of employees with different skills and personalities who have to co-operate with each other to achieve desired outcomes (Bellou, 2007). Each group of actors plays a crucial role in the patient–physician relationship and the patient's perception of quality of the service and 360-degree appraisals with input from service users, peers and external colleagues can help staff understand the contribution their own input makes.
- ***Interrelatedness*** – Patients require education to help them understand the service and thus help them in their evaluation (O'Connor et al., 1988). Online resources help in this, although there is a risk that information gathered can be taken out of context by laypeople.

Operationally, measuring quality presents other difficulties, including a lack of resources to collect and analyse large amounts of data, a lack of interest in (and resistance by staff to) data collection, as well as inexperience and lack of training for

managers and staff to develop and use evaluation models (Eiriz and Figueiredo, 2005). Often those who are given the responsibility of managing quality are given the role as an add-on to their main job (Desombre and Eccles, 1998). They are also diverted by a constant demand to provide data for national evaluation initiatives, which may be at the expense of gathering intelligence for local strategic purposes.

Although the professional and patient share the same objectives, historically patients have been seen as the passive actor in a relationship where they are subordinate to the doctor or senior management. This is an antithesis to the ideal where patients should hold an equal status with professionals since they are expected to comply with their advice (Pajinkihar, 2008). Respect is integral to this; if patients believe they are listened to they feel they are respected as people rather than merely simply being viewed as collections of symptoms and are more likely to follow instructions and advice (Pajinkihar, 2008).

Each stakeholder has their own priorities which can often conflict with others, potentially leading to tension. The patients will value not only outcomes but comfort and wants; effectiveness of medical procedures will be the main focus for the physician, while costs and managing resources will be one of the main concerns for management (Manjunath, 2008). When tensions arise between the patient and clinician it has usually been the latter who has held the power and, in parallel with other professional services, evidence suggests that patients are less likely to make complaints against providers in health care than against service providers in general. This may be because the patient, who might feel vulnerable, often does not believe they are in a position to criticise the person who is offering his/her skills to help (Baron-Epel et al., 2001; Desombre and Eccles, 1998), or that they are in awe of the clinician and feel they should not complain about an individual or organisation which is trying to improve their quality of life (Dougall et al., 1999; Angelopoulou et al., 1998; Swartz and Brown, 1989)

3.7.2 User Involvement

Paternalism is becoming outdated amidst government demands for patients to be involved in the decision-making over their treatment (Owusu-Frimpong et al., 2010), a phenomenon that is now included in UK government statute (Department of Health,

2010). The patient is now seen as a crucial player in service delivery and evaluation. Health care provides an environment where improvements to the technical elements of the service, due to medical advances, often lead to better quality of life, while positive interrelations with professionals result in the patient being more likely to follow the advice and instructions of the physician, ultimately maximising potential outcomes (Baron-Epel et al., 2001).

In the contemporary world of health care, three types of patients can be identified:

- Passive patients.
- Those with low expectations.
- Patients who behave as consumers.

(Baron-Epel et al., 2001)

While the first of these accepts their role as subordinate to (and unquestioning of) the professional, the other two are likely to judge services and see the relationship between themselves and the physician on a more equal basis. They are likely to be more involved in the process (Baron-Epel et al., 2001) and, therefore, more inclined towards co-creation. The increased evidence of patient involvement has been identified as a key factor in helping patients evaluate the service (Rhee and Rha, 2009). It reflects Government aspirations for patient involvement in service design as well as with their own treatment. It is leading to a definite shift from them being the operand resources with treatment simply being done to them, towards operant partners where they are key in the service delivery and have increased responsibility for the outcomes of treatment (Sharp et al., 2000). Chapter 2 discusses this in more detail.

The word ‘user’ in the sub-heading of this section has been chosen carefully as it should be remembered that evaluation of services in health care is not always solely the domain of the patient. Family, carers or friends who have involvement with the patient and their care are part of the process and will have their own expectations and evaluation of the service encounters (Conway and Huffcutt, 2003). With local doctors taking responsibility for contracts with hospitals, they become the interim customer between the provider and the patient. This places a different emphasis on relationships between the customer and provider and how the construct of quality is assimilated in terms of the clinical/technical side of care. While patients and their families will continue to evaluate the functional elements, local doctors will monitor

both functional and clinical outcomes on their behalf as part of their contract with the hospital or other provider.

3.7.3 Dimensionality in Health Care

Quality in health care has been conceptualised as “the provision of appropriate and technically sound care that produces the anticipated effect” (McAlexander et al., 1994, pg. 34). While suggesting that it is the technical side of service provision that is prominent, other factors such as the environment, interactions, comfort, etc. are deemed as contributing to the overall concept of service quality (McAlexander et al., 1994). Being at ease with a staff member can reduce anxiety as well as making the customer feel respected (Macintosh, 2009; Lloyd and Luk, 2009). This is particularly relevant in the case of health care where dignity and respect are high on the agenda and an integral part of government statute. As already discussed, where comfort or intimacy exists, it is more likely that the customer will provide the necessary information to help the provider deliver the most appropriate service (Lloyd and Luk, 2009). Again, this can be seen as particularly important in the field of health care where patients are anxious and may feel uneasy, or even embarrassed, in confiding everything. They may fail to identify important snippets of information which they see as insignificant. It reflects the challenge of which dimensions should be applied in a sector with unique characteristics. While the clinical procedures and outcomes are the shared aims of the patient and physician, much literature has been based on the peripheral (functional) items (Lytle and Mokwa, 1992). While it may be easier for patients to evaluate these elements, debate continues around their subjectivity compared with technical processes and outcomes which are reported through performance indicators and used for accountability, regulation and accreditation (Rubin et al., 2001(a)).

Arguably, these elements are more crucial in health care than in other professional services as they can help in the recovery of the patient and can reduce the risk of unnecessary suffering, as evidenced in the Inquiry into Mid Staffordshire NHS Foundation Trust (Francis, 2013).

Table 3.10 Dimensions in Health Care

AUTHOR	DIMENSIONS	
(Angelopoulou et al., 1998)	Physician's manner Quality of information sources Physician's professional/technical competence Interpersonal relations/skills	
(Pajinkihar, 2008)	Autonomy Information Communications	Empathy Respect Dignity
(Dagger et al., 2007)	Technical Interpersonal	Amenities
(Jabnoun and Chaker, 2003)	Tangibles Accessibility Understanding Courtesy Reliability	Security Credibility Responsiveness Communication Competence
(Hasin et al., 2001)	Communication Responsiveness Courtesy	Cost Cleanliness
World Health Organisation (Murray et al., 2001)	Respect for People: Dignity, autonomy, confidentiality, information Client Orientation: Prompt attention, provision of basic amenities, social support networks, choice	
(Walters and Jones, 2001)	Security Performance Aesthetics	Convenience Economy Reliability
(Zineldin, 2000)	Object (Technical) Processes (Functional) Infrastructure	Interaction Atmosphere
(Camilleri and O'Callaghan, 1998)	Professional and technical care Service personalisation Price	Patient amenities Accessibility Catering Environment
(Andaleeb, 1995)	Communication Cost Facility	Competence Demeanour
(Tomes and Ng, 1995)	Empathy Understanding of illness Relationship of mutual respect	Dignity Food Physical environment Religious needs
(Lytle and Mokwa, 1992)	Core benefit: condition/treatment/outcome Intangibles : Reliability, empathy, assurance, responsiveness Tangible: Appearance of personnel, decor of facilities, location of facilities, appearance of facilities	
(Smith et al., 1986)	Expressive aspects – the art of care Instrumental aspects – quality of care, efficacy of treatment, continuity of care Access/cost aspects – including cost and convenience	

(Compiled by the author)

Table 3.10 illustrates the variety of other interpretations of dimensionality in the sector.

Despite this variety of dimensions, there is some consensus that interactions and environment/atmosphere all come together with clinical outcomes to contribute to the overall experience in health care (Dagger et al., 2007; Zineldin, 2006; Lytle and Mokwa, 1992).

As with other professional services, technical elements are seen as implicit elements of the service. At the same time, patients believe their lack of knowledge and expertise in the clinical aspects of care means that these elements are not helpful to them when evaluating the service (Rashid and Jusoff, 2009; Conway and Huffcutt, 2003). This differentiation between the functional and technical elements has been defined as that between care and cure (Conway and Huffcutt, 2003).

A dominant dimension is that of communication, which is seen as a critical but complex dimension in the overall service encounter, with patients having concerns over the quality of explanations given, the amount of information they receive about their appointment, or the quality of advice on self-care (Vukmir, 2006, Epstein et al., 2005). It can be defined as:

- Eliciting and understanding patient concerns, ideals, expectations, feelings
- Understanding the patient in their psychosocial context.
- Reaching a shared understanding of the patient's condition and required treatment that meets with the patient's values.
- Empowering patients and giving them responsibility through involvement in their choices.

(Epstein et al., 2005)

Despite its significance, a number of models completely fail to recognise communication as a dimension in its own right or, where it is included, they do not address its multifaceted nature as referred to later in section 5.3.1.

Similarly, dignity features only twice, despite it being seen as so integral to health care. It allows people to feel in control, valued, confident, comfortable and able to make decisions for themselves (Scrivener, 2011). Nor is privacy mentioned, although it is an antecedent of dignity (Epstein et al., 2005).

3.7.4 Measuring Service Quality in Health Care

Evaluating quality in health care amplifies the usual difficulties associated with service quality due to its complex and multidimensional nature (Dagger et al., 2007; Lytle and Mokwa, 1992; Singh, 1990). It is a service where the consumer is likely to receive service from a variety of actors. These may include the physician, nurse, physiotherapist, catering staff, administrative staff, or others. The complexities this creates compound the challenges. The patient has, then, to evaluate a plethora of distinct dimensions across individual players and situations.

Additional challenges arise when the hierarchy of provision is taken into consideration. This might be at a macro level where all activity is measured across facilities at the highest stratum (in the UK, this would be across the NHS), or at a lower level across all wards in a department. Micro level refers to all actions being evaluated within one area, for example one ward or one clinic (Evans et al., 2001). Quality can be measured across a single organisation, multiple sites within that organisation or multiple functions/departments (Dagger et al., 2007). This presents the opportunity to benchmark between each individual unit.

Further complexities arise with the multiple audiences receiving data, each of which have their own needs. The multidimensionality of the service quality construct in health care requires clearly laid-out goals and purposes for data gathered. Now that the NHS is giving patients greater choice and GPs more decentralised autonomy to purchase services on behalf of their patients, each audience requires differing levels of information in order to make informed judgements. The result is that consumers seek more information about quality delivered by specialists and hospital trusts, while GP consortia require data to monitor quality in their new commissioning role. Patients will not be interested in the minutiae of performance against strategic plans, but will want to know about a provider's reputation (Eiriz and Figueiredo, 2005; Rubin et al., 2001b). At a macro level, a comparative study was carried out in the US, UK and Australia, three countries which face similar challenges in providing health care but with different health care structures. Each country focuses on performance indicators for evaluating quality. Although their findings were across differing systems, there

was a need within all three to differentiate between national and local reporting: the former to respond to the needs of accountability and the latter to provide information about the effectiveness of service provision to the local population (McLoughlin et al., 2001).

The fact that clinicians are accustomed to being autonomous has already been alluded to in section 3.2.5. Having to adhere to top-down measures is not something they enjoy because it conflicts with their desire to provide the best services based on clinical judgement rather than targets. At the same time, patients see the measures as being manipulated by managers. Such measures fail to provide a means by which patients can assess the technical elements prior to service delivery. Only the long-term outcome can determine these and even then this may be based on their expectations, either realistic or otherwise. These measures are also open to criticism because the socioeconomic and environmental factors of local populations affect morbidity rates, rendering them less than accurate (Calnan and Rowe, 2008). The different way in which organisations report their statistics can also affect their interpretation and apparent outcomes, meaning that benchmarking on a national basis is flawed.

Physicians need to understand how patients perceive services, but often they are oblivious to the true picture. There are large variations in the level of evaluation carried out by health care providers but much of it is based on the use of questionnaires and scales. While this is useful to a generalise results, used on its own it does not provide the rich data required to fully understand the intricacies of such a highly complex service. There is a lack of data from internal sources where members of staff, particularly those on the front line, can provide invaluable information about problems that occur and patient concerns. There are some signs of improvement where most local doctors now have patient groups comprising patient representatives who work alongside physicians to get a greater understanding of patient needs/concerns, identify best practice and generally improve services (Williamson, 1994).

A study across two sigmoidoscopy services established that while questionnaires were useful in context, talking to patients about their experiences provided far richer

data (Dougall et al., 1999). Patients receiving treatment at a UK hospital took part, some responding via questionnaires, the remainder taking part in in-depth research. The findings endorsed the view that patients refrain from criticising the medical profession, particularly the elderly. Patients completing the questionnaire suggested high levels of satisfaction, while interviews carried out privately in the respondents' homes delved deeper to reveal experiences and perceptions which were not as clear-cut. There is a line of thought that clinicians are more likely to take notice of such personal accounts than of statistics via questionnaires (Dougall et al., 1999).

The use of questionnaires has been described as no more than a troubleshooting exercise (Murray et al., 2001; Dougall et al., 1999). While far from being useless, they would benefit from being developed into a more sophisticated tool which takes into account the multidimensional aspects of satisfaction and the evaluation of single episodes.

3.7.5 In Conclusion

Research into service quality within the NHS remains inadequate (Dougall et al., 1999; Taylor, 1994) and despite a plethora of targets and performance measures there has been little evidence of any improvement of service quality or trust of patients (Calnan and Rowe, 2008). New service-specific scales are needed that can be easily used at operational level. The multitude of dimensions accorded to health care makes this difficult but advances are needed (Taylor, 1994). If properly designed, questionnaires provide a valuable tool to provide information about patient perceptions. Their value can be maximised, though, if used in conjunction with in-depth qualitative work.

3.8 APPLYING THE LITERATURE

The findings of this literature review underpin the work of this study to identify dimensions for use in the evaluation of quality in health care suitable for use at a number of levels: organisational, departmental, ward, clinic or general practice (local doctor). This is at a time when all health policy is pushing for greater stakeholder involvement and there are increasing calls to improve the experience of patients at a vulnerable time in their lives.

The literature endorses the view that, while the use of performance measurement tools such as dashboards, balanced scorecards, lean, etc. has a place in ensuring quality, these alone are insufficient in the context of service delivery where human elements play such a pivotal role. They fail to acknowledge the traditional characteristics of services and the complexities of human interaction and co-creation.

Little recognition is given to items such as rapport and respect, which are both antecedents to trust, an important dimension in professional services of which health care is one. Nor is there much evidence of deconstructing the communications dimension into explanatory items. Even the much-acclaimed SERVQUAL model fails to address these in any depth. While it does include empathy, which comprises understanding the needs of the customer; having the customer's best interests at heart; and giving personal and individual attention as well as convenient opening hours, these are quite nebulous in their application when contextualised in health care. It is hypothesised that the results of this study will confirm the components of human factors as being key indicators of quality.

SERVQUAL is based on expectation/disconfirmation theory which was an essential part of the early discussions. More recently it has generated a lot of debate about whether the items in the survey are sufficiently comprehensive, as well as whether the use of two questionnaires (one addressing expectations, the other delivery) is both cumbersome and, arguably, of limited value. Furthermore, there is a lack of clarity concerning what is meant by expectation and confusion about its use in determining service quality.

The literature differentiates between customer satisfaction and service quality, where quality is a long-term means of evaluation based on affective or emotional responses to service, as opposed to satisfaction which is cognitive and based on individual experiences. Scholars agree that quality is an attitude. The questionnaire which was designed for this study (Appendix 4) comprises attitude scales based on Likert scales which capture the content, valence and intensity of each item without the need for more than one set of questions.

There is a need to manage quality at all levels of the organisation. While Likert-type questionnaires are routinely used, they are insufficient to draw a complete picture of service quality (Rust et al., 1999). To overcome this means exploiting a range of measurement tools: questionnaires, talking/listening to customers during the course of transactions, data from other sources (Sharp et al., 2000), complaints, general feedback, focus groups and interviews can be included as examples in this context. The use of techniques such as critical incident provide an additional form of gathering rich in-depth data which allows the researcher to delve into specific events and behaviours (Bitner et al., 1990). Equally, quality evaluation should be carried out across both providers and professionals to gain the richest data which allows the manager to understand where gaps exist between the perceptions of actors. While questionnaires and surveys are not deemed sufficiently robust as stand-alone instruments to determine long-term service quality, if designed correctly they can be effective in evaluating customer service, and when used longitudinally can determine longer-term service quality. They are simple to use and do not require trained researchers to employ them.

The objective of this study is to design an effective sector-specific questionnaire developed with input from health care managers, clinicians and service users. The dimensions can also be utilised to develop qualitative streams of work through interviews and focus groups with both patients and staff.

CHAPTER 4

METHODOLOGY AND METHOD

4.1 METHODOLOGY

4.1.1 Relevance of Research

Philosophy might seem superfluous to the practicalities of carrying out research when most researchers are practitioners rather than philosophers. Few might give much thought to epistemology and ontology. However, the relevance of philosophy is that it is seen as helping in the interpretation of data and the consequences of methods adopted. To refer to an old proverb (Van De Ven, 2007), “Well begun is half done”. If the research is well designed, the job is halfway to an effective conclusion. Philosophy helps in retaining the quality of the management research conducted. It clarifies research design, helps identify which methods work best in that area of work and directs the researcher in creating the design methods and adapting them according to the project (Easterby-Smith et al., 2008).

Often researchers inherit a philosophical stance from the traditions of their area of study or from mentors, rather than choosing one. However, “It is better to choose a philosophy of science than to inherit one by default” (Van De Ven, 2007, pg. 37). This chapter considers the role of philosophy within the context of this study and the reasoning behind the pragmatic stance adopted.

4.1.2 Reality in Social Sciences – Does it Exist?

The accredited modern-day business philosopher Karl Popper argued that no matter how well developed and tested a scientific principle is, it cannot be taken as a truth – it has simply not been proved to be false (Miller, 1983). In other words, theories are constantly challenged. He called his theory ‘falsification’. In a business context where things are constantly fluid, in line with changing societies and economies, business practices change accordingly. While a few principles may have longevity in

strengthening business and management ways of working, many are subject to ongoing reworking in order to adapt to the modern world, or even come to be seen as no longer relevant. In this, no matter how well tested and established these theories are, they remain vulnerable to 'falsification' – they are no longer true in terms of business. This is just as true in the public sector as in the business world. In terms of UK health care, the NHS is especially vulnerable to the vagaries of government where there have been years of restructuring, culminating in 2013 which saw the biggest restructuring since its birth in 1948. The thinking behind falsification clearly applies in such a fluid environment, where management practices are regularly remodelled and new theories put into practice to cater for changing social and economic influences.

4.1.3 The Role of Paradigms

Popper's theory coincides with that of Thomas Kuhn, who believed that there is no absolute reality (Bird, 2011).

Possibly the most influential philosopher of the 20th century (Bird, 2011), Kuhn developed the concept of paradigms. He believed that there is no absolute reality and referred to the notion of puzzle-solving. Even in the field of natural sciences individual scientists will look at theories in different ways, and cumulatively science is made up of a set of puzzles where phenomena which have originally been seen as absolute can be disproven at a later stage. This is in line with Karl Popper's theory of falsification.

The theory of falsification has become known as constructivism, where phenomena are open to interpretation. The different perspectives individual researchers place on evidence is dependent on a range of influences: social or economic factors; their own life experience; and their view of life, as demonstrated by the gestalt example where an image may be seen as some as a duck and by others as a rabbit, depending on the angle it is viewed from (Bird, 2011).

The constructs of reality and objectivity fail to stand up in a field where language can be ambiguous, context is important and data is based on the perceptions of individuals. Even within quantitative work, which is more usually associated with

objectivity, the construction of sentences or questions can lead to vagaries in interpretation, ultimately affecting responses.

Kuhn developed the concept of paradigms which he described as “a cluster of beliefs and diktats which for scientists in a particular discipline influence what should be studied, how research should be done, [and] how results should be interpreted” (Bryman and Bell, 2003, pg. 23) The theories can be applied to solve difficult and important problems with new techniques. This is reflected in his concerns that social sciences comprise competing paradigms and no one is prevalent.

Paradigms traditionally fell into four categories:

Positivism

Objective, often numerical or statistical. Although associated with natural sciences, it can be useful in social sciences where quantitative techniques of data collection are used, most commonly through questionnaires. Those of a positivist viewpoint would argue against a Kuhnian view of the world. They hold a scientific view that, once laws are discovered, they are absolute and are not part of our imagination (Easterby-Smith et al., 2008).

The ontology associated with this paradigm is realism, where the researcher is external to the process. It adopts a scientific epistemology which assumes that facts can be proven and generalised.

Post-Positivism

This is based on the belief that science and common sense are both based on reality but to different degrees. While science is very carefully measured, common sense in everyday life does not apply the same accuracy. Knowledge can be challenged (Trochim, 2006).

Critical Realism

Accepts that knowledge of the world can be discovered through science (realism) but that it must be seen in context (critical).

Constructivism (Interpretivism)

Influenced by the experiences, beliefs and background of the researcher who constructs his/her own interpretation of what is being observed.

Constructivism is defined as a means of researching social phenomena by looking at the beliefs, emotions, feelings, etc. of the actors being studied (Sobh and Perry, 2006). It has 'multiple realities' where "Realities appear as multiple realities which are socially and experientially based intangible mental constructions of individual persons" (Sobh and Perry, 2006, pg. 1195). In other words, the realities are based on the perceptions of individuals and to them perception is reality. Interpretation is through the eyes of the researcher (Crotty, 2008). Arguably, the fact that operationally it is rare for a researcher to be completely independent of their study in social sciences supports this school.

4.1.4 The Fifth Paradigm – Pragmatism

More recently, a fifth paradigm has become increasingly established, that of pragmatism.

Pragmatism is a problem-centred approach which focuses on actions and consequences. It brings together elements of both positivism and constructivism to some extent and allows researchers to mix different approaches in order to understand research questions. It is ideally suited to multiple methods where techniques representing both qualitative and quantitative research are employed to complement each other. The paradigm is characterised by a belief that knowing and doing are indivisible. It is seen to exploit the strengths of both positivism and constructivism, at the same time overcoming the weaknesses of each.

This new approach to research, pragmatism, has quickly generated debate over its credibility, with critics arguing that the philosophical traditions of quantitative and qualitative research are incommensurate with each other. Epistemologically and ontologically, constructivism and positivism are seen by some to be too far apart to be sustainable (Johnson and Onwuegbuzie, 2007).

The term ‘incommensurate’ is Kuhnian. Having developed the concept of paradigms, Kuhn was strongly of the view that they were mutually exclusive. Purists remain of the same mind and consider that a positivist piece of work cannot be aligned with a subjective approach: they are mutually exclusive.

Others disagree, arguing that there exists an “artificial demarcation line between qualitative and quantitative” (Gummesson, 2001b, pg. 43). “To generate new knowledge in marketing, scholars should be guided by curiosity and the search for truth” (Gummesson, 2001b, pg. 44). The most important thing is not whether a piece of work is labelled quantitative or qualitative but that the right processes are used. While claims by purists that an individual cannot be both positivist and constructivist continue to thrive, some posit that research methods and epistemologies are not sacrosanct and that qualitative and quantitative research techniques can complement each other without compromising their philosophical stance (Johnson and Onwuegbuzie, 2007; Lowe et al., 2005; Sale et al., 2002): “Be pragmatic, use all roads available to gain knowledge” (Gummesson, 2001b pg. 29).

Pragmatism is the philosophical movement which accommodates this. It is based on practicalities and does not differentiate between theory and practice. The paradigm is gaining increasing amounts of attention in social sciences where supporters see the pluralistic approach as practical. It does not close the gap between the purists in the qualitative/quantitative debate but it does offer a workable alternative (Johnson and Onwuegbuzie, 2007).

It finds a middle ground between methods by taking a practical stance and in this is seen as falling almost outside the rules of philosophy (Johnson and Onwuegbuzie, 2007). The preference of pragmatism for action rather than philosophy and theory allows researchers to address research head-on using whatever techniques best suit the problem.

4.1.5 Source and Type of Knowledge

Source and type of knowledge are encapsulated within epistemology, which asks three main questions:

- How do we know that a proposition about a phenomenon is true?
- How do we gain knowledge and how do we know that the process we use is the correct one?
- When faced with competing facts how do we know which is true?

(Steup, 2012)

How we gain knowledge and the process used has been discussed in the preceding paragraphs, but how far we can rely on a phenomenon or fact to be true must also be considered.

Terminology concerning types of knowledge can be confusing, with theorists referring to a myriad of categorisations. Some merely distinguish between *explicit* and *tacit* knowledge (Duguid, 2005; Jankowicz, 2001). Explicit knowledge refers to that which can be codified and is easy to communicate, often through technology. Tacit knowledge is based on experience, beliefs and values of an individual, very much in line with this study where service quality is focused on personal perceptions of experience.

Others assume the distinction between *a priori* and *a posteriori* knowledge. *A priori* refers to existing knowledge, where it is unnecessary to study the world as it is independent of experience. *A posteriori* knowledge requires empirical observation and it could be assumed that all a priori knowledge ultimately originates from this (Russell, 2012). It is easier to believe in *a priori* knowledge in relation to assumptions which are based on logic, for example 5+10 = 15, than it is to believe in *a posteriori* knowledge which is based on experience. Nevertheless this is only reliable as far as the reasoning or logic used to explain it is valid. While this study uses extant literature *(a priori)* to form the basis of the research, it compares the results of the fieldwork *(a posteriori)* with the existing knowledge relating to the service quality construct to investigate how closely they correlate, and thereby strengthen the assumptions that the existing evidence is true and valid

The fallibility of *a priori* knowledge rests on the fact that it implies belief. It can be associated with logic but it can also rely on semantic propositions where interpretation of the meaning of words applies; it is also systematic, with reliance on the relationship between symbols, or empirical, based on observation, experimentation, confirmation or falsification (Pecorino, 2000).

This study uses empirical means to acquire *a posteriori* data which, by nature, is tacit knowledge (based on perception and experience). While the data and knowledge gained may indeed be fallible, it furthers the contribution towards the enigmatic construct of service quality.

4.1.6 Traditions of Health Care Research

A study of research into service quality found that out of 1,195 articles published between 1993 and 2002 in three reputable marketing journals, only 24.8% used qualitative methods. 46.28% drew on quantitative research, and the remaining articles featured mixed methods (Hanson and Grimmer, 2007). Three main reasons for this positivist approach were suggested:

- The historical belief that good research depends on the reliability and validity of numbers and the ability to generalise that these bring.
- The lack of a definition as to what constitutes good qualitative research.
- The more pragmatic constraint around the number of words allowed by journals – it is argued that a limit of 3,000 to 8,000 words challenges any qualitative article.

While their research showed an increase in articles of a qualitative nature over a period of time, even this trend had reversed more recently. Meanwhile Alvesson and Deetz (2000) identify qualitative research as being increasingly popular. They claim that it produces an "increased likelihood of developing empirically supported new ideas and theories, together with increased relevance and interest for practitioners." (Alvesson and Deetz, 2000, pg 60).

Little research has been devoted to health care, most of it having been developed for cross-industry purposes (Dagger et al., 2007). SERVQUAL is one such model. Operationally, SERVQUAL comes from the positivist school through the use of scales. However, its development crossed the boundaries of two methodologies and philosophies, it having originally been the outcome of constructivism through a series

of interviews and later being refined by way of quantitative work (see, section 3.5.5.2).

Despite a paucity of academic work within the health care sector specifically, the literature points to an overwhelming tradition of positivism in the research that has been done (Sale et al., 2002). This is supported from an operational viewpoint (see Section 2.4) where most management tools used in service evaluation are based on a positivist approach through an extensive use of questionnaires.

4.1.7 Justifying Pragmatism in Health Care Research

The nature of health care is hugely complex. It engages a myriad of agencies and employees to provide services tailored for individual patient needs. The professional relationship between providers and service users is, by necessity, personal. The ontological assumption of positivism does not offer sufficient flexibility to recognise these complexities. The necessity to build relationships in service delivery requires a more subjective approach (Lowe et al., 2005).

While purists claim that qualitative and quantitative research are represented by two distinct philosophical schools they can, in fact, be seen as two poles on a continuum where acceptable knowledge changes according to its position (Morgan and Smircich, 1980). The fact that they are seen as incommensurate does not prevent them being used together where each complements the other to obtain a range of data (Sale et al., 2002), as in the use of multiple methods. This is a misleading concept where qualitative work is carried out independently of quantitative techniques. The word ‘multiple’ as opposed to ‘mixed’ is deliberately used: the former refers to using distinct methods independently to acquire different types of data whereas the other implies blending methods together. The process closes the gap which can result from using one dominant approach, especially when studying complex social phenomena (Bryman and Bell, 2007).

Qualitative and quantitative research techniques study different phenomena which can be distinguished in the way they are described in the research process. In health care this may be the way in which a patient evaluates an element of service quality, which is described as their own perception. It is, therefore, qualitative. The priorities

they place on those elements can be measured in a more numeric or quantitative manner (Sale et al., 2002).

The aim of this study is "to validate a construct of service quality in health care". It sets out to achieve this through four research objectives:

1. Review extant models and measures of service quality.
2. Identify and evaluate existing service quality approaches in health care.
3. Understand the meaning of quality to health care users and managers.
4. Propose a construct of service quality relevant to health care.

To understand the meaning of quality to service users and managers (Objective 3) requires an understanding of how services become quality services. In doing so it should take a holistic view of service users, giving a first-person description of experience (Schembri and Sandberg, 2002). It is a constructivist approach, one of the fundamental features of which is that participants socially construct their own views on life (Andrew, 2004). The results can, therefore, be flawed if the researcher's perceptions of constructs, which again may be subject to their social background, are allowed to be a part of the process. They may also be flawed if the sample is not sufficiently representative of the population.

Objective 4 requires the validation of a proposed NHS-relevant construct of service quality. The nature of quantitative research is that it provides information on the perceptions of large numbers of people from which generalisations can be made. It is suited to the inductive nature of the study in that it forms patterns and assesses if relationships exist between variables, which forms the basis of designing a diagnostic tool for service quality.

The use of the multiple techniques in this way ensures that greater confidence can be applied to the results (Johnson and Onwuegbuzie, 2007).

4.1.8 In Conclusion

The pragmatic epistemology concurs with the concept that there is increased assurance in the results when using multiple methods. It is not the theory but the practice that is important. With that thought, the door is open to mixed methods and

the advantages of the pluralistic approach to research. Qualitative techniques were used in this study to generate in-depth data about the meaning of quality to both service users and providers. This data was then used as the basis of a questionnaire distributed across a wide demographic sample.

4.2 METHOD

The study used multiple methods sequentially, the in-depth data from focus groups and interviews being used to inform the design of a questionnaire for the quantitative part of the research. It was carried out in three phases (Table 4.1):

Phase 1. Qualitative – interviews with patients, carers or family members.
Phase 2. Qualitative – interviews with service providers and focus groups comprising members of the public.
Phase 3. Qualitative – a questionnaire designed from the results of the qualitative work and sent out to the general public.

Table 4.1. The Three Phases of Research

OBJECTIVE	PHASE	METHOD	TYPE OF KNOWLEDGE
3	1	Interviews with patients, carers or family members	Identifying themes around negative and positive critical incidents in experience
3	2	Qualitative research – staff interviews and focus groups with members of the public/patient groups, thematic analysis	Priorities placed by service users and external agencies on elements of service quality Management perceptions of priorities
4	3	Quantitative research – questionnaire, factor analysis	Generalisation of priorities Generation of themes How do socioeconomic factors and age affect priorities?

(Compiled by the author)

4.2.1 Phase 1 - Critical Incident/Storytelling

Objective 3: Understand the meaning of quality to health care users and managers.

4.2.1.1 Approach

The approach used for this phase was critical incident/storytelling techniques to gain a meaningful insight into patient experience. Participants were asked to reflect on their own experiences of health care episodes or the experiences

of family. The interviews were unstructured which allowed them to express their own ideas of what were either negative or positive critical incidents which they felt were significant during their encounter with services (Cohen and Mallon, 2001).

4.2.1.2 Instrument Design

The development of this phase was designed in accordance with literature relating in particular to storytelling and critical incident techniques, and conducting sensitive interviews. The sensitive nature of the interviews was taken into consideration in the design stage with particular reference to the selection of the venue and the format of the interview. The management and analysis of data was also based on recognised techniques in qualitative research.

4.2.1.3 Implementation

The participants were told the nature of the interviews, which were held informally in venues selected by the participant (usually their home) so they felt comfortable in the surroundings (Elwood and Martin, 2010). With their permission, they were digitally recorded or notes taken in shorthand (the researcher was skilled in this). Taking notes in longhand would have prevented the involvement of the researcher in the process and carried the risk of important issues being missed. Confidentiality was guaranteed in all interviews and respondents were assured that data would only be used in the context of the research being conducted, unless prior permission was sought. The interviews took place over a period of six months. Each was transcribed within a week of it taking place. Each lasted between 30 minutes and an hour. Although 30 minutes is seen as an acceptable length of interview (Rowley, 2012), some participants seemed to use the experience as a cathartic process and were happy to talk at length.

An introduction to the study and the purpose of the interview was given before inviting them to tell their story in their own words. Where necessary, questions were asked in order to obtain greater explanation of something or to establish a fact if a comment was ambiguous in any way (Rowley, 2012).

The nature of the interviews was potentially very sensitive. Several participants were reflecting on the care loved ones were receiving right up until their deaths, and the feeling of loss was most likely to be exacerbated when the participant felt that care had not been as good as it should have been, which resulted in a degree of high emotion. The emotive nature of the interview did, in some cases, raise the question of objectivity (McCosker et al., 2003). However, all service quality is based on perception and taking it into the realms of health care is merely an extension of that.

Participants were told at the start of the interview that they could terminate it at any point (McCosker et al., 2003). None did.

The work required empathy and patience on the part of the researcher as well as listening skills (Koerber and McMichael, 2008). The fact that, in many cases, the researcher and participant were already known to each other ensured trust, and some rapport already existed between the parties. This was further enhanced by the fact that the researcher had previous professional experience of conducting interviews and focus groups in a health care setting. Scheduling of interviews was completely informal, with appointments being made at mutually convenient times for the participant and researcher. They were not conducted in any particular order but merely as soon as possible, once contact had been made with the respondent. If the interview concerned a recent stay in hospital, a suitable length of time was left to allow the patient to recover completely and to get back into their normal routine. No interviews were conducted less than one month after discharge from hospital. Some were held several months, or in one case a couple of years, after their experience. While their recollections may have been swayed by the time lapse, the incidents being described were of sufficient importance and magnitude to remain valid.

A paragraph about the researcher's background is included in section 5. 2.1 (Sobh and Perry, 2006; Denzin and Lincoln, 1994; Creswell, 2009).

4.2.1.4 Sampling

Eighteen patients or carers were asked to reflect on their experiences of care in a hospital setting.

Table 4.2 Profiles of Respondents

RESPONDENT	DEMOGRAPHICS/SOCIOECONOMICS
1	White British. Highly educated, academic background, socio-group A. Age group of patient 70–79
2	White British. Skilled, socio-group C1. Age group of patient 60–69
3	White British. Professional, socio-group B. Age group of patient 80–89
4	White British. Skilled, socio-group C2. Age group 40–49
5	White British. Highly educated, professional, socio-group B. Representing two deceased patients. Age group of both patients 80–89
6	White British. Entrepreneurial, skilled, socio-group C1**.** Age group 30–39
7	White British. Highly educated, middle management, socio-group B. Age group of patient 80–89
8	White British. Retired, socio-group C1. Age group 70–79
9	White British. Middle management, socio-group C1. Age group 40–49
10	Asian. Middle management, socio-group C1. Maternity and young child. Age group 30–40
11	White British. Junior management, socio-group C2. Age group 20–29
12	White British. Student, socio-group C1. Age group 20–29
13	White British. Middle management, socio-group B. Age group of patient 80–89
14	White British. Secretarial, socio-group B. Age group 40–49
15	White British. Secretarial, socio-group C2. Age group 40–49
16	White British. Professional. Socio-group C1. Age group 60–69
17	White British. Professional Socio-group B. Age group 40–49
18	White British. Professional. Socio-group B. Age group of patient – young child.

An overview of the profiles of respondents is set out in Table 4.2. In cases 1, 2, 3, 5, 7, 8 and 18, the profiles represent the interviewees, who were reflecting on the experiences of family members rather than of their own. In these cases the age group of the patient is given.

Participants were selected through convenience sampling, mainly using personal contacts. They were primarily of the B, C1 or C2 socio-demographic groups and geographically based in the North West of England. Fifteen were

females and three were males. Ages ranged from 18 to 86, although one respondent was reflecting on the experiences of her five-year-old son. While the sample was not representative of the wider population it did reflect a range of situations and differing experiences. Some respondents were recalling treatment for relatively minor conditions, while others were talking about the care given to family members who had died.

4.2.1.5 Data Management

The raw data was first transcribed from either shorthand or digital recordings, collected and organised in preparation for analysis and then read through to get a general sense of meaning. The extent and complexity of the data required a process of reduction to help in the organisation of it (Sobh and Perry, 2006). This was achieved by reading and rereading to get a thorough understanding of it, before key words and pieces of texts were extracted and grouped together to form themes where possible.

4.2.1.6 Data Analysis

Once the data was arranged into themes, coding was undertaken. This was first done against *a priori* codes taken from the original SERVQUAL model of ten items and the refined model with five items. A further coding exercise was done using open coding.

Relevant quotes or passages were taken from the transcripts to illustrate themes where appropriate.

An interpretation of the data provided a comparison between the *a priori* coding and open coding to establish how relevant the SERVQUAL model was in relation to this part of the study.

The nature of the critical incidents which refer only to hospital care, rather than those occurring in by general practice and in the community, was later compared with the findings from Phases 2 and 3 of the work to identify if those elements identified as priority elements of service were failing.

All analysis was done manually.

4.2.2. Phase 2 - Interviews/Focus Groups

Objective 3: Understand the meaning of quality to health care users and managers.

4.2.2.1 Approach

Phase 2 of the study involved more in-depth qualitative research in the form of interviews with health care staff and external agencies, along with focus groups comprising members of the public. The aim was to gain an understanding of what quality in health care means to different stakeholders.

4.2.2.2 Instrument Design

The design of this phase was determined by Objective 3 – to understand what service quality means to service users and providers. To achieve this the research set out to give participants the opportunity to express their own beliefs in a similar manner to Phase 1 although the interviews and focus groups were semi-structured rather than using the more unstructured approach of the previous tranche of research. This was to explore the construct of service quality in detail (Rowley, 2012; Cohen and Mallon, 2001).

Opening questions for focus groups related to what participants thought health care meant, and where they expected to receive it and from whom. They were then asked what could make them feel more at ease and comfortable with their experience. The groups were closed by a final question asking what they thought about the factors in the refined SERVQUAL model.

The interviews with providers opened with a question about what they believed was important to patients and their family/carers. They were also asked about their reaction to the SERVQUAL model and, finally, were asked to explain how their organisation monitored quality.

Interviews with other external stakeholders (CQC, MP and local authority) were less structured, with an opening question about their perception of the service quality construct followed by extemporised supplementary questions to guide the discussion.

4.2.2.3 Implementation

The interviews and focus groups were conducted concurrently to accommodate personal diaries. The provider interviews were conducted with staff from acute trusts, one hospice and one private practice, all of which were based in the North West of England. Each interview lasted approximately one hour and collectively they were carried out over a six-month period. Interviews were held in a work situation for convenience.

Focus groups were also carried out over a six-month period and took place in a venue to best suit the need of the group:

- Residential home for the elderly.
- Young mums at a primary school.
- People with complex needs at a local community centre.
- Peers in academia in a university seminar room.
- Tree groups of personal contacts at the researcher's home.
- Members of a general practice patient user group at the surgery.

Refreshments were provided to add a feeling of informality.

In the case of the elderly, staff were on hand to offer practical help to participants where necessary and, for those with complex needs, chaperones were present to help with communication problems.

The groups lasted, approximately, between 30 minutes and one and a half hours, according to the experiences of those taking part.

An earlier career in the NHS equipped the researcher with experience in communicating with staff at all levels and in dealing with sensitive issues among a wide cross section of patients and carers.

4.2.2.4 Sampling

Interviews with staff were carried out at all levels of the organisation – administrative staff, managers, directors and clinicians – and from different disciplines, as well as external stakeholders as set out in Table 4.3. The sample was selected according to personal contacts and snowballing.

Table 4.3 Interviewees Representing Service Providers and Other Stakeholders

Organisation	Representative
Large teaching hospital	Chair Director of Facilities Specialist Cancer Nurse
Local district general hospital	Medical Director Director of Nursing Receptionist in A and E
Hospice	Matron
Private practice	Physiotherapist
Primary Care Trust	Medical Director/former GP Complaints Manager Senior Nurse Manager
Strategic Health Authority (NHS North West	Director of Innovation
Care Quality Commission	Regional Director
Political representative	Local MP
Local council	Executive - with responsibility for monitoring health care

A series of eight focus groups comprising patients, carers and general members of the public were held. Members of most of the focus groups were again selected from personal contacts and snowballing. The elderly and those with complex needs were selected on recommendation from Tameside and Glossop Primary Care Trust. Membership ranged in age from early 20s upwards and was from socio-demographic groups B, C1, C2, D and E. They were all from north-east Manchester. Groups are listed in Table 4.4.

Table 4.4 Profile of Focus Group Membership

Group no.	Focus Group	Group Size	Profile of Members
1	Residential home for the elderly	5	Aged approx 75+ with varying levels of disability. Socioeconomic groups C1, C2, D
2	Young mums	5	Aged 25–35. Socioeconomic groups B, C1, C2
3	People with complex needs	8	Aged approx. 35+. Socioeconomic group assessed as C1, C2 and D
4	Academic	7	Aged 25 to 50 approx. Socioeconomic groups B,C1, C2
5	Sample of the general populace	6	Aged 55+. Socioeconomic group C1, C2, D
6	Sample of the general populace	5	Aged 24+ Socioeconomic group B, C1, C
7	Sample of the general populace	5	Aged 45+. Socioeconomic group B, C1, C2
8	Patient group	7	Aged 60+. Socioeconomic group C1, C2, D.

4.2.2.5 Data Management

The interviews and group discussions were digitally recorded and later transcribed. A sample is attached as Appendix 3. Some sections had to be played and replayed several times to determine the nature of the discussion due to background noise or because participants had difficulty communicating. Those taking part were invited to see the transcripts to check their input had been accurately reflected. Any necessary amends were made before analysis.

4.2.2.6 Data Analysis

The transcripts were read through twice to acquire a general feel for themes coming out. They were then coded against the two SERVQUAL models and open-coded to determine how the data compared with the existing models and to identify additional service elements. These were then drawn together into themes (Tables 5.1, 5.2 and 5.3). This was an iterative process, as the complexity of data required revisiting in order to ensure reliability and effectiveness in the coding. This was especially the case when transcribing groups comprising participants who had complex needs and for whom communication was difficult. Analysis was done manually.

4.2.3 Phase 3 – Quantitative Process

Objective 4: Propose a construct of service quality relevant to health care.

4.2.3.1 Approach

Phase 3 was a quantitative piece of work designed to generalise and validate Phases 1 and 2. It was in the form of a detailed questionnaire which was designed using the themes pulled out of Phase 2 of the study. The instrument, which was self-administered and comprised 104 statements about service quality in health care which respondents were asked to prioritise using a seven-point Likert scale (Appendix 4). The data was used to confirm or falsify dimensions currently used in the evaluation of service quality in health care, leading to the development of an instrument which can be adapted for use in clinics, local doctors' surgeries or hospitals.

4.2.3.2 Instrument Design

The questionnaire was designed using the data extrapolated from the focus groups and interviews in Phase 2 of the study. A total of 104 questions were formulated, which were then placed into seven themes: environment, caring, communications/involvement, responsiveness, trust, access/reliability, and food. A Likert scale was used with each pole being labelled 'Not so important' and 'Very important' respectively. The terms were chosen since, arguably, every item included could be seen to have some importance, making an alternative label of 'Not important' invalid. A section also asked for information including their current or former job/career, level of education attained and age. The questionnaire was then piloted among eight personal contacts, with suggested amendments being incorporated before a second pilot was carried out and the final version distributed. The final design also had the support of two senior academics.

4.2.3.3 Implementation

Although the process was completely confidential, respondents were given the option to give their contact details to take part in a draw for a voucher worth £25. Distribution took place over a period of three months using personal contacts, local support meetings and two databases. Six and a half thousand

questionnaires were sent out with almost 1,200 being returned (a response rate of 18.5%). A letter explaining the work was attached (Appendix 5). A few were sent out electronically with the majority being distributed by post. There was no need for a reminder to be sent out. The input of data into SPSS was a gradual process taking place as completed questionnaires were returned. This took a period of approximately two months.

4.2.3.4 Sampling

As health care is relevant to everyone it was important that the sample for distribution comprised a wide demographic. Anyone over the age of 18 was deemed relevant. This age was chosen as a cut-off, as approaching a younger sample would create ethical issues.

Distribution was via a number of channels:

- Convenience sampling using personal contacts of the researcher.
- Snowballing techniques through personal contacts.
- Support meetings for elderly people with mental health problems.
- A database of 950 from the voluntary sector based in the north-east of Manchester.
- A national database of 5,500 taken from mail order customers and representing all socioeconomic groups and demographics.

Inevitably some groups were represented more than others. Surprisingly few people from ethnic minorities were included in the national database and, although the voluntary sector was located in a part of Manchester with a high number of people from ethnic minorities, the response rate from these groups was low.

4.2.3.5 Data Management

SPSS was used for data management. Data was inputted as the questionnaires were returned in order to make the process manageable. Questionnaires were given individual numbers, and hard copies were retained so they could be cross-referenced at any time if required.

4.2.3.6 Data Analysis

Factor analysis using SPSS was applied to the results to reduce the service quality items and group them in the most optimum number of factors. Other items that received high scoring as priorities were added to the final iteration of the model.

The results were then used to develop a service quality diagnostic tool for use in the health sector.

4.2.4 Reliability

Phase 1

Prior to each interview, the researcher explained the purpose of the work and her own professional background (Creswell, 2009; Sobh and Perry, 2006; Denzin and Lincoln, 1994).

While it is advised that transcripts were sent to the participant to ensure they were accurate (Denzin and Lincoln, 1994), it was considered inappropriate in some cases since emotions were often raw and there was a risk that wounds could be reopened. For those interviews which were not as emotive, interviewees were invited to review the transcripts for accuracy.

A peer debrief took place (Denzin and Lincoln, 1994) with a senior academic to discuss the process and findings, after completion of the process.

Phase 2

Each interview and focus group was preceded with the objectives of the research being explained, along with the professional background of the researcher, in a manner similar to Phase 1.

Once transcripts were completed, copies were sent to the interviewees and to at least one member of each focus group to ensure that they were an accurate reflection of what had taken place. In the case of the groups which comprised participants with multiple and complex needs and the elderly, chaperones who were present were asked to check for reliability on behalf of the group members.

A debrief took place with a senior academic during and after the process.

Phase 3

The reliability of the questionnaire was tested by two piloted versions. Each iteration was tested by eight people. The same group was used for each version to ensure that the questionnaire had been adapted according to their comments. They were asked to look at:

- How easy statements were to interpret.
- The use of the Likert scale – did the terms 'not so important' and 'very important' make sense?
- The number of points on the scale (5, 7 or 9).
- How easy the questionnaire was to read – font size and lay out
- The time it took to complete.

The final version was seen by two senior academics for their feedback before being sent out.

4.2.5 Ethics

Phase 1 of the study involved respondents who were personal contacts of the researcher. For this reason full NHS ethics approval was not required. Ethics approval was, however, sanctioned by Manchester Metropolitan University. Phases 2 and 3 were involved in accessing respondents from NHS sources as well as a national database. For this reason the proposal went through the National Research Ethics Committee North West – Preston. On the advice of this Committee, a dedicated email address and mobile telephone number were used for any queries relating to the study.

Participants were all over the age of 18 for ethical reasons and efforts were made to include a range of service users (including those from vulnerable groups, such as those with complex needs and mental health problems). This was again on the advice of the Ethics Committee, to ensure that such groups were not discriminated against.

All participants of the focus groups and interviews in Phase 2 were given an information sheet explaining the work and asked to sign a form which had been approved by the National Research Ethics Committee NW (Appendices 6 and 7).

CHAPTER 5

RESULTS

5.1 INTRODUCTION

This chapter takes each phase of the study independently. Firstly, it identifies themes arising from the analysis of feedback from critical incidents. It takes a similar approach with the interviews and focus group findings, before comparing the priorities arising from these with the findings from the critical incidents. In each of these qualitative phases, quotes are taken from participants to illustrate the evidence. The results of the quantitative phase are set out in Section 4, where factor analysis is used to identify service dimensions. These are compared to both the original and the adapted SERVQUAL models to assess the validity of their dimensions in terms of service quality in health care.

5.2 PHASE 1 – CRITICAL INCIDENT/STORYTELLING

Feedback from interviewees taking part in the first phase of the study was used to identify themes around which critical incidents were identified by respondents. These were either of a positive nature where things went particularly well, or alternatively they represented situations where problems had arisen.

5.2.1 Researcher's Professional Background

In line with good practice in relation to the validity and reliability of qualitative research (Denzin and Lincoln, 1994), a brief resume of the researcher's professional background is set out below:

Coming from Greater Manchester, the researcher is 55 years of age, with 11 years experience in the NHS, complemented by a further 15 years in public relations and general marketing and one year lecturing in these fields. Her educational qualifications include the Chartered Institute of Marketing Diploma, a master's degree which focused on benchmarking service quality in the arts and culture sector and a

master's degree in research discussing service quality in health care. Much of her experience has been with the public sector, although seven years were spent in the private sector, which has given her the advantage of understanding the nature of service quality in both contexts. Her academic experience of research is augmented by a previous role as head of communications and public engagement within the NHS which saw her conducting user group meetings as part of major consultation exercises. This role required an objective approach during which personal influences and beliefs were not allowed to encroach on debates or findings. She is experienced in working with people from a wide cross section of society, including those who have complex medical needs (often with a range of disabilities) and of working with sensitive issues. Both of these complement the skills used in carrying out research relevant to this study.

5.2.2 Themes from Critical Incidents

An overview of the profiles of respondents is set out in Table 4.2 which is reproduced here for reference purposes. In cases 1, 2, 3, 5, 7, 8 and 18, the profiles represent the interviewees, who were reflecting on the experiences of family members rather than of their own. In these cases the age group of the patient is given.

Profiles of Respondents

RESPONDENT	DEMOGRAPHICS/SOCIOECONOMICS
1	White British. Highly educated, academic background, socio-group A. Age group of patient 70–79
2	White British. Skilled, socio-group C1. Age group of patient 60–69
3	White British. Professional, socio-group B. Age group of patient 80–89
4	White British. Skilled, socio-group C2. Age group 40–49
5	White British. Highly educated, professional, socio-group B. Representing two deceased patients. Age group of both patients 80–89
6	White British. Entrepreneurial, skilled, socio-group C1**.** Age group 30–39
7	White British. Highly educated, middle management, socio-group B. Age group of patient 80–89
8	White British. Retired, socio-group C1. Age group 70–79
9	White British. Middle management, socio-group C1. Age group 40–49
10	Asian. Middle management, socio-group C1. Maternity and young child. Age group 30–40
11	White British. Junior management, socio-group C2. Age group 20–29
12	White British. Student, socio-group C1. Age group 20–29
13	White British. Middle management, socio-group B. Age group of patient 80–89
14	White British. Secretarial, socio-group B. Age group; 40–49
15	White British. Secretarial, socio-group C2. Age group 40–49
16	White British. Professional, socio-group C1. Age group 60–69
17	White British. Professional, socio-group B. Age Group 40–49
18	White British. Professional, socio-group B. Age group of patient – young child

Tables 5.1, 5.2 and 5.4 set out the results of coding the data against each of the two SERVQUAL models (original and adapted) and using open coding.

ANALYSIS OF DATA

Table 5.1 CODING AGAINST SERVQUAL – Original Framework with Ten Dimensions

	RESPONDENT		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18	
	TOTAL NO. EVENTS																																			
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
RY	6	14	-	-	-	1	-	-	-	1	-	1	-	-	-	3	-	2	1	1	-	-	-	-	-	1	-	1	4	-	1	1	-	-	-	2	-	-
RV	23	48	-	3	-	1	1	4	1	6	3	4	-	-	2	2	3	7	1	2	-	6	-	2	-	2	2	5	2	-	4	1	-	-	1	1	3	1
CE	30	28	-	2	-	2	-	-	-	-	6	-	1	-	-	5	3	3	4	-	1	1	-	-	1	2	-	-	4	-	1	-	4	3	1	3	4	7
AC	9	37	-	4	-	-	-	1	-	4	2	7	-	-	-	1	-	1	1	1	-	2	-	-	-	-	-	2	-	-	2	3	2	1	1	2	1	7
CS	24	14	-	-	-	-	2	-	-	-	-	1	2	1	-	-	1	1	3	2	1	2	6	1	3	-	-	-	1	2	2	-	3	2	1	2	-	-
CM	20	89	1	6	-	4	1	5	1	3	2	4	1	-	9	-	-	6	9	-	-	3	1	1	3	2	-	2	2	3	3	-	4	7	-	-	1	18
CY	1	51	-	3	-	6	-	-	-	-	-	1	-	-	1	10	-	2	-	-	-	4	-	-	-	3	-	4	-	1	-	-	-	2	-	1	-	13
SY	10	21	-	-	-	-	-	-	-	-	1	6	-	-	-	2	1	5	2	-	-	1	-	1	-	-	-	6	-	-	6	-	-	-	-	-	-	-
KC	12	21	-	1	-	1	-	2	-	2	-	1	-	-	-	-	-	2	-	2	-	-	2	1	-	2	-	2	6	2	1	-	4	1	-	-	-	2
TG	21	11	-	1	-	-	-	-	-	-	1	2	1	-	-	-	-	-	-	-	-	1	-	-	1	3	-	3	4	-	7	-	7	-	-	1	-	-
O	10	85	-	4	-	-	2	-	-	4	4	6	-	-	2	5	-	9	-	11	-	6	-	3	2	7	-	4	2	3	2	2	4	2	2	8	-	11
TOTAL *	166	419	1	24	-	15	6	12	2	20	19	33	4	1	1	28	8	38	21	19	2	26	9	9	10	23	2	29	25	10	28	8	28	18	6	20	8	59

RY – Reliability, RV – Responsiveness, CE – Competence, AC – Access, CS – Courtesy, CM – Communications,
CY – Credibility, SY – Safety, KC – Knowing the customer, TG – Tangibles, O – Other

Table 5.2 CODING AGAINST SERVQUAL – Modified Framework with Five Dimensions

	RESPONDT			1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18	
	TOTAL NO. EVENTS																																				
	+	-	Total	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
EY	65	170	235	-	16	-	3	2	3	1	7	9	16	-	2	2	13	3	28	12	23	1	17	3	3	6	10	-	11	9	4	7	-	8	4	1	7	1	3
AS	60	173	233	1	15	-	13	5	3	1	2	8	9	3	2	-	26	2	31	6	16	-	18	5	-	2	4	-	6	8	4	8	-	6	3	1	2	3	19
RV	57	119	176	1	4	-	2	1	1	-	9	9	12	-	2	-	13	-	16	2	6	-	14	4	2	1	7	2	6	14	-	7	3	7	1	1	8	8	13
TG	24	29	55	1	1	-	-	-	-	-	-	6	5	1	-	-	1	-	-	2	5	-	2	1	2	1	3	-	5	2	-	8	-	-	4	2	-	1	1
O	27	134	161	-	9	-	-	3	3	-	15	7	13	-	-	1	14	-	6	-	16	-	4	1	1	2	7	-	3	5	2	3	2	2	7	2	4	1	29
RY	14	87	103	-	10	-	8	-	2	-	6	3	5	-	-	-	13	-	10	3	10	-	6	1	1	1	2	-	5	4	-	1	1	-	-	1	6	-	2
TOTAL	247	712		3	55	-	26	10	12	2	39	42	60	4	6	3	80	5	91	25	76	1	61	15	10	13	31	2	36	42	10	34	6	23	19	8	27	14	67

EY - Empathy, AS – Assurance, RV - Responsiveness, TG – Tangibles, O - Other, RY – Reliability

Table 5.3 Open Coding

	RESPDNT		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18	
	TOTAL NO. EVENTS																																				
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
AT	82	95		7	-	3	2	1	2	2	9	7	3	3	2	3	7	10	9	7	2	17	8	1	11	7	1	5	7	3	5	-	10	4	2	8	2	7
RY	57	129		5	-	4	-	3	-	11	11	5	3	-	-	20	4	17	15	4	1	15	1	3	2	11	2	10	7	-	2	1	8	1	-	3	8	16
CM	24	129	2	7	-	10	2	10	1	8	2	8	1	-	-	15	-	7	-	19	-	3	1	1	3	3	-	-	5	-	3	-	4	8	-	-	-	20
TG	23	30		1	-	-	1	-	-	-	3	4	1	-	-	2	-	1	3	5	-	2	1	1	-	3	-	5	-	-	13	-	-	5	1	-	-	1
KC	12	36	1	4	-	0	1	1	-	2	2	2	-	-	-	2	1	4	-	11	-	-	-	1	1	1	-	3	5	2	-	-	1	1	-	-	-	2
PS	11	46		2	-	1	-	-	1	3	-	1	-	-	-	11	-	3	-	6	-	-	-	-	-	1	-	6	7	-	2	3	1	3	-	3	-	3
O	11	7		2	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-	-		-	4	1	-	-	-	-	-	-	4	2	-	-	1	-	-	1
AC	10	55		6	-	-	-	-	-	4	3	9	-	-	-	7	-	2	2	2	-	5	-	2	-	2	-	2	2	-	1	3	1	2	-	1	1	8
ST	8	30			-	-	-	-	2	4	5	7	-	-	-	2	-	-	-	1	-	3	-	-	-	3	-	2	1	-	-	-	-	-	-	1	-	7
TR	5	41		2	-	8	-	3	-	-	-	2	-	-	-	9	3	5	2	4	-	5	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	2
RD	-	23		2	-	-	-	-	-	1	-	1	-	-	-	4	-	13	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TTL	243	621	3	38	-	26	6	18	6	37	35	46	8	3	2	76	15	62	31	60	3	51	14	10	17	32	3	33	34	5	30	9	25	24	4	16	11	67

AT – Attitude, RY – Reliability, CM – Communications, TG – Tangibility, KC – Knowing the Customer, PS – Process,
O – Other, AC – Access, ST – Staffing, TR – Trust, RD – Respect/Dignity

(Compiled by the author)

Understanding the themes coming out of the data was far from simple as many of them interlink, one having a direct or indirect effect on another, a potentially significant factor in the overall care of a patient. The following section discusses those dimensions that appear to be of interest, either because of failings or because they went well.

5.2.2.1 Communications

The nature of communications makes it a difficult dimension to describe. It can be deconstructed into a multitude of elements, and, when put into the context of a hugely complex sector such as health care, the challenges that arise are significantly compounded and contribute to problems, as highlighted in the open coding set out in Table 5.3 where 129 incidents of failure are identified. Respondents identified instances where communications could be between:

- Staff and patient/carer
- Colleague and colleague
- Department and department
- Organisation and organisation.

The feedback suggested the dimension comprised a number of elements:

- Listening to the patient/carer
- Understanding the patient
- Accent of foreign members of staff
- Use of plain English
- Breakdown in communications
- Contradictory messages from different staff members or organisations
- Incorrect information
- Lack of information
- Access to staff.

Older patients found it particularly challenging when staff failed to appreciate their needs or underlying health problems and when they had difficulty in understanding what was being said by foreign members of staff with strong accents.

Evidence suggested there was a tendency for staff to assume that the age of some patients meant they were confused rather than appreciating that they were simply hard of hearing or perhaps didn’t understand an accent.

Respondent no. 3 is quoted as saying about her mother's care:

> *"They seemed to think she was not completely there and talked across her to us which was annoying."*

…while respondent no. 13 expressed concern about the way in which both her mother and another elderly patient were addressed:

> *"They treated her like some silly old lady who did not know what she was doing."*

and

> *"They were talking to her like a child."*

She went on to say that when her mother was moved to another tertiary (specialist) hospital a similar issue arose:

> *"The doctor did an assessment. He was Indian and mum could not understand what he was saying. He said the results of the tests confirmed that she could not understand him but did not seem to believe that this was because of his accent."*

While these issues are primarily communications issues, they also highlight concerns around both respecting and understanding the patient, potentially bringing into question the credibility of the approach.

Respondent 5, describing the care of his elderly and seriously ill father and mother, expressed similar concerns over issues of communications. However, he was able to reflect positively on experiences when his father was in intensive care stating that:

> *"There were always a lot of staff around answering all our questions."*

When his father was transferred to a general ward this changed:

> *"We weren't kept in the picture of what was going on although the family were at the hospital a great deal of the time."*

Of his mother's care in a general ward at a different hospital he said:

> *"Staff were elusive. It wasn't possible to get to talk to any doctors at all ... nursing staff were very good. It was more a case of not being able to speak to medical staff."*

Yet another respondent had difficulties in accessing senior medical staff in an attempt to get information about the care of her father.

> *"I was passed between the secretaries of the orthopaedic consultant and the medical consultant, each one saying that I*

> *needed to speak to the other without consulting their respective boss."* Respondent 7

One of the more distressing examples of lack of information was given by a mother whose young son was ill and had been admitted as an emergency to the children's ward.

> *"We were left in a room for four to five hours and no one came in. At night it was particularly bad. There was a complete lack of information. I was crying at that stage because I didn't know what was happening."* Respondent 18

Alongside these difficulties lies the frustration of patients or their carers having to continually repeat their history to different professionals. This was raised by several of the respondents but a telling example was described by the mother of the young boy when explaining how she was finding it difficult to get to speak to someone:

> *"Eventually an Asian guy in scrubs walked past and I asked him to come in. His English was not good. I explained the problem and how long we had been waiting. He went out to get a nurse. She came in and I had to tell the story again. She said she would get a doctor. It was the same chap who I had asked to come in before."* Respondent 18

It would be unfair to suggest that all communications were poor. Several examples were given about being kept in the picture, although these did tend to relate to younger patients, with one former patient in her 40s saying:

> *"The experience was almost leisurely and laid-back. They explained everything that was happening. I did not feel that I was being rushed at all."* Respondent 9

Open coding of the results showed communications to account for 129 experiences of negative incidents relating to items associated with dimension, 89 within the original ten-item model of SERVQUAL (Tables 5.3 and 5.1 respectively). The variance is due to differences in means of coding where incidents may occur in more than one dimension according to the model. These figures not only point to the challenges around communications but they also suggest the scale of importance respondents placed on the dimension.

5.2.2.2 Attitude/Respect/Empathy

According to the literature, respect and empathy are antecedents to trust and as such should be intrinsic to health care. The attitude of one person to another might be seen to reflect levels of respect between the two parties. While attitude featured in open coding with 95 negative incidents, 82 positive events were also recorded. It was not possible to draw out their profile within the original SERVQUAL model since none of them featured in their own right but they were implicit within credibility and courtesy. Empathy, however, was notable within the adapted SERVQUAL model, where there were 170 occasions when the dimension was seen to be lacking, compared to just 65 experiences of merit.

The results provided evidence of occasions when the attitude of staff was a serious concern. Incredibly, three respondents described an almost irresponsible attitude:

> *"Nursing staff were awful. They just sat there at the reception desk playing cards and watching TV."* Respondent 18

> *"The nurse who came to take me to theatre had an iPod on and was listening to music. It felt like a sitcom. I called her the mad nurse."* Respondent 9

> *"The nurses were talking at the nurses' station. It was a social chit-chat."* Respondent 5

In another case, the father of a respondent had died and there was a question over whether the failure to administer a drug had resulted in this fatality. The family attended a meeting with the consultant and staff nurse who were both on duty when her father died. She said:

> *"The nurse was very defensive and abrupt. She was there to support the consultant more than anything."* Respondent 2

This was an extreme example, but it did raise concern about the attitude of a member of staff towards a bereaved family.

Another respondent was upset at the attitude of staff towards her mother when she was offered little in the way of empathy or respect on a number of occasions.

> *"We asked if we could take mum to the hospital café. They said if we did she would have to wear a nappy. Their attitude was bad."*

On another day they were present when her mother wanted to use the toilet.

> *"They came in with a commode and cardboard insert. We had to ask her to be taken to the toilet for some privacy rather than going at her bedside."*
> Both quotes were from respondent 13

At another hospital, after using a urine bottle in bed, male patients had nowhere to place the used receptacle other than on the tray that goes over the bed – neither sanitary nor dignified.

There were, however, more reassuring instances where patients were made to feel more relaxed. Anaesthetists, in particular, rated highly in this respect, where more than one respondent commented on their approach, although, again, these did tend to relate to younger patients.

> *"The anaesthetist was fabulous; he had a great bedside manner. I trusted him completely and he made me feel so comfortable."*
> Respondent 9

> *"The surgeons and anaesthetists were extremely good and really nice. A registrar came to visit me and he talked to me rather than my parents. He explained everything and crouched down so that he was on the same level as me when talking to me."* Respondent 12

> *"Before the operation the anaesthetist came. He was really nice and wanted to know why I was so nervous."* Respondent 16

There was only one example of a senior member of the medical team demonstrating a poor attitude and that was from one respondent who otherwise rated the level of her care as extremely high, but was disappointed when the consultant came to see her.

> *"He asked in a bit of a brusque manner how I was. ... He didn't introduce himself and I felt he thought it was a bit beneath him to do that."* Respondent 9

5.2.2.3 Access

Access was another issue which was raised on a number of occasions and one which covered either access to staff, to services or to premises. Some of these accounts related incidents that amounted to little more

than fairly minor annoyances, while other occurrences impinged on treatment. While it could easily be seen as an independent construct within open coding (55 negative and ten positive instances) and the original version of SERVQUAL, with 37 concerns being raised, it was merely a component item under empathy in the later model.

One patient who was in her early 70s was suffering from ulcers on her legs. Although a sister had said they needed cleaning, there was no member of staff available to carry this out. On another occasion the daughter of an elderly patient found that her father was not receiving prescribed chest massages to help his pneumonia and even the doctor raised concern. The reason was that over the Christmas period there were insufficient physiotherapists around.

One case illustrated how, after being asked to be at the hospital for 7.30 am, she arrived to find the clinic she was required to report to was locked up, and the porter had to find a member of staff to unlock the facilities. It was almost an hour later before a nurse appeared.

There was also evidence to suggest that getting access to speak to a consultant was extremely difficult, with secretaries acting as gatekeepers in some cases. It was especially trying in cases where more junior staff did not have the authority to give information.

> *"I rang one of my father's consultants and was told by his secretary that I needed to speak to another, his orthopaedic surgeon. I explained that it was my father's medical condition that we were concerned about but to no avail. I rang the orthopaedic surgeon's secretary and, as expected, was referred back to the medical consultant before being put through to the ward where nobody was able to help me."* Respondent 7

It should be noted that this was not the case in intensive care, where staff were always available.

> *"The care he got in intensive care was very good. He was there for about five weeks. There were a lot of staff around answering all their questions. They were very attentive to him and the family. All staff were excellent. Consultant was there all the time and was really on the ball."* Respondent 5

5.2.2.4 Knowing the Patient

In a commercial world, knowing or understanding the needs of a customer is imperative to gain competitive advantage. It follows that this is a vital component of patient care, where services, through necessity, should be tailored to individual patient needs. Unfortunately this is not always the case.

> *"Staff were concerned that my father wasn't eating. He was being given supplement drinks and most often we found this was vanilla flavour which he really did not like and refused to drink. We told the staff this numerous times and it was noted on a white board adjacent to the nurses' station but still he was not given alternative flavours until we arrived and asked for them."* Respondent 7

When this dimension fails, it can also be reflected in communications, empathy or responding to the patient's medical needs.

A more general comment made by one respondent sums up weaknesses in this dimension:

> *"Overall the information you get before admission is all very general. There is nothing specific to you. I want to be treated more as an individual. The doctors need to be aware that it is not a day-to-day thing for the patient, although it might be for them ... They need to be a bit more personal."* Respondent 16

Reassuringly, this dimension was not one of the most prolific in terms of detrimental incidents, although a number of failings were apparent. This may be because respondents did not see it as a priority. It is more likely that the critical incidents they were recalling manifested themselves in other dimensions.

5.2.2.5 Tangibles

The definition of tangible was the same for all coding purposes and included the physical environment, equipment, appearance of staff, cleanliness, noise, light and food. Cleanliness featured across two dimensions in the SERVQUAL models: tangibles and security in the original model, and tangibles and assurance in the adapted version.

In contrast to much media coverage about the increase in MRSA and C. difficile, cleanliness was, for the most part, seen as being good:

> *"The cleanliness was fine, very thorough."* Respondent 16

> *"I was discharged and they cleaned the room ready for the next person. I was impressed with this. They washed everything down; the floors the tables, everything."* Respondent 15

One respondent whose general experience in other parts of their care was not so good also expressed confidence in the cleanliness of the ward:

> *"It was clean, though, and bedding was regularly changed."* Respondent 8

The main complaint about the tangible aspects of the service concerned noise and light on the ward at night. As one respondent said:

> *"I had no complaints at all except at night when I couldn't sleep because it was so noisy. They were talking and moving furniture around. The noise never stopped ... I was in a side room so I could shut the door, which helped, but it must have been bad for others."* Respondent 14

Interestingly only one respondent had complaints about the food. While it did not arise often in the interviews, when it was mentioned it was seen as being reasonably good.

5.2.2.6 General

There were some quotes from the interviews which seemed to reflect the general feelings of respondents. While they do not apply to every case, they do offer an insight into how care is perceived.

> *"The experiences left no room for trust in the services."* Respondent 13

> *"My overall conclusion is that it seems to be the more concentrated the treatment the better. But maybe this is because there are more staff in these cases. Unfortunately, in cases where the patient is older once you are transferred to a general ward, the care appeared to us to be lacking compared to that given to younger people."* Respondent 5

Speaking of her favourable experience, one respondent said:

> *"I feel that two things were in my favour: I am young and I think that older patients get worse treatment. I was also extremely friendly and courteous to them so they responded."* Respondent 6

"Hospitals are very good places when you are really ill, but not good for getting better." Respondent 5

"I remember thinking I am a statistic now." Respondent 17

An older patient said:

"I didn't have any problem with the medical side, it was the people' side that was poor." Respondent 8

5.3 PHASE 2 – FOCUS GROUPS AND INTERVIEWS

5.3.1 Analysis of the Data

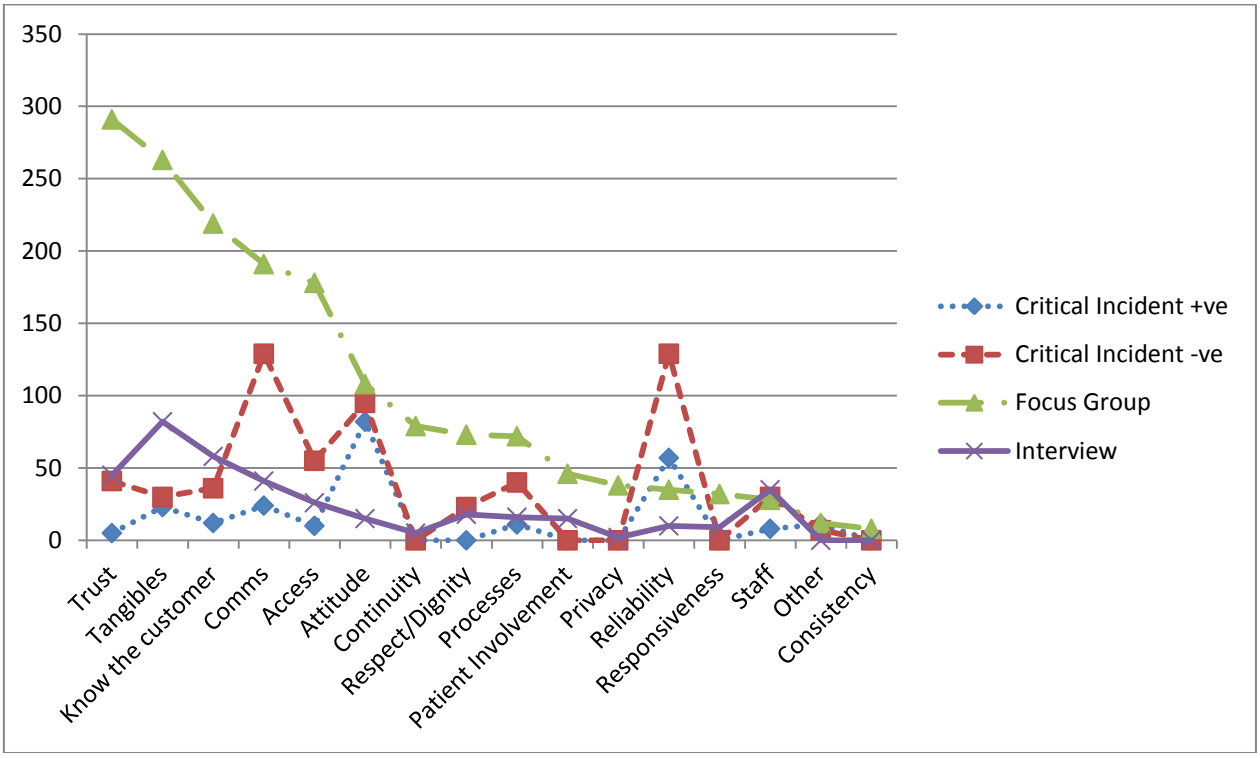
This section examines the feedback from the focus groups and interviews and compares it with responses from Phase 1. It first analyses the results of responses from the public and service providers with each model in order to evaluate how closely they relate to each SERVQUAL model. By showing the level of priority each group placed on service elements it exposes any gaps between the two. Furthermore, by measuring the results against the occurrences of positive and negative critical incidents, identified in Phase 1, an assessment can be made to identify where those elements deemed to be important are either performing particularly well, or facing challenges. Tables 5.4, 5.5 and 5.6 and the flowcharts illustrated in Figures 5.1, 5.2 and 5.3 show the patterns in trends arising from the results.

Table 5.4 A Comparison of Open Coding for Phases 1 and 2

ITEMS	FOCUS GROUPS	INTERVIEWS	CRITICAL INCIDENT COMMENTS	
			+ve	-ve
Trust	291	45	5	41
Tangibles/food	263	82	23	30
Knowing the customer	219	58	12	36
Communications	191	41	24	129
Access	178	26	10	55
Attitude	108	15	82	95
Continuity	79	5	0	0
Respect/Dignity	73	18	0	23
Processes	72	16	11	40
Patient involvement	46	15	0	0
Privacy	38	2	0	0
Reliability	35	10	57	129
Responsiveness	32	9	0	0
Staff	28	35	8	30
Other	12	5	11	7
Consistency	8	0	0	0

(Compiled by the author)

Figure 5.1 A Comparison of Open Coding for Phases 1 and 2



(Compiled by the author)

Note: the lower scores represented by the interviews reflect the views of fewer participants - it is the trajectory of the paths which illustrate the pertinent information.

The analysis of the open coding shows little congruence between the priorities respondents placed on items in Phase 2 of the study and the occurrence of critical incidents. While trust was recognised as having the highest priority for the public in terms of health care in Phase 2, it is notable that there were relatively few occasions where the trust in the service was questioned by respondents in Phase 1 and even fewer where it was mentioned in a positive manner. This latter trend may be explained if trust is seen as being something which should be inherent in service quality; then it may be more subliminal and it does not occur to someone to raise it as an independent factor – it doesn't need consideration. It is worth observing that, in contrast, there was far less weighting given to it by those representing service providers, again perhaps suggesting that it is seen as something to be taken for granted. Conversely, the highest-scoring issue for negative incidents is reliability, although this was seen as being a fairly low priority. Attitude threw up a similar conflicting picture where, although it ranked third in terms of the occurrence of negative incidents, it was not seen as being one of the highest priorities.

Communications, however, did demonstrate a parallel between both sets of responses where it was one of the higher-scoring priorities but was also the second-highest rating (after reliability) for problems. Analysis from the focus groups showed it to be a complex construct comprising a range of items similar to the responses from Phase 1.

Phase 2	**Phase 1**
Between departments	Between departments
Between agencies	Between agencies
Between staff	Between staff
How staff speak to patients	Staff to patients
Patronising manner	Understanding the patient
Repeating information to different staff	Breakdown in communications
Staff having information to hand	Contradictory messages from staff
Information given in simple terms	Use of plain English
Accents	Accents
Appropriate information given	Incorrect information
Ability to ask questions	Lack of information
Listening	Listening
Face to face/body language	Access to staff
Patients being hard of hearing	

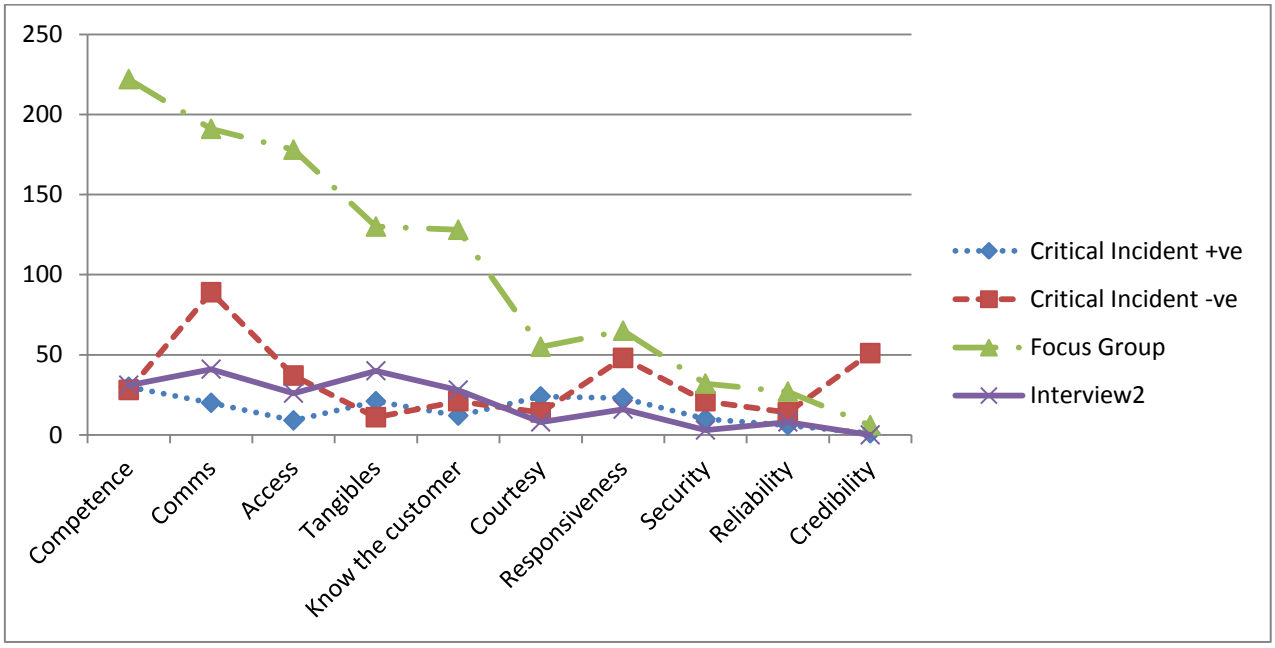
The most overriding priority from the focus groups was that of ‘appropriate information is given’, although this was not reflected in what service providers said, where it appeared as one of the lowest-priority items (Table 5.7). There was a similar contradiction with other items which ranked highly for the public: how staff speak to patients, patronising manners, having to repeat information, listening and body language. None of these arose with any frequency during interviews with providers. In fact, there was little similarity between the ratings of any priorities within the communication construct when broken down, despite it being seen as important by both groups as a whole.

Table 5.5 A Comparison of the Original SERVQUAL Model for Phases 1 and 2

ITEMS (SERVQUAL 10)	FOCUS GROUPS	INTERVIEWS	CRITICAL INCIDENT	
			+ve	-ve
Competence	222	31	30	28
Communications	191	41	20	89
Access	178	26	9	37
Tangibles	130	40	21	11
Knowing the customer	128	28	12	21
Courtesy	55	8	24	14
Responsiveness	65	16	23	48
Safety	32	3	10	21
Reliability	27	8	6	14
Credibility	6	0	1	51

(Compiled by the author)

Figure 5.2 A Comparison of the Original SERVQUAL Model for Phases 1 and 2



(Compiled by the author)

Trust (in this instance referred to as competence) was once again by far the highest priority but similarly attracted a low number of comments within the critical incident interviews. In general the path was very similar to open coding where communications, access, and tangibles were each seen by the public as having relatively high priority.

An exception to this, however, is around the notion of reliability where there were significantly fewer critical incidents than were identified in open coding. The anomaly

is most likely due to the definitions of ‘reliability’. SERVQUAL defines it as: consistency of performance and dependability (Parasuraman et al., 1988), while open coding extends beyond that to include 'giving explanations where reliability fails’ and the ‘interaction of the professional during consultations’.

An apparent omission in the original SERVQUAL model is staff. This attracted a substantial amount of interest from service providers (it was ranked second with open coding) yet the model makes no provision for staff as an item in its own right. This can be explained by the fact that the construct was defined by items such as training and leadership, factors which would be difficult for service users to evaluate and therefore not relevant to the model.

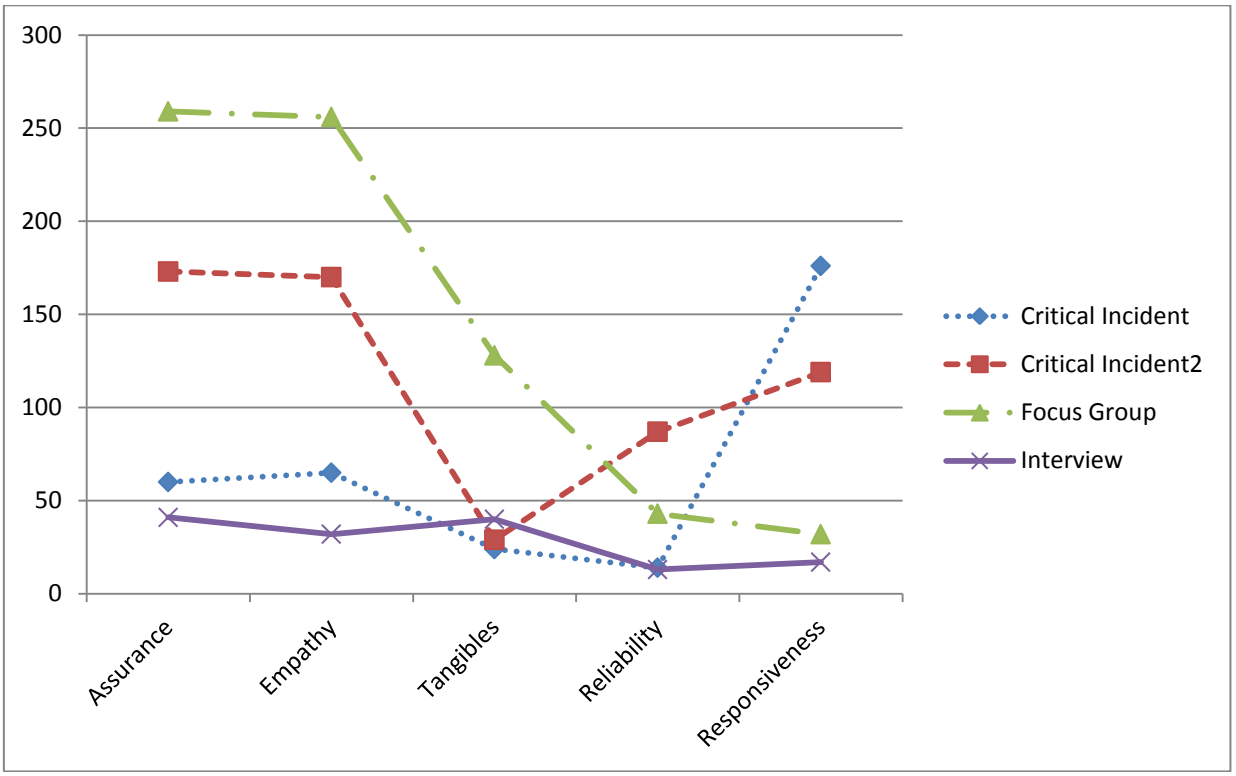
Interestingly credibility and competence were at opposite poles in the rankings appropriated from both the public and service providers, with the former registering very low. Nevertheless, credibility did appear as a significant concern during critical incident interviews. While they featured as two distinct constructs within the original SERVQUAL model, they were merged in both the adapted model and open coding, and appeared as 'assurance' and 'trust' respectively. Although at first they appeared relatively straightforward, the structure of these constructs is complex and is discussed in more detail in, section 6.1.3.

Table 5.6. A Comparison of the Adapted SERVQUAL Model for Phases 1 and 2

ITEMS (SERVQUAL 5)	FOCUS GROUPS	INTERVIEWS	CRITICAL INCIDENT comments	
			+ve	-ve
Assurance	259	41	60	173
Empathy	256	32	65	170
Tangibles	128	40	24	29
Reliability	43	13	14	87
Responsiveness	32	17	57	119

Note: Doesn’t include food, communications or access.
(Compiled by the author)

Figure 5.3 A Comparison of the Adapted SERVQUAL Model for Phases 1 and 2



(Compiled by the author)

As far as comparisons can be made, the trajectories of the two SERVQUAL models follow a similar pattern, with competence and assurance both appearing as high priorities for the public while reliability and responsiveness are towards the lower end. The scorings for empathy and tangibles also reflect those from comparable elements within the open coding and the original SERVQUAL models. The variance with critical incident is notable: compared with open coding, communications, attitude and reliability feature at a far more frequent rate as negative experiences in comparison to the priority placed on these constructs by either the public or service providers. Table 5.7 provides a more detailed definition of the service elements that were drawn out of the results and these were then used to inform the questionnaire for the quantitative stage of the study.

The data in the table clearly highlights the complex nature of some of the dimensions, in particular access, communications and tangibles which between them represent three of the five highest priorities for both staff and public when measured against open coding. Yet neither communications nor access feature as dimensions

in their own right within the modified SERVQUAL model. While access is included in the original model it only takes account of opening hours, access via phone and location of facilities. It fails to recognise other items associated with health care such as home visits, access for disabled people, time with the clinician, etc. The adapted model relegates it to ‘convenient hours’ as an item within the empathy dimension.

There is also some disparity with attitude which, as the highest scoring priority, open coding breaks down into health-care-specific items, particularly respect and privacy. While the SERVQUAL models recognise the significance of ‘knowing the customer’; ‘having the customer’s interests at heart’, 'courtesy' and ‘providing personal attention’, these lack some sector-specific details.

It is of no surprise that assurance is a significant factor within all models. While section 6 of the literature review debates in some detail the constructs of trust and professional competence and whether, in professional services, these can be evaluated by the layperson, the service user can use prompts to create a feeling of confidence. Again, the SERVQUAL models fail to acknowledge more detailed items which are specific to health care, not least of which is cleanliness.

Both public and service providers saw the tangible aspects of service to be of importance, particularly the environment. In a hospital setting, where patients may be confined to a ward for several days (or even weeks), pleasing decor and a light, spacious atmosphere is important. This is especially the case during what is invariably a stressful event in an individual’s life and when surroundings can contribute towards recovery. Food is an item which SERVQUAL neglects to recognise, a surprising omission since it is an element of service which is not only appropriate for health care for inpatients, but also for the hospitality industry.
While the results suggest a synergy between the priorities the public and service providers place on service elements, there are numerous disparities in the dimensions between open coding and the two SERVQUAL models. This is most notable in terms of how the latter fail to recognise the complexity of service elements in a sector as diverse and unique as health care.

Table 5.7 Questions Set Against Data from Focus Groups and Interviews

SERVQUAL 5 ITEMS	Pu*	Pr*	SERVQUAL 10 ITEMS	Pu	Pr	OPEN CODING	Pu	Pr	QUESTIONNAIRE STATEMENTS I want:
EMPATHY			**COURTESY**			**ATTITUDE**			
Understanding/knowing the patient	169	20	Courtesy	55	8	Friendliness	48	3	the professional to be friendly and informal
Staff have patient's interests at heart	15					Staff have interest in patient not a set of symptoms	12		the professional to show an interest in me as a person, not a set of symptoms
Patients receive personal attention	55	11							
						Reception			
						Attitude(courtesy)	39	10	the receptionist to be friendly and courteous
						Asking for medical information	9	2	not to be asked for medical information by the receptionist
			Understanding/knowing the patient	128	28	Understanding/knowing the patient			
						Empathy			
						The doctor understands me	26	12	the doctor to understand me as a person and what my needs are
						The professional cares about me	18	8	the professional to show he/she cares about me
						The doctor and I know each other	18	8	to see the same professional to make me feel more at ease
						Staff have sympathetic manner	10	5	staff to have people skills
						Staff to help me feel relaxed	6	4	the professional to help me relax during consultation
						I am treated as an equal	5	1	to feel that I am an equal partner with the health care professional
						General	25		
						Respect			
						Feeling of being respected	38	9	The professional to show respect towards me
						What name to use	35	9	To be asked what name I should be addressed by
						Privacy			
						Dialogue can't be overheard in waiting areas/wards/consulting room	24	1	Not to be asked for personal/medical information in a public area/waiting room
						Personal information not passed on in error	14	1	To be sure that personal/medical information will not be passed on in error
Convenient hours are in place	17	1							
TOTAL	**256**	**32**		**183**	**36**		**327**	**73**	
ASSURANCE			**CREDIBILITY**			**CONFIDENCE/TRUST**			
Patients/family can trust staff	232	36	Competence	222	31	Patients trust staff competence	227	35	to be able to trust the clinical ability of the person treating me
			Credibility	6					the hospital I attend to have a good reputation/be free from public criticism
									to know my doctor
									to see the same professional to make me feel more at ease
									the doctor to refer to a book/website if unsure about something
									the doctor to have my full medical history to hand
									the doctor to take into account my full medical history if diagnosis is difficult
									to feel the professional knows me well enough to understand my needs
									there to be co-ordination between staff/departments so my care is provided smoothly
									the professionals to agree about my treatment
						The doctor takes time with me	5		to feel unrushed during a consultation
						Details about my specialist are available	4		information about the professional history of my specialist to be available to me
						The doctor trusts what patient tells him/her	4		to feel that the doctor trusts what I tell him/her
Staff are polite	27	5							staff to have people skills
									the professional to be friendly and informal
									the receptionist to be friendly and courteous
			Security	32	3	Safety			
						Cleanliness	49	9	the hospital to look clean
									the environment at the local doctor/clinic to look clean
						Security			
						Access to wards	1	1	access to wards to be controlled
						Threat of injury through accidents	1		to feel there is no danger of accidents in hospital
TOTAL	**259**	**41**		**260**	**34**		**291**	**45**	

SERVQUAL 5 ITEMS	Up	Pr	SERVQUAL 10 ITEMS	Up	Pr	OPEN CODING	Pu	Pr	QUESTIONNAIRE STATEMENTS I want:
			COMMUNICATIONS			**COMMUNICATIONS**			
			Communications	172	38	Appropriate information is given	60	3	to be given appropriate information at all times during my care
						Face to face/body language	20		to receive information face to face rather than by letter
						Listening	18	1	my doctor or other health care professional to listen to what I say
						How staff speak to patients (general comments)	17	1	
						Patronising	14	1	staff not to speak to me in a patronising manner
						Repeating information to different staff	14	1	not to have to repeat information to different professionals
						information is passed to other departments/agencies/staff	13	4	to feel assured that information is passed to other departments/agencies/staff where necessary
						Information is given in simple terms	13		information always to be given in simple, jargon free terms
						Staff have information to hand	10	3	professionals to have all the relevant information about me to hand
						Ability to ask questions	5	1	to feel comfortable asking questions
						Patients hard of hearing	3	10	staff to be aware if patients are hard of hearing and speak accordingly
						Accents	2	16	professionals to ask if I understand what has been said in case of accents or terminology
TOTAL				**172**	**38**		**191**	**41**	
			ACCESS			**ACCESS**			
			Approachability and ease of contact	81	14	Physical access			
					14	Car parking			
						Ease of parking	6	1	plenty of car parking to be available
						Parking fees	1	3	car parking to be free of charge
						For disabled	5		there to be easy physical access to premises which takes account of people with physical disabilities
			Waiting time	32	4	Access to services			
						Getting appointments	32	5	it to be easy to get timely appointments with my local doctor/clinic to be able to discuss more than one problem at one appointment a choice of dates if I need inpatient treatment
						Time with clinician	25	5	not to feel rushed when I see a doctor or other professional
Convenient hour are in place	17	1	Opening hours	17	1	Opening hours	17	1	opening hours of local surgeries/clinics to extend beyond normal office hours
						Going private for a quicker appointment	10		Not to have to pay to get a faster or more convenient appointment
						Home visits	8	4	home visits to be easily available when needed, especially for children and the elderly
						To specialist GPs	8		to have the option to see a GP who specialises in my needs
						General	39	4	
			The service is easily accessible by phone	4	3	Getting through on the phone	4	3	to be able to get through on the phone to surgeries or hospital
			Location of facilities	3		Location of facilities	3		the location of services to be convenient
TOTAL	**17**	**1**		**137**	**22**		**178**	**26**	
						CONTINUITY			
						Seeing the same professional	76	5	to see the same professional every time so that I can feel more at ease to feel the professional knows me well enough to understand my needs to know my doctor
						Between staff/departments	3		professionals to agree about my treatment
TOTAL							**79**	**5**	

SERVQUAL 5 ITEMS	Pu	Pr	SERVQUAL 10 ITEMS	Pu	Pr	OPEN CODING	Pu	Pr	QUESTIONNAIRE STATEMENTS I want:
TANGIBLES			**TANGIBLES**			**TANGIBLES**			
Equipment looks modern/works first time	33	12	Equipment looks modern/works first time	11	4	Equipment			
						Equipment looks modern/works first time	15	4	equipment appears to be modern equipment to be undamaged and work first time
Facilities in keeping with service	38	1	Physical facilities	81	25	Environment			
						decor/light/spacious	80	19	decor in a hospital ward to be bright, cheerful and welcoming local clinics/doctors' surgeries to be bright and well decorated
						Waiting area			
						Ambience/seating	15		there to be sufficient comfortable seating in waiting rooms
						Shops/ things to do	5	4	hospital waiting areas have things to do
						general	11	5	
Staff well dressed and neat	48	33	Smart personnel	38	11	Staff			
						Look smart/wear uniform	47	14	staff to be smart staff to wear uniforms which help identify their position and seniority staff not to wear uniforms
						Wear ID badges	38		staff to wear badges providing their name and job role
						Food			
						Is appetising	12	3	food to be appetising and tasty light snacks such as toast, teacakes, fruit, ice creams to be readily available
						Patients helped to eat when needed	5	3	volunteers to be on duty to help patients eat
						Dedicated meal times with no other activity		1	there to be no activities (except emergencies) during meal time so staff can help
						general	20	14	not to have to decide the day before what I want to eat the following day
						Relaxing	11		efforts to be made to make hospital environments as relaxing as possible
						Sufficient signage	2		hospital signage to be clear
						Bedside entertainment	2	1	there to be good bedside entertainment such as TV/radio to be available if in hospital, even if I pay for it
			Other service users	2		General	3	15	All service users to be respectful and not to cause problems for other users
TOTAL	**128**	**40**		**132**	**40**		**263**	**82**	
						PROCESSES			
						Co-ordination with departments/agencies	22	4	there to be co-ordination between staff/departments/agencies so my car is provided smoothly
						Record keeping	26	5	my records to be made available to me on request
						Patients understand processes	15	4	to know who to speak to if concerns arise
						Doctors having medical history to hand	9	3	professionals to have all the relevant information about me to hand
TOTAL							**72**	**16**	
RESPONSIVENESS			**RESPONSIVENESS**			**RESPONSIVENESS**			
patients told when to expect service			Responsiveness	65	16	Help is timely when needed	13	1	nurses/assistants in hospital to answer calls for assistance in a timely manner
Prompt service	10	5				Staff see my needs	8	4	nurses to be aware of my personal needs/concerns/fears
Staff willing to help patients	22	12				Willing staff	6	4	staff to show a willingness to be helpful
Staff not too busy to give prompt service						Ward transfers not to happen at night	2		not to be transferred between wards during the night or at mealtimes not to be moved from a ward with no notice
						Feel able to ask for help	2		not to feel a nuisance if I ask for help in hospital it is easy to speak to a member of the ward staff if I am in hospital to know who to speak to if I have concerns to be able to speak to the person in charge of my care in hospital
						Reassurance given during procedures	1		someone to be available to reassure me during uncomfortable/painful procedures
TOTAL	**32**	**17**		**65**	**16**		**32**	**9**	

SERVQUAL 5 ITEMS	Pu	Pr	SERVQUAL 10 ITEMS	Pu	Pr	OPEN CODING	Pu	Pr	QUESTIONNAIRE STATEMENTS I want:
						INVOLVEMENT			
						Involvement in choice of treatment	21	3	to be given my options and able to be involved in deciding appropriate treatment
						Choice of hospital/clinician	10	12	to be able to choose where I am treated to be able to choose who treats me
						General	25		
TOTAL							**46**	**15**	
RELIABILITY			**RELIABILITY**			**RELIABILITY**			
Sympathetic staff	18	5	Reliability	27	8	*This was included in ATTITUDE within open coding*			the professionals to be friendly and informal the professional to show interest in me as a person, not a set of symptoms the professional to help me relax during consultation
When something is promised by a certain time it is achieved	12					Appointment times kept to	30	6	explanations to be given if appointments run late not to have to spend lengthy periods in waiting rooms
Services provided at time they are promised	8	8				Actions carried out when promised	5	4	staff to do what they say they will when say they say
Dependability	5								
TOTAL	43	13		27	8		35	10	
						STAFF			
						Staff have time for me	9	2	staff to have time to cater for my needs and to make me feel comfortable
						Number of staff on the wards	6	6	staffing on wards to be sufficient to provide a good service
						Training			
						Academic versus on the job	5	11	
						In personal skills	3	14	staff to have people skills
						Apparent leadership	1	2	strong leadership to be apparent and reflected in the level of care
						General	4		
TOTAL							**28**	**35**	
						CONSISTENCY	**8**		Know that all wards/departments in a hospital offer similar standards of service Information given to me by different professionals is consistent Professionals to agree about my treatment
						OTHER USERS	**8**		All service users to be respectful and not to cause problems for other users
						COMPLAINTS	**7**	**1**	Complaints to be handled in a timely manner Any complaint I might make to be addressed Not feel uncomfortable if I have to make a complaint
						VALUES OF THE ORGANISAION AS SHOWN BY STAFF	**2**	**3**	
						OUTCOMES OF TREATMENT	**1**	**1**	
						OTHER			

* Pu – public
** Pr – service provider
SERVQUAL 5 refers to the condensed version of SERQUAL containing five constructs.
SERVQUAL 10 refers to the original version of SERVQUAL containing ten constructs.

Some questions occur more than once where they are applicable to more than one dimension.

(Compiled by the author)

Table 5.7 sets out the items from each stage of coding against the questionnaire statements. The first column lists the items under the adapted SERVQUAL model with the second and third columns recording the number of times the items arose in the public focus groups or staff interviews respectively. The same pattern is followed in the following columns for the original 10 items SERVQUAL model and from open coding. The final column lists the questionnaire statements that reflect the items.

5.3.2 Supporting Evidence from Service Providers/Stakeholders

The following narrative highlights some of the more significant comments taken from interviews with staff from service provider organisations and other stakeholders such as the CQC and local council. These are illustrated in Table 4.3 replicated here. The quotes used provide qualitative evidence to support the data contained in the tables in the previous section. The dimensions are not taken in any particular order, but feature those seen as being of significant importance.

Interviewees Representing Service Providers and other Stakeholders

Organisation	Representative
Large teaching hospital	Chair Director of Facilities Specialist Cancer Nurse
Local district general hospital x	Medical Director Director of Nursing Receptionist in A and E
Hospice	Matron
Private practice	Physiotherapist
Primary Care Trust	Medical Director/former GP Complaints Manager Senior Nurse Manager
Strategic Health Authority (NHS North West	Director of Innovation
Care Quality Commission	Regional Director
Political representative	Local MP
Local council	Executive - with responsibility for monitoring health care

5.3.2.1 Empathy

The Board at the large teaching hospital placed service quality firmly on the agenda. They saw it as very much the responsibility of everyone, from directors to cleaners:

> *"We are dealing with people in distress. Patients and families need to interact with a whole range of staff. Mike Connelly (a McMillan nurse) and a number of staff have developed a training package called Sage and Time which is one of the best packages I have. It is based on role-play and trains staff at all levels including porters and cleaners to help someone in distress. It doesn't tell them what to do but what can be done."*

This quote came from the chair of the trust who has extensive experience in the field of customer care and service quality from other roles as a director of a large marketing/PR agency and chair of a large arts venue. She has herself completed the training programme.

5.3.2.2 Attitude

A former GP and medical director of a PCT has seen service quality from both sides: as a service provider and a user. She said:

> *"When my son was in hospital the nurse would come to do blood pressure, bloods, etc., and never utter a word to him ... Receptionists take their cue from the doctors in general practice. If they aren't treated with respect by the doctors then this is passed on. I believe you should treat people how you want to be treated yourself. Give them your full attention. If the phone rings unless it is the red phone* (emergency) *do not answer it. If you are already on the phone acknowledge the person to show you know they are there."*

The complaints manager from a PCT believes that attitude is important to enable someone to have faith in their health professional:

> *"If they have the wrong attitude, can you have faith in their professionalism? Attitude and communication generate a feeling of whether a person is making the right clinical decisions. They may have made the right decision but the patient may not have confidence that it is right. The right attitude gives the patient confidence."*

A senior nurse manager, also from a PCT, refers to the ethos of John Lewis:

> "*They recognise that staff may be having a bad day but they teach them to leave it at the front door and to come into work very focused. I'm not saying that you do everything the patient wants but you have to go the extra mile. The cut-off, of course, must be safety."*

It might even be something as simple as "*putting the patient at their ease by having a laugh with them"*, as the physiotherapist in private practice points out.

5.3.2.3 Assurance

The question of assurance and trust did not feature much in the interviews despite the fact that, as a receptionist in accident and emergency points out, *"your life is literally in their hands".*

The local council executive expressed concern that "*nurses are sometimes in charge even though they don't have the experience or authority".*

5.3.2.4 Access

Access was raised on a relatively large number of occasions by providers as something that should be more flexible than it currently is. As the medical director of a local district general hospital points out:

> *"Why do we have to provide services between 9.00 am and 5.00 pm? Why can't we have evening and Saturday sessions? I think this will happen. Ultimately it will save the country money because people do not have to take time off work."*

5.3.2.5 Tangibles

Tangibles can be a surprisingly important aspect of health care and one identified by service users as a priority. While they may not be so important in clinics or GP surgeries where patients spend only short periods of time and may only be there for relatively minor problems, in hospitals they are a more crucial element. Several interviewees raised this:

> *"Surroundings are important. Is there something to do while you are waiting? Shops, big screen, etc. Patients become very stressed and these all go to helping to alleviate nerves. Patients are also more likely to have confidence in you if the environment is right."* Medical director of local district general hospital

> *"I always check the toilets as this gives an indication of the type of surgery it is."* Medical director of Primary Care Trust/former GP

> *"There has been a lot of research around patient experience and the ambience of somewhere does make a difference to mood. Even the effect of colours can have an effect. Pastel shades are relaxing where a colour such as red has the opposite effect."* Hospice matron

From a more service-specific perspective, food is another important element of the tangible dimension in health care.

"Good nutrition has a major impact on patient recovery as well as environment. We have a professional nutritional team which is consultant led. We also ensure the only activity on wards during mealtimes is to help those patients who are unable to feed themselves. We have a team of dining companions comprising volunteers specially trained in this. I am a member of this team myself." Chair of large teaching hospital

"We used to have a situation where the catering departments told wards what was available. Now dietetics are involved so everyone is getting the correct diet. It is part of the personal care package. The quality of food and choice helps make patients look forward to mealtimes. We have health and well-being groups where people such as clinicians, dieticians, patients, facilities staff and patient surveys all contribute to catering. In addition, every three months the Board samples the patient menu." Director of facilities, large teaching hospital

5.3.2.6 Staff

Perhaps unsurprisingly, the results showed staff elements to be a comparatively high priority for service providers. It was again the chair of the teaching hospital who raised some pertinent points.

"You can't micromanage things. The only way you can manage something as complex as a hospital is to have the right people in the right jobs with the right training and the right motivation and without anyone having to keep checking up. We see ourselves as all one team. Patient safety and quality is everyone's responsibility. This is reflected in training and appraisals."

The hospice matron sees issues with training:

"Old-time nurses think modern training is shocking. Nevertheless, in times gone by training would not have been academic enough. Nurse training used to be more hands-on but would not have covered things such as taking bloods or canulation which nurses do now. Nursing is far more advanced these days.

"However, students do tend to be mollycoddled. They are put in classrooms for too long. When they qualify they are not prepared as they are used to being supernumerary and not had to take as much responsibility for practical work during their training. They do not have as much hands-on experience as students used to."

5.3.2.7 Reliability

Reliability was not one of the highest-scoring elements; nonetheless, it did raise some comments:

"It is important that messages are passed on. If a patient is told the doctor will phone back then that should happen. Try to explain to people why they are having to wait. How do you explain to someone why someone has gone in first when they have waited the longest? Do not patronise people but explain why the person has gone in." Medical director of a PCT/former GP

"One of the big bugbears in the NHS is time management. You should always apologise if you are late and explain to the patient why you were late." Physiotherapist in private practice (referring to his time in the NHS)

5.3.2.8 Responsiveness

Responsiveness was identified as being both of reasonably high importance and a complex element.

The PCT medical director described it as *"about going that extra little bit. The staff should not be too busy to see people",* she said.

Meanwhile, the senior nurse manager saw responsiveness as the way in which professionals dealt with patients:

"My surgery always guaranteed to see people the same day and I worked until everyone was seen. This gave them confidence that where possible things could be sorted out the same day."

"*Some of the most competent doctors are the best at dealing with patients. They are confident and very approachable. I had to go to a specialist who was very experienced. The consultant called me in from the waiting room himself. He helped me get dressed and undressed. He explained everything. He organised things for me. Nothing was beneath him."*

5.3.2.9 Continuity

While continuity did not attract a great deal of comment from providers, one quote from the complaints manager did sum up how it can be a crucial factor: one doctor expressed concern about a patient's treatment and asked:

"'Why are you on that medication, you shouldn't be.' They might not be in full ownership of the facts."

5.3.2.10 Involvement

Involvement was another factor that did not receive a great deal of comment from providers, although the medical director of the local district hospital did say that:

> "Patients ask more questions, I think, and are getting more involved in their health care. It needs to be a partnership. We need to know if they are happy with their treatment."

5.3.2.11 General

Each respondent was asked to comment on elements form the adapted SERVQUAL model.

The accident and emergency receptionist felt there are too many variables in a hospital for SERVQUAL:

> *"In accident and emergency things are different to things on the ward. It is difficult to generalise because departments in individual hospitals have different needs. There is a lot going on in the background that patients do not always see."*

The complaints manager felt:

> *"The* (reference is made to the SERVQUAL elements) *are desirable but are they achievable? Clinical competence is missing. I think a patient can measure clinical competence. If you have not got the competence then the service will suffer."*

Ranking the SERVQUAL elements, the physiotherapist believed empathy to be "*by far the most important"*, with responsiveness next in line:

> "*Going that bit extra and being a bit creative with time so that everyone can be seen. This is lacking because academics is put first. The training is now academic. We are getting the wrong people in the job.*"

His definition is similar to the way he refers to reliability as: "*Ensuring people are seen when they have been told they will be seen".* He also made an interesting comment relating to assurance; he claims that:

> *"Assurance is two ways. The patient must trust the professional, but the professional has to be sure that the patient will take their own responsibility in following advice*."

Perhaps one of the most telling quotes was, again, from the chair of the teaching trust, who cited:

> *"kindness, consideration, reassurance, eye contact and a smile as being key to good service. It is not surprising there is aggression and violence in A and E when people are injured and drunk – they are not given eye contact, maybe ignored, no smiles, etc."*

5.3.2.12 Service Evaluation

Evidence suggested considerable diversity in the way in which service is evaluated. The director of innovation at NHS North West (the former Strategic Health Authority) considered:

> *"measurement to be an art rather than a science. There is more to it than Sigma and lean working, and the design of the mandatory annual patient survey which came from the USA begs the question if it is the most appropriate tool. Is it cross-cultural? The way in which patients assess the service they received is based on eight emotions: honesty, respect, self-confidence, safety, understanding where information is given in a meaningful way, comfort, effectiveness and reassurance*."

One of the two local district hospitals was committed to using this model in their own service evaluation.

> *"Traditionally we concentrate on measuring things such as process and waiting times, rather than emotions which actually represent over 50% of patient experience. Patients are anxious, they cannot park the car, they are having to give information over and over again. This all makes the experience more stressful The work we are doing is from the highest level of management and involves staff at all levels. It is led by a non-executive director from the banking industry. We also carry out patient surveys, audits, nursing care indicators, and staff satisfaction questionnaires. We are also considering how we can measure quality through family feedback."* Director of nursing at a district general hospital

Evaluation is seen as very different in the second of the district general hospitals, where a more performance-related approach is taken:

> *"We measure services through PROMS*, Dr Foster and the national audit processes, as well as the usual national dashboards alongside ones we have designed specifically for our hospital. We also use Patient Opinion which allows patients to comment on our services online in a similar way to Trip Advisor. We are getting to a more granular level – performance of individual doctors. Some doctors are doing more complicated operations so it is difficult to measure. Patients do ask what the success rates are. Complaints are also used*." Medical director of district general hospital

(*PROMS measures the health gains for patients after surgical treatment using pre- and post-operative surveys).

The chair of the teaching hospital felt strongly that *"improvements cannot be made through targets. We use the term measure rather than targets."*

The specialist cancer nurse described how a holistic approach is taken for cancer care at the same hospital:

> *"Our team comprises a lead cancer manager, a lead cancer clinician and a specialist cancer nurse. This means there is no bias towards one lead, for example, nursing implications, management or budgetary restrictions, or medical emphasis."*

Quality rather than performance was also seen as the focus for the CQC:

> *"There is a difference between quality and performance. Performance should be both qualitative and quantitative. Qualitative is about the way we do things, as well as targets. It is a difficult balance. There are dangers if you put quantitative data before qualitative research because quality can go by the wayside. Boards of directors should be aware of that. They are meeting targets and they should put in measures to keep up quality. It is quality we measure, not performance."* Regional director of CQC

While there is recognition that much work needs to be done to improve standards and that quality should be the focus rather than targets and performance, there was a belief from some that expectations have risen in recent years.

> *"I don't think standards have slipped. There have always been issues. It is that expectations have increased and problems are highlighted more nowadays."* CQC regional director

> *"Patient expectations have increased. People have grown up with choice. They travel abroad and experience other places for health care. There are a lot of reasons why expectations have changed. People are much more informed because of the Internet, they are more educated and more articulate. You have to change with them and get that customer care focus."* Senior nursing manager at PCT

5.3.3 Supporting Evidence from the Public

The sensitive nature of groups 1 and 3 (as in Table 4.4 replicated here) necessitated a certain amount of estimation in terms of demographic profiles.

Profile of Focus Group Membership

Group no.	Focus Group	Group Size	Profile of Members
1	Residential home for the elderly	5	Aged approx 75+ with varying levels of disability. Socioeconomic groups C1, C2, D
2	Young mums	5	Aged 25–35. Socioeconomic groups B, C1, C2
3	People with complex needs	8	Aged approx. 35+. Socioeconomic group assessed as C1, C2 and D
4	Academic	7	Aged 25 to 50 approx. Socioeconomic groups B,C1, C2
5	Sample of the general populace	6	Aged 55+. Socioeconomic group C1, C2, D
6	Sample of the general populace	5	Aged 24+ Socioeconomic group B, C1, C
7	Sample of the general populace	5	Aged 45+. Socioeconomic group B, C1, C2
8	Patient group	7	Aged 60+. Socioeconomic group C1, C2, D.

5.3.3.1 Empathy

Empathy was one of the highest-scoring factors for the public but was defined in a number of ways:

> *"Being treated as equal."*
>
> *"Not to be treated like a kid."*
>
> *"Some health professionals (not all) think that you just happen to be there and that you don't have a life to lead. They just do things to you. They tell you what to do."*
>
> *"One of the things I like about my doctor is that he treats me as a person. When I first go in he asks me how are you, not what is wrong with you. We just have a bit of a chat and I like that, that he sees me as a person first and a patient second. It is very important for me."* All quotes from group 6
>
> *"I am nervous of dentists but he put me at my ease as soon as I went in. He joked with me and talked to me and I wasn't frightened anymore."* Quote taken from group 8
>
> "*When I went to the doctor this time. I had never seen this doctor before and as soon as I started talking I knew I was going to like him because all he did was sit and listen. He didn't seem as if he didn't have the time."* Quote taken from group 2

5.3.3.2 Access

Access was seen at different levels. Some were concerned about how long it can take to get an appointment:

> *"You might not get an appointment for two weeks at the doctor's. Doctors don't come out to see you anymore. It's not personal anymore.*

> *You have to go to Go to Doc* (out of hours service)*. Even when a little child is poorly you have to take them out of the house."* Quote taken from group 2

Others wanted to see longer opening hours to accommodate people with full-time jobs. As one person pointed out:

> *"This is even more important now because employers are demanding a lot more because of the economic climate and it is seen as a weakness if you have got an appointment at the doctor's or the dentist."* Quote taken from group 7

Length of appointments was an issue for some, especially because doctors expected patients to present no more than one complaint. Not surprisingly, those respondents with what are known as complex needs (generally people with serious disabilities) had a particular issue with this:

> *"one appointment, one problem. That didn't used to happen years ago. If you had something to discuss you went whether it was one or three problems. Now they won't let you do that unless you have a double appointment."* Quote taken from group 3

A member of this group had also experienced problems with physical access at her local doctors' surgery where automatic doors made it difficult for her to manoeuvre her wheelchair. For a local health clinic this is a significant flaw, but it was only mentioned once.

5.3.3.3 Communications

Of all elements, communications was the most complex, comprising a variety of items.

One of the most important and frustrating aspects was where information was not forwarded, especially in the case where more than one specialty was involved:

> *"I know from more than one incident affecting the family that shift handovers and notes were not being handled properly. Information wasn't passed on and in one of them it beggars belief that the hospital couldn't trace the doctor who had given drugs. Who is to say he was a doctor?"* Quote take from group 7

This respondent was referring to two cases where a family member had died – one which was a direct result of breakdown in communications, the other

which contributed to by poor care. In one case two medical teams were involved – one of which *"was very effective"* but with *"no communication with the other team."*

This was an example which saw communications and attitude very closely aligned with each other:

> *"Things we said were noted and put up on the board at the nurses' station but they were still ignored. I don't think it was communications, I think it was a don't-care attitude."*

The respondent had also made comments on a feedback sheet which:

> *"was supposed to be read every 24 hours and they obviously weren't. When we challenged them, they said they didn't even know the sheets were there. Good communications."*

Trying to find out information about a family member was also identified as challenging:

> *"I want to go there and if I ask someone to get an answer, to even to be able to find someone to ask something. … At one point I literally had to kidnap a student doctor and keep him in a room until I could get the consultant to answer a few questions."* Quote taken from group 6

One of the problems with communications came from the complaints manager of the primary care trust where it is sometimes difficult for the professional to judge how much, and what kind of information, each patient prefers. A respondent who had recently been diagnosed with multiple sclerosis said:

> *"the neurologist told the GP not to tell me about the diagnosis. I wanted to know … It should be my choice."* Quote taken from group 8

Yet another patient who had recently been diagnosed with cancer had experienced problems about the way in which information had been passed on to her:

> *"I got a letter last week from Christies with some results of the treatment and it was all numbers. I didn't understand any of it. I got the letter a week ago and I have only just spoken to someone. I phoned the doctor, I phoned the nurse, I phoned the Christie secretary and it was only yesterday that anyone got back to me."* Quote taken from group 2

Communications is a two-way process in which listening must be a key component, not least in health care. A respondent who had visited her doctor

with stress-related symptoms recognised just how important this was in her experience:

> *"the doctor actually seemed as though he wanted to listen to me and let me blubber everything out and I really felt that he was bothered."* Quote taken from group 7

5.3.3.4 Tangibles

Arguably the tangible element of service has a unique position in health care. Feedback from the service providers has already suggested that the environment can help to promote recovery of patients (section 5.2.2.5). Its influence is seen by service users in other ways, where it makes a significant contribution towards trust.

> *"It's okay having these fancy new places but they don't get maintained. In five years they are as big a wreck as the old. At my dentist it is pretty grim where you have to wait. There is a general malaise in the way things are maintained and it makes you wonder about the rest of management. It gives a bad impression."* Quote taken from group 7

Maybe it was significant that this respondent was an engineer and is probably more conscious of this; however, someone else did agree, suggesting that a pleasant environment makes you feel *"you have gone somewhere where they can help".*

A member of group 5 was herself partially blind and had a husband who was totally blind. They were both frequent visitors to the Manchester Royal Eye Hospital. She made some interesting comments:

> *"Jeff and I have been on a user group for the eye hospital because that is horrendous when you have sight problems. Finding your way round, information in small print. …There is an empty reception desk and I say 'why don't you put a volunteer on it?' There is nobody to tell you where to go. They have built a beautiful new atrium where there is no logic to it. If they changed these things you wouldn't feel as angry after you have waited hours for your appointment."* Quote taken from group 7

Appearance and general smartness of staff was mentioned but did not appear to be a major influencing factor in the perception of service quality.

5.3.3.5 Staff

It is difficult for a patient to judge the level of support or training staff receive or, indeed, the quality of leadership, all of which affect service quality. Nevertheless, it was raised in a couple of the focus groups, including in a discussion about care in wards for the elderly, which they saw as being *"very unpleasant".*

> *"...compare that to a children's ward where you get a different level of service which is really good. There are different centres of excellence from what I have seen. But it isn't replicated across the hospital. It comes from leadership."* Quote taken from group 4

> *"I've noticed that they have a three-year degree now and they go straight on to the wards and then suddenly find they don't like it. Before, they had to go through the rough and smooth while training and they knew if they weren't going to like it. My grandma was a matron and she looks at nurses now and despairs. There used to be a time when it didn't matter who you were, whatever level you were, you cleaned up the mess."* Quote taken from group 2

5.3.3.6 Reliability

In general, reliability was seen in terms of appointments running on time and staff apologising and keeping patients informed.

A member of the patient user group acted as a volunteer, taking elderly patients to hospital appointments, and found that late appointments were not an unusual phenomenon:

> *"I can go to Tameside* [the local hospital] *five times in a week and I stay with whoever I have taken. Sometimes they are late. I have been five hours late with one person. Then they are only in with the doctor ten minutes. You don't know why they are keeping you waiting."*

Someone else commented:

> *"I've been and it has been a 1 pm appointment but it has been 4.30 pm before I have been seen. Only on one occasion did the nurse come out and say 'I'm terribly sorry, we've had some problems and Dr such and such is running late'."*

> *"There used to be a card up, didn't there, that said if you have waited longer than 30 minutes to see a doctor let us know? They don't have that now."*

> All comments were from group 8

Group 4 placed a different definition on reliability, referring to accurate records, an element that might not be quite as easy for patients to evaluate. The comment was made in relation to the SERVQUAL elements.

> *"Under reliability – that records are kept accurately and disseminated appropriately for treatment. This doesn't happen in many places. That staff know what their responsibilities are and that they communicate that to the patient in terms of timescales."*

5.3.3.7 Responsiveness

> "*You need to sympathise with that person and treat them with dignity. You were concerned about receptionists who didn't have that skill. You were trying to get into a system with barriers to stop you getting to the person you wanted to see. It is about accessing the right person, respect, the personalised service."* Quote taken from group 8

The woman whose husband is blind articulated a wonderful example of how responsiveness in this way can make a major difference.

> *"The last three years my husband has had testicular cancer. We went to hospitals, both inpatient and outpatient. He had to go as an inpatient for chemo. My husband is completely blind. They made sure on the ward he had the same bed, so he knew exactly where he was. Those small things helped. If he was due in, they would shift someone out of the bed and stick him in it. The same hospital, the consultants always say who they are. He had to go to X-ray and the consultant said 'Oh come on, I'll take you'. Trots off and … you know. It's lovely."* Quote taken from group 5

Meanwhile the respondent, who had herself been diagnosed with cancer, had a less than satisfactory experience while having to wait to receive the results she had been promised within a certain timescale and which did not arrive until some time later, as explained in section 5.3.3.3.

5.3.3.8 Continuity

Continuity of service (or lack of it) is an element which can lead to extreme frustration for patients or family/carers. The inevitable complexity of health services makes this a particularly vulnerable element.

> *"There are all these different agencies doing different things and sometimes I feel lost in it as a patient. If you go into the doctor to get blood tests, you have to go back a different day to get them and*

sometimes it takes ages to get them back because of the different agency taking them up to the hospital." Quote taken from group 5

"I have been trying to think of a simile, the only thing I came up with is a hospital is like a jigsaw. You have a picture on the front and then you have all the people in the hospital and you try to match the picture on the front with the pieces you have got. All the people in the hospital try to match the picture on the front. The trouble is then there are patients, and the patients mess it all up totally in the hospital." Quote taken from group 6

"Sometimes there are too many people involved in health care. Too many to deal with it to be integrated. You go to the secretary, then go to the doctor, then to the pharmacist and back to the secretary. Then to the referrer. By the time you've met all those different personalities and they all things very differently." Quote taken from group 2

Continuity was just one more dimension that was linked with other elements. As one respondent suggested, it is associated with relationships and, therefore, trust:

"Relationships come over time. When we were all younger and you had a doctor it was a family doctor. It was the same doctor you saw. From being very young we had the same doctor and were seeing him for years and years. Something recently has happened in the surgery, that doctor has gone. There was no explanation. I don't suppose they do have to explain it. Now there seems to be a different doctor every time you go. I don't know that person and I don't want to speak to a stranger about my health." *Quote taken from group 2*

"It is important to me with ongoing treatment. If I started treatment with Dr Spock, I would want to stay with that doctor all the way through." Quote taken from group 8

Continuity can have a significant influence on the overall provision of health care; where things go right, it helps enormously.

"When my daughter had specialist treatment from the ages of 13 to 18 and there were only two specialists involved and nothing went wrong. It was very complicated treatment but not one thing went wrong. A lot of people involved, but two main specialists." Quote taken from group 7

On the opposite side of the spectrum, where this goes wrong it can be relatively serious:

"Our experience was the opposite with two medical teams because they were different things. One of whom was very effective but there seemed to be no communication with the other team." Quote taken from group 7

This respondent was commenting on the care of his father who was receiving treatment for a broken femur, which was successful, and for other medical complications, including pneumonia, which eventually resulted in his death. He was supposed to receive chest physiotherapy but, due to the Christmas holidays, didn't. The ward staff were unaware how often he was receiving this treatment.

The dimension could be seen as being of particular importance for those with complex needs who are likely to have to see clinicians on a regular basis:

> *"At our practice there are six or seven different doctors and to make an appointment I have to take a chance. My doctor knows I have epilepsy."* Quote taken from group 3

> *"I always see the same doctor and have done for five years. Sometimes you have to wait 20 minutes but that is OK. I trust the doctor."* Quote taken from group 3

This last quote, again, highlights the relationship with trust.

5.3.3.9 Involvement

In contrast to government guidelines which continually promote patient involvement, this was not seen as one of the key dimensions for the public.

One respondent did have a concern that he had been given little reassurance in terms of his treatment for a damaged knee:

> *"The consultant wouldn't send me for an X-ray or scan. He said, 'I know what that is, I can operate.' I wasn't given an option. You try and argue with them but you can't."* Quote taken from group 6

Other members of the same group commented on the choice of hospital but saw it from different perspectives, with one suggesting that *"it is important to choose which hospital you want to go to",* while another felt that *"it depends on what is wrong."* Another felt that it was more important to choose the doctor than the hospital:

> *"You are choosing the doctor rather than the hospital. The consultant might be 30 miles away, but your local hospital is four miles away and*

with very good facilities. But if that doctor is not there you might make an appointment with them."

In general it did not appear to be a dimension that evoked much strength of feeling.

5.3.3.10 General – Measuring against SERVQUAL

A brief explanation was given about SERVQUAL, including the sectors on which it was based, and groups were asked their opinion about the dimensions included within the SERVQUAL adapted model. One response was:

> *"It is based on all those industries that are shocking."* This comment came from a member of group 6.

This comment attracted some consensus, with another respondent suggesting that there was nothing based on training or qualifications.

> *"It is all based on outcomes. If I was taking my car to a garage and it was based on this I wouldn't leave it."*

A similar concern was expressed in group 7, with one respondent saying:

> *"Those sectors it was based on are the worst possible examples."*

Another alluded to the lack of reference to competence by saying:

> *"Just because you are polite doesn't make you a good professional. My dentist is quite obnoxious but is the best I have had."*

Competency was also referred to by group 4:

> *"Sometimes you are putting your life in someone else's hands and you hope that you are going to get the right knowledge and care."*

One respondent felt competency was embraced in each of the areas of reliability, assurance and responsiveness. In reference to the concept of services comprising technical and functional elements, one respondent from the academic group believed:

> *"I think if they had the technical factors in place, the enhancing* [functional] *factors wouldn't be as important. ... In the UK you shouldn't have to be discussing this."*

Again, in group 7 a comment was made about empathy:

> *"Under empathy it says staff should know what the needs of the patients are. That is OK so long as they don't just assume they know what the needs are."*

This is an interesting point, since it represents the purpose of the SERVQUAL model to identify gaps between the organisation's understanding of what the customer wants and their actual desires or needs.

The notion of respect was raised by the woman who was partially blind, who had considerable experience with using health services:

> *"Respect means something different for everyone. It is about finding what that person is comfortable with and acting on it quickly. Like being called Mrs. I absolutely detest being call Mrs. I am Sue and want to be Sue to the world. So to respect my wishes will be to call me Sue."*

Accessibility was seen as missing by some, with the group of young mums having particular issues:

> *"You can only see somebody between certain hours which does not help anybody."*
>
> *"I had norovirus but nobody would come out. I was being sick all over the place but they asked if I could come to the doctor. I said no. I had to speak to someone over the phone."*
>
> *"My daughter had a temperature of 40°c and was screaming all night. She was six months old and they wanted me to drive her to the other side of Manchester."*
>
> *"They used to have doctors working during the night. ... why don't they have someone working during the night but they don't work during the day?"*

The same sentiment was raised in group 5, where they identified access as being a dimension that was important.

In contrast to the view of some that tangibles contribute towards trust, some felt that tangibles were not very important so long as facilities and staff were clean.

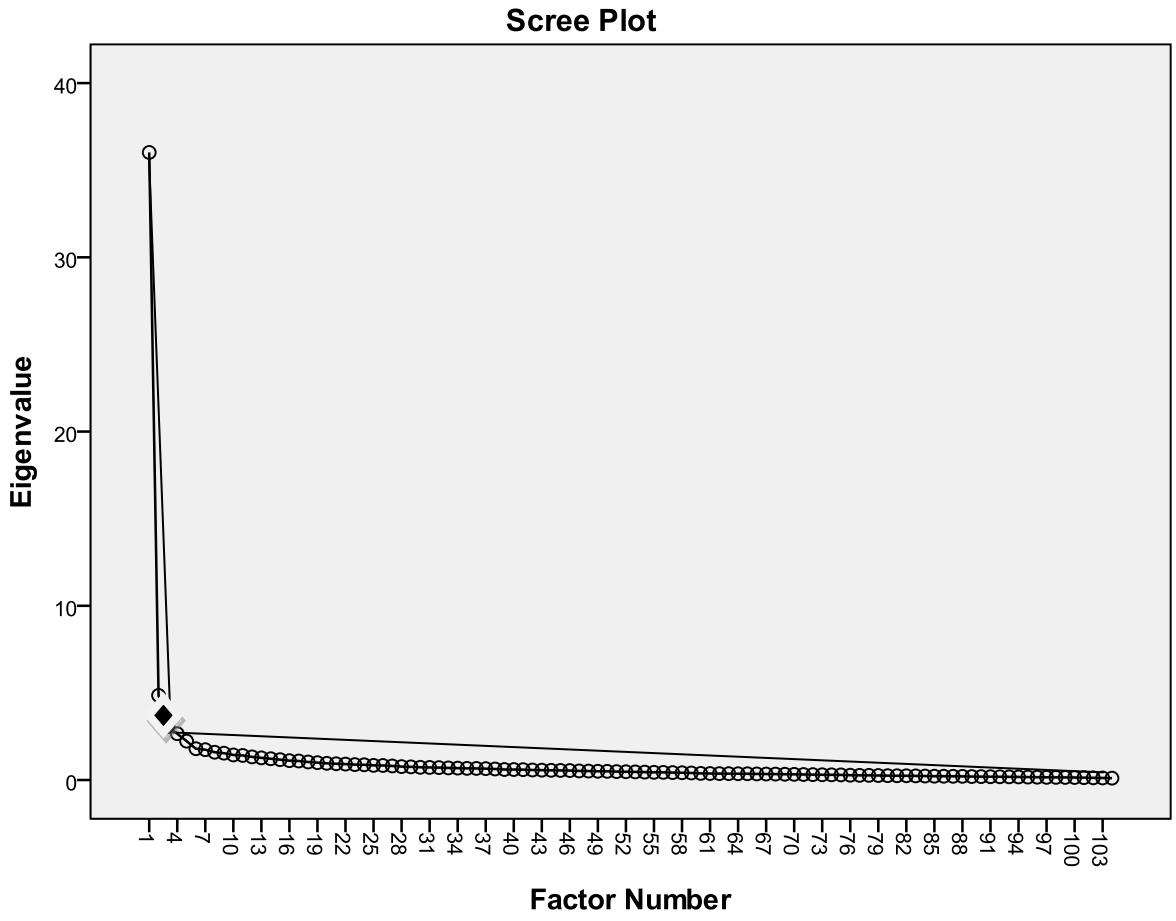
5.4 PHASE 3 – QUESTIONNAIRE

The data from more than 1159 completed questionnaires was entered into SPSS. Of these, 603 (51.5%) were valid with all questions being answered.

Principal axis factoring was then used to reduce the items and determine factors. Theory recommends that for a sample of more than 250 a scree plot can be used to determine the number of factors extracted, and one was, therefore, used in the analysis of the data for this study (Field, 2011). The point of inflection in the scree plot (Figure 5.4) suggested four factors. For confirmatory reasons, the factor analysis was also carried out for three, five and six factors. Coefficients of less than .3 were surprised and communalites of less than .6 were removed to provide the final output. For samples over 250, communalities of more than .6 are seen as appropriate (for smaller samples .7 is more acceptable) (Field, 2011). The results were then rotated using Varimax as the most commonly used orthogonal tool and then by oblique rotation using Direct Oblimin for comparison purposes.

Modelling using five and six factors was immediately discarded since it failed to generate any strong patterns with either oblique or orthogonal rotation. The three- and four-factor models accounted for almost 50% of variance (46.704% and 48.797% oblique and 46.964% and 49.064% orthogonal respectively). Although these are at the lower levels of acceptability, with most theory suggesting 50% as being the minimum, the scree plot justifies the use of three or four factors. A decision was taken to adopt the four-factor version to take account of the slightly higher level of variance, which represents stronger results.

Figure 5.4 Scree Plot



- Point of inflection

5.4.1 Reliability and Validity

The standard deviation for each is well within expected levels, as set out in Table 5.10. The Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy is an index used to assess the reliability of the data. This was .972 for both orthogonal and oblique rotation.

Cronbach's Alpha was applied to each factor. This determines the interrelatedness between different items. Low scores may suggest items are heterogeneous with little correlation with others. Opinions differ about the optimum score but most consider anything between 0.7 and 0.95 to be suitable (Tavakol, 2011). The closer this is to the value of 1.0 the more reliable the results, although anything over .6 is generally considered to be valid. With the test showing results between .755 and .906, reliability is good.

The results accounted for total variances of

Oblique	46.704% for three factors
	48.797% for four factors
Orthogonal	46.964% for three factors
	49.064% for four factors

5.4.2 Oblique versus Orthogonal Rotation

The results of this exercise were not immediately clear as both Varimax and Direct Oblimin generated numerous cross-factor loadings, which created challenges with the interpretation.

In taking a decision about which to use, various issues were considered. Many researchers recommend the use of oblique rotation for studies which measure behaviour, since items are not heterogeneous and there is always some level of correlation between them. Oblique techniques are based on the assumption that correlations exist; for this reason the results which are produced are seen to be more accurate. Those supporting this school of thought often assert that orthogonal

techniques are used merely because they are easier to interpret (Rennie, 1997). Other researchers argue that this assumption is naive and justify the use of orthogonal techniques: their simplicity means they are more likely to be replicated in future studies (Rennie, 1997). The generalisability of orthogonal rotation should also be taken into account. If the purpose of the research is to obtain results that have the best fit with the data then oblique is the better fit. If it is to produce results that can be generalised then orthogonal methods should be used (Rennie, 1997).
Tables 5.11 and 5.12 set out the results from each technique respectively.

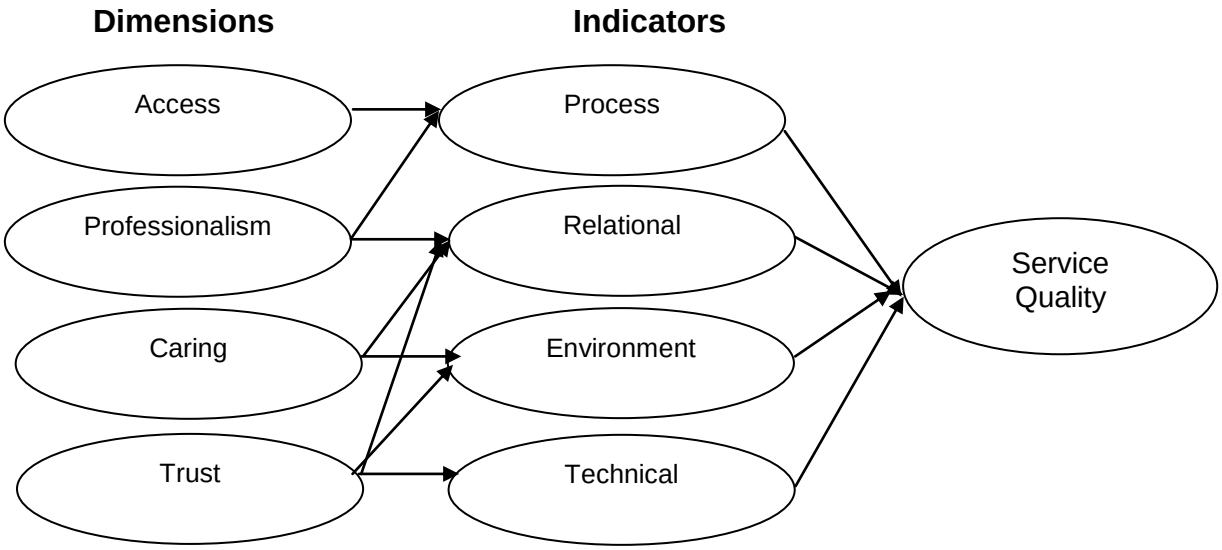
While Cronbach's Alpha is stronger in the orthogonal rotation, it is still acceptable for oblique. The factor loadings for each were similar. Factor loadings of .5 and above were included where there were no cross loadings with factors above .3. This reduced the number of items from 104 to 21 for orthogonal and 32 for oblique.

Neither model reflected the means of the priorities respondents placed on items to a satisfactory level, but oblique was slightly better. The fact that the purpose was to attempt to fit with the data meant that oblique rotation was chosen.

Nevertheless, the results were not conclusive in terms of creating a reliable model which could be used in the design of a service-specific questionnaire. Too many items were removed which were seen as being of particularly high priority to respondents. Taking items with a mean of 6 and over out of a potential score of 7 as being significant meant that factor analysis removed 34 items which were seen as particularly important by respondents while the process retained seven which received a relatively low mean priority score from participants.

There is an element of ambiguity in the definition of individual factors where overlaps occur, generating additional complexities in the model.

Figure 5.5 Conceptual Model For Health Care



Adapted from (Dagger et al., 2007)

These results suggest that, although the model has some value, it is not strong enough to stand alone as a tool for the evaluation of service quality in health care, but is more likely to be of use when used alongside qualitative work. The results also suggest more work is required to develop individual tools specific to inpatient care and local services.

The findings do, however, offer sufficient evidence on which to base a proposed conceptual model for health care (Figure 5.5). Further research is needed to refine this further

Table 5.8 Descriptives

THE ENVIRONMENT IN WHICH I AM CARED FOR										
I want ...	**Not so Important**			**%**			**Very Important**	**N**	**Sd**	**Mean**
	1	**2**	**3**	**4**	**5**	**6**	**7**		**Dev.**	
staff to be smart	**1.3**	**1.3**	**5.7**	**12.8**	**20.4**	**27.5**	**31.7**	**1117**	**1.367**	**5.57**
hospital signposting to be clear	*0.7*	*0.8*	*2.0*	*7.0*	*13.7*	*2.8*	*54.0*	*1126*	*1.192*	*6.14*
hospital waiting areas to have things to do	**7.8**	**9.2**	**18.1**	**23.1**	**20.9**	**10.8**	**10.1**	**1088**	**1.670**	**4.13**
staff to wear badges providing their name and job role	0.8	2.1	4.8	9.7	16.2	24.8	41.6	1108	1.375	5.79
decor in a hospital ward to be bright, cheerful and welcoming	**1.1**	**2.2**	**4.8**	**16.3**	**24.6**	**26.3**	**26.3**	**1120**	**1.353**	**5.39**
staff to wear uniforms which help identify their position and seniority	1.4	1.5	4.1	11.2	18.5	24.5	38.8	1126	1.382	5.73
local clinics/doctors' surgeries to be bright and well decorated	**1.3**	**2.2**	**5.9**	**21.7**	**23.5**	**28.2**	**17.1**	**1113**	**1.345**	**5.17**
equipment to appear to be modern	2.6	2.1	3.4	10.0	19.0	28.3	34.6	1115	1.448	5.64
staff not to wear uniforms	**53.9**	**12.4**	**7.5**	**8.9**	**4.2**	**4.2**	**9.1**	**1058**	**2.018**	**2.46**
efforts to be made to make hospital environments as relaxing as possible	1.7	1.4	5.7	16.0	25.1	23.9	26.2	1124	1.390	5.38
good bedside entertainment such as TV/radio to be available if confined to hospital	**5.1**	**3.0**	**6.0**	**16.1**	**21.2**	**22.3**	**26.2**	**1132**	**1.654**	**5.17**
equipment to be undamaged and works first time	*0.4*	*0.1*	*1.1*	*3.9*	*7.9*	*20.3*	*66.3*	*1121*	*0.960*	*6.45*
there to be sufficient comfortable seating in waiting rooms	**0.2**	**0.9**	**2.5**	**11.0**	**22.3**	**28.5**	**34.6**	**1138**	**1.173**	**5.78**

A CARING APPROACH										
I want ...	**Not so Important**			**%**			**Very Important**	**N**	**Sd**	**Mean**
	1	**2**	**3**	**4**	**5**	**6**	**7**		**Dev.**	
the receptionist to be friendly and courteous	**0.1**	**0.3**	**0.7**	**3.8**	**10.8**	**25.4**	**58.9**	**1144**	**0.916**	**6.37**
not to be asked for medical information by the receptionist	4.4	5.4	7.4	13.0	15.5	20.7	33.6	1138	1.763	5.26
to be asked what name I should be addressed by	**9.5**	**7.8**	**7.9**	**18.1**	**17.7**	**17.3**	**21.8**	**1142**	**1.908**	**4.66**
the professional to show interest in me as a person, not a set of symptoms	*1.0*	*0.8*	*2.2*	*5.9*	*11.2*	*25.4*	*53.5*	*1147*	*1.193*	*6.16*
the professional to show respect towards me	***0.3***	***0.1***	***0.8***	***3.1***	***8.6***	***24.4***	***62.9***	***1145***	***0.890***	***6.44***
the professional to help me to relax during a consultation	*0.3*	*0.2*	*0.9*	*4.3*	*13.4*	*30.0*	*50.9*	*1146*	*0.976*	*6.24*
the professional to be friendly and informal	**0.9**	**0.6**	**2.6**	**6.6**	**8.6**	**31.2**	**39.6**	**1145**	**1.180**	**5.93**
the doctor to understand me as a person and my needs	*0.1*	*0.4*	*0.6*	*2.9*	*10.1*	*24.2*	*61.8*	*1151*	*0.897*	*6.42*
all wards/departments to offer similar standards of service	***0.2***	***0.3***	***0.6***	***3.9***	***11.9***	***28.6***	***54.6***	***1147***	***0.930***	***6.31***
staff to have 'people skills'	*0.0*	*0.5*	*0.6*	*3.7*	*10.5*	*28.9*	*55.7*	*1149*	*0.915*	*6.34*

COMMUNICATIONS/INVOLVEMENT IN MY OWN CARE – knowing what's going on										
I want ...	**Not so Important 1**	**2**	**3**	**%** **4**	**5**	**6**	**Very Important 7**	**N**	**Sd Dev.**	**Mean**
to feel comfortable in asking questions	***0.1***	***0.0***	***0.3***	***2.5***	***10.0***	***26.3***	***60.8***	***1141***	***0.811***	***6.45***
to choose where I am treated	1.0	1.6	3.3	10.8	19.7	26.4	37.3	1144	1.315	5.75
professionals to have all the relevant information about me to hand	**0.2**	**0.4**	**0.7**	**1.8**	**6.6**	**20.4**	**669.9**	**1140**	**0.835**	**6.55**
information to always be given in simple, jargon-free terms	*0.2*	*0.3*	*0.6*	*3.2*	*8.0*	*24.2*	*63.6*	*1150*	*0.883*	*6.45*
to be given appropriate information at all times during my care	**0.1**	**0.2**	**0.2**	**1.9**	**6.7**	**23.5**	**67.5**	**1141**	**0.761**	**6.55**
to choose who treats me	3.6	3.4	5.1	16.8	24.5	25.3	21.3	1138	2.856	5.16
to receive important information face to face rather than by letter	**0.9**	**1.1**	**1.7**	**10.2**	**13.3**	**25.8**	**46.9**	**1143**	**1.253**	**5.99**
my records to be made available to me on request	1.1	1.8	3.0	8.9	17.2	27.4	40.7	1141	1.313	5.84
not to have to repeat information to different professionals	**1.1**	**1.1**	**3.1**	**7.2**	**13.4**	**27.9**	**46.2**	**1138**	**1.271**	**5.99**
professionals to ask if I understand what they have said in case of accents or terminology	*0.4*	*0.3*	*0.9*	*4.7*	*11.0*	*24.4*	*58.2*	*1152*	*1.011*	*6.32*
to feel my doctor or other health care professional listens to what I say	**0.0**	**0.1**	**0.4**	**1.2**	**5.4**	**23.1**	**69.8**	**1154**	**0.699**	**6.60**
to feel assured information is passed to other departments/agencies if necessary	0.3	0.4	0.4	3.1	8.5	26.3	61.1	1142	0.895	6.42
staff to refer to notes about concerns I have, my dislikes/likes, etc.	***0.3***	***0.8***	***2.8***	***6.8***	***17.7***	***31.6***	***39.9***	***1144***	***1.146***	***5.95***
information given by different staff/departments to be consistent	0.2	0.3	0.7	3.0	9.6	28.5	57.7	1142	0.893	6.38
to be given my options and involved in deciding the appropriate treatment	***0.3***	***0.6***	***0.9***	***3.9***	***10.3***	***25.9***	***58.0***	***1146***	***0.998***	***6.33***
to feel that I am an equal partner with the health care professional is important	1.3	1.2	1.9	7.2	15.0	27.6	45.8	1143	1.262	5.99
equipment to be available to allow me to take my own cholesterol and blood pressure	**12.9**	**8.7**	**12.3**	**22.3**	**20.0**	**13.6**	**10.1**	**1144**	**1.812**	**4.09**
staff to be aware of patients who are hard of hearing and speak accordingly	*0.4*	*0.6*	*2.2*	*5.2*	*11.7*	*26.0*	*53.8*	*1135*	*1.109*	*6.20*
staff not to speak to me in a patronising manner	***0.6***	***0.3***	***1.3***	***3.0***	***5.3***	***18.5***	***71.0***	***1148***	***0.972***	***6.51***

RESPONDING TO MY NEEDS										
I want ...	**Not so Important**			**%**			**Very Important**	**N**	**Sd Dev.**	**Mean**
	1	**2**	**3**	**4**	**5**	**6**	**7**			
not to feel a nuisance if I ask for help when in hospital	**0.2**	**0.1**	**0.2**	**2.6**	**6.0**	**22.7**	**68.2**	1149	0.784	6.55
nurses/assistants in hospital to answer calls for assistance in a timely manner	0.1	0.2	0.8	2.2	8.4	26.5	61.9	1154	0.837	6.46
complaints to be handled in a timely manner	***0.3***	***0.3***	***0.5***	***3.7***	***13.0***	***29.5***	***52.6***	***1144***	***0.959***	***6.28***
not to be moved from a ward with no notice	1.6	1.6	2.4	8.3	16.3	24.7	45.2	1142	1.342	5.91
someone to be available to reassure me during uncomfortable/painful procedures	***0.4***	***0.3***	***1.4***	***3.6***	***10.9***	***26.9***	***56.4***	***1155***	***1.007***	***6.30***
any complaint I may make to be addressed appropriately	*0.4*	*0.2*	*0.5*	*4.5*	*11.7*	*29.3*	*53.4*	*1148*	*0.968*	*6.28*
staff to show a willingness to be helpful	**0.1**	**0.1**	**0.3**	**2.3**	**9.2**	**28.9**	**59.0**	**1147**	**0.813**	**6.43**
to know who to speak to if I have concerns	0.1	0.3	0.3	2.9	9.0	27.2	62.2	1145	0.848	6.43
to not be transferred between wards during the night or at mealtimes	**1.7**	**2.9**	**3.5**	**8.5**	**14.9**	**21.4**	**47.0**	**1144**	**0.466**	**5.84**
my needs to be assessed and appropriate action is taken if I have a problem	0.1	0.2	0.8	3.1	9.0	28.9	58.0	1149	0.873	6.39
nurses to be aware of my personal needs/concerns/fears	***0.3***	***0.3***	***1.0***	***3.1***	***12.2***	***28.5***	***54.5***	***1150***	***0.957***	***6.30***
not to feel uncomfortable if I have to make a complaint	*0.5*	*0.4*	*1.4*	*4.2*	*11.5*	*26.2*	*55.7*	*1130*	*1.049*	*6.27*
staff to have time to cater for my needs and to make me feel comfortable	***0.2***	***0.8***	***0.8***	***4.3***	***11.0***	***24.5***	***53.5***	***1140***	***0.991***	***6.28***

HAVING TRUST IN MY CARE										
I want ...	Not so Important 1	2	3	% 4	5	6	Very Important 7	N	Sd Dev.	Mean
to see the environment at the local doctor/clinic is clean	*0.3*	*0.2*	*0.3*	*3.1*	*8.5*	*21.3*	*66.2*	*1148*	*0.874*	*6.48*
to feel that the doctor trusts what I tell him/her	0.0	0.0	0.3	1.7	7.5	24.6	65.9	1145	0.728	6.54
the doctor to refer to a book/website if unsure about something	***1.0***	***1.1***	***1.3***	***6.1***	***13.0***	***26.3***	***51.2***	***1139***	***1.188***	***6.13***
the professional to take time to conduct an examination, treatment and/or tests	0.2	0.1	0.3	1.7	6.0	23.3	68.5	1143	0.753	6.57
to have trust in the clinical ability of the person treating me	**0.1**	**0.0**	**0.1**	**1.3**	**3.7**	**18.6**	**76.3**	**1142**	**0.634**	**6.69**
information about the professional history of my specialist to be available to me	2.8	1.8	4.1	12.9	23.5	27.6	27.2	1140	1.442	5.44
not to be asked for personal/medical information in a public area/waiting room	***0.6***	***1.5***	***1.3***	***5.5***	***8.8***	***20.6***	***61.6***	***143***	***1.163***	***6.29***
where possible, to see the same professional	1.0	0.6	0.6	3.1	9.1	29.7	56.0	1143	1.033	6.32
the hospital to look clean	**0.2**	**0.0**	**0.7**	**2.9**	**8.1**	**20.1**	**68.0**	**1139**	**0.850**	**6.51**
the doctor to be sufficiently competent to not have to refer to a book/website	3.4	3.1	3.6	10.2	16.4	24.9	38.4	1131	1.572	5.62
the hospital I attend to have a good reputation/be free from public criticism	**0.3**	**0.7**	**1.7**	**6.6**	**12.8**	**26.0**	**51.7**	**1144**	**1.116**	**6.16**
to feel the professional knows me well enough to understand my needs	0.4	0.6	1.8	5.2	16.0	30.7	45.3	1133	1.087	6.09
there to be co-ordination between staff/departments providing my care In hospital	**0.2**	**0.2**	**0.3**	**2.4**	**8.4**	**27.3**	**61.3**	**1144**	**0.829**	**6.46**
to know my doctor	1.5	1.3	4.5	10.7	14.2	26.6	41.2	1137	1.389	5.79
the doctor to have my full medical history to hand	**0.2**	**0.1**	**0.9**	**2.0**	**5.2**	**20.7**	**71.0**	**1137**	**0.904**	**6.58**
the doctor to take into account my medical history where diagnosis is difficult	0.0	0.2	0.6	1.6	4.9	19.8	73.4	1142	0.733	6.62
to be sure my personal/medical history will not be passed on in error	***0.4***	***0.6***	***1.6***	***3.9***	***5.3***	***14.9***	***73.4***	***1142***	***1.005***	***6.51***
access to wards to be controlled	1.0	1.1	3.1	10.9	19.4	26.6	37.8	1143	1.296	5.78
there to be general agreement between professionals about my treatment	**0.3**	**0.4**	**0.7**	**2.8**	**10.1**	**28.6**	**57.1**	**1136**	**0.916**	**6.37**
to feel there is no danger of accidents when in hospital	0.3	0.3	1.0	4.7	9.1	22.8	61.8	1145	0.982	6.38
to know the doctor is competent even if he/she is not friendly	***0.3***	***0.3***	***0.4***	***2.8***	***6.0***	***23.0***	***67.0***	***1146***	***0.875***	***6.51***
strong leadership to be apparent and reflected in the level of care	0.3	0.4	1.0	3.6	10.0	25.8	59.0	1143	0.963	6.26
to see the hospital's record on cleanliness, E. coli and MRSA clearly displayed	**1.5**	**1.0**	**2.7**	**9.1**	**12.7**	**21.9**	**51.1**	**1150**	**1.330**	**6.01**

EASE OF ACCESS TO AND RELIABILITY OF SERVICES										
I want ...	**Not so Important**			**%**			**Very Important**	**N**	**Sd**	**Mean**
	1	**2**	**3**	**4**	**5**	**6**	**7**		**Dev.**	
it to be easy to get timely appointments with my local doctor/clinic	***0.2***	***0.2***	***0.3***	***1.7***	***6.9***	***27.6***	***63.1***	***1143***	***0.783***	***6.50***
appointments not to run late	0.9	1.0	2.8	10.4	24.5	33.4	27.0	1141	1.199	5.65
to be able to easily get through on the phone to the local surgery or hospitals	**0.2**	**0.2**	**0.6**	**2.0**	**10.7**	**28.0**	**58.3**	**1141**	**0.858**	**6.40**
opening hours of local surgeries/clinics to extend beyond normal office hours	1.1	2.1	3.3	10.7	17.6	27.9	37.3	1138	1.348	5.75
the location of services to be convenient	**0.2**	**0.5**	**1.5**	**7.0**	**17.9**	**31.6**	**41.3**	**1142**	**1.065**	**6.02**
an explanation if appointment times are not kept to	1.0	1.4	4.2	10.3	20.4	29.7	33.1	1146	1.301	5.69
to have the option to see a GP who specialises in my needs	**0.3**	**0.6**	**1.6**	**5.0**	**11.22**	**29.8**	**51.5**	**1149**	**1.042**	**6.22**
not to have to spend lengthy periods in waiting rooms	0.4	0.4	2.5	9.1	18.9	30.9	37.8	1138	1.140	5.90
not to have to pay to get a faster or more convenient appointment	***1.5***	***0.7***	***11.4***	***4.5***	***7.8***	***18.4***	***65.6***	***1138***	***1.188***	***6.35***
physical access to premises to take account of people with disabilities	*0.3*	*0.6*	*1.5*	*4.3*	*10.6*	*22.8*	*59.9*	*1146*	*1.046*	*6.32*
home visits to be easily available when needed especially for children/elderly	**0.2**	**0.4**	**1.4**	**4.5**	**7.8**	**18.4**	**65.5**	**1150**	**0.973**	**6.37**
it to be easy to speak to the right person	0.2	0.2	0.7	4.3	10.3	32.8	53.0	1145	0.878	6.34
it to be easy to speak to a member of the ward staff if I am in hospital	**0.2**	**0.4**	**0.7**	**2.3**	**8.8**	**33.6**	**54.0**	**1142**	**0.868**	**6.36**
to feel unrushed when I see a doctor or other professional	0.2	0.1	0.6	3.1	8.7	29.4	57.9	1146	0.866	6.40
to have plenty of notice and reasons given if my appointment is cancelled	**0.5**	**0.5**	**1.8**	**7.7**	**15.9**	**30.5**	**43.1**	**1145**	**1.132**	**6.02**
to be able to discuss more than one problem at one appointment	*0.7*	*0.9*	*1..0*	*5.2*	*13.7*	*27.2*	*51.4*	*1144*	*1.110*	*6.18*
staff to do what they say they will when they say they will do it	**0.0**	**0.8**	**0.8**	**3.1**	**9.1**	**28.5**	**58.2**	**1146**	**0.871**	**6.40**
plenty of car parking to be available	1.7	1.5	2.7	9.1	15.9	24.4	44.6	1143	1.369	5.88
be able to get timely appointments for specialist services	**0.2**	**0.3**	**0.4**	**3.3**	**10.8**	**32.4**	**52.5**	**1144**	**0.898**	**6.32**
a choice of dates in the case of needing inpatient treatment	0.5	1.2	2.6	8.5	19.2	33.5	34.4	1141	1.189	5.83
car parking to be free of charge	**3.9**	**2.7**	**4.3**	**11.4**	**11.8**	**14.4**	**51.5**	**1147**	**1.679**	**5.74**

FOOD										
I want ...	**Not so Important 1**	**2**	**3**	**% 4**	**5**	**6**	**Very Important 7**	**N**	**Sd Dev.**	**Mean**
volunteers to be on duty to help patients eat	**2.7**	**2.4**	**4.5**	**10.4**	**17.6**	**21.5**	**40.9**	**1120**	**1.532**	**5.66**
light snacks such as toast, teacakes, fruit, ice cream to be readily available	3.9	5.2	7.9	16.0	20.6	24.2	22.2	1124	1.643	5.06
no activities (except emergencies) to take place during mealtime to allow staff to help patients	**1.4**	**2.4**	**5.2**	**9.6**	**17.4**	**23.4**	**40.5**	**1143**	**1.444**	**5.72**
not to have to decide the day before what I want to eat the following day	12.0	7.6	8.9	20.0	17.7	18.1	15.6	1140	1.903	4.40
food to be appetising and tasty	***0.5***	***0.5***	***1.0***	***4.0***	***11.1***	***25.0***	***57.8***	***1142***	***1.028***	***6.31***

Table 5.9 Factor Analysis: Variables Evolved from Factor Analysis – Orthogonal Rotation

		1	2	3	4
Trust	***Cronbach's Alpha = .906***				
Information is passed to other departments/agencies if necessary		.673			
Calls for assistance are answered in a timely manner		.666			
Not to feel a nuisance when asking for help in hospital		.659			
Professional takes time to conduct examination, treatment/tests		.655			
Having trust in the clinical ability of the professional		.642			
Being given appropriate information at all times		.638			
Information given by different staff/departments is consistent		.633			
Professionals have all relevant information about me to hand		.611			
Feeling the professional listens to what I say		.611			
Needs are assessed and appropriate action taken if there is a problem		.609			
Access	***Cronbach's Alpha = .880***				
Not to spend lengthy periods in waiting rooms			.713		
Explanations to be given if appointments run late			.653		
Plenty of notice given for cancelled appointments			.629		
Appointments not to run late			.613		
Caring Approach	***Cronbach's Alpha =.868***				
Professional to be friendly and informal				.558	
Local clinics/surgeries to be visually pleasing				.518	
Hospital wards to be bright and welcoming				.503	
Professionalism	***Cronbach's Alpha = .846***				
The professional knows me and understands my needs					.599
Hospital's records on cleanliness/MRSA/CDiff/e-coli are available					.560
To know my doctor					.560
The hospital has a good reputation					.537

(Compiled by the author)

Table 5.12 Factor Analysis: Variables Evolved from Factor Analysis – Oblique Rotation

		1	2	3	4
Trust	***Cronbach's Alpha = .948***				
Having trust in the clinical ability of the professional		.726			
Information is passed to other departments/agencies if necessary		.716			
Professional takes time to conduct examination/ treatment/tests		.712			
Calls for assistance are answered in a timely manner		.666			
My full medical history is used when necessary in making a diagnosis		.695			
Not to feel a nuisance when asking for help in hospital		.685			
Professionals have all relevant information about me to hand		.659			
Information given by different staff/departments is consistent		.644			
Appropriate information is given to me at all times		.629			
Professionals have all relevant information about me to hand		.611			
Needs are assessed and appropriate action taken if there is a problem		.607			
Feeling the professional listens to what I say		.593			
Staff show a willingness to help		.559			
To feel the doctor trusts me		.541			
Staff do what they say when they say		.537			
Staff are aware of my fears		.518			
Complaints are addressed in a timely manner		.517			
I know who to speak to if I have concerns		.506			
Access	***Cronbach's Alpha = .819***				
Not to spend lengthy periods in waiting rooms			.734		
Appointments not to run late			.655		
Explanations to be given if appointments run late			.651		
Plenty of notice given for cancelled appointments			.611		
Caring Approach	***Cronbach's Alpha = .839***				
Professional helps me to relax				.661	
Professional to be friendly and informal				.606	
Local clinics/surgeries to be visually pleasing				.554	
Hospital wards to be bright and welcoming				.532	
To be shown respect				.521	
Staff to have 'people skills'				.505	
Professionalism	***Cronbach's Alpha = .755***				
The professional knows me and understands my needs					.542
Hospital's records on cleanliness/MRSA/ C. diff./E. coli are available					.535
To know my doctor					.530
The hospital has a good reputation					.508

(Compiled by the author)

5.5 IN CONCLUSION

Phase 1 demonstrated the way in which communication can be deconstructed into a multitude of elements. The complexity of a sector such as health care makes this an even more difficult dimension to manage. The data showed communications, reliability and attitude to register the most concern in terms of negative experiences. Despite the stream of negative press over recent years about MRSA, tangibles was not an issue with the cleanliness of wards being seen as good.

The second phase highlighted a gap between the priorities members of the public placed on elements and those of staff. Public placed most importance on attitude, the human elements of trust and communications respectively while for the service providers it was attitude, tangibles staff issues. For service providers the priorities were attitudes, tangibles and staff issues. This indicates that management fails to recognise the significance of communications, both in terms of its importance and risk of failure.

The quantitative data developed a model with four dimensions: trust, access, a caring approach and professionalism. However, the lack of strong patterns falling from the factor analysis and the fact that some of the elements which scored as high priorities fell out, suggests that questionnaires alone are an insufficient means of monitoring service quality and must be supported by qualitative work.

CHAPTER 6

DISCUSSION

This chapter takes the results from the study and applies them to each objective individually. It is structured in eight sections:

6.1 Objective 1: Review of Extant Models and Measures of Service Quality
- 6.1.1 Evaluating Theoretical Service Characteristics (IHIP).
- 6.1.2 Testing against Extant Service Quality Dimensions.
- 6.1.3 Review of the SERVQUAL Models.

6.2 Objective 2: Identify and Evaluate Existing Service Quality Approaches in Health Care
- 6.2.1 Test Extant Theoretical Health Care Dimensions.
- 6.2.2 Existing Approaches in Health Care Evaluation.

6.3 Objective 3: Understanding the Meaning of Quality in Health Care
- 6.3.1 What Quality Means to Users and Managers.
- 6.3.2 A Comparison of Critical Incident, Focus Group/Interview and Questionnaire Data.
- 6.3.3 The Use of Questionnaires in the Evaluation of Health Care.

6.4 Objective 4: Propose a Construct of Service Quality Relevant to Health Care in the UK
- 6.4.1 Contributions to Theory.
- 6.4.2 Contributions to Practice.

6.5 Limitations

6.6 Further Research

6.7 Conclusions
- 6.7.1 Review of Extant Models and Measures of Service Quality.
- 6.7.2 Identify and Evaluate Existing Service Quality Approaches in Health Care.
- 6.7.3 Understand the Meaning of Quality to Health Care Users and Managers.
- 6.7.4 Propose a Construct of Service Quality Relevant to Health Care.

6.8. Personal Reflections

6.8.1 Reflections on the Qualitative Process.
6.8.2 Reflections on the Quantitative Process.
6.8.3 Reflections on the Methodology.

6.1 OBJECTIVE 1: REVIEW OF EXTANT MODELS AND MEASURES OF SERVICE QUALITY

6.1.1 Evaluating Theoretical Service Characteristics (IHIP)

The characteristics normally associated with services (intangibility, heterogeneity, inseparability and perishability) have already been discussed at some length from a theoretical stance in section 3.2.2, where it was concluded that it was inappropriate to apply them rigidly to services in general. This section furthers the debate by evaluating their relevance against the collective results of Phases 1, 2 and 3 of this study.

6.1.1.1 Intangibility

Any ambiguity over the tangibility of services is put to rest when considering this in context of health care. Tangibles should not be considered as peripherals to clinical interventions and sight must not be lost of their importance, as cleanliness, equipment, food and, in the case of hospital inpatients, the general environment (including decor, light and noise) are all key components of what is a hugely complex and diverse service. Notably, out of 16 academic papers reviewed in Table 3.9 (section 3.6), ten included tangible elements in some form.

There has been considerable concern in recent years over hospital-acquired infections such as MRSA and C. difficile, which has called into question the cleanliness of hospital environments. Cleanliness is not only paramount to the speed of recovery but raises the risk that patients become more seriously ill than before their admission and, in more serious cases, vulnerable patients can die. While there is debate over the cause of these infections (that they are not merely the result of unclean environments), there is no doubt that this tangible element is critical. Indeed the data from the questionnaire showed cleanliness to be one of the highest-scoring items in terms of priority for the public. While this may more readily be seen as a constituent part of

dimensions concerned with safety, or assurance, in this instance it clearly also pertains to tangible aspects of the service.

Another important tangible aspect of the clinician's work is the equipment, and, as a physiotherapist pointed out, this can be difficult for patients to judge. What looks sleek and modern may not necessarily be the most appropriate. Nevertheless, its average score was in the higher range and, as expected, the score against 'equipment working first time' was particularly high.

The general environment is seen as being a contributory factor to the universal concept of service quality, where it is seen as representing the professionalism of an organisation. In health care it is more complex, especially for hospital inpatients who may be confined to a ward for some time. While the overall ambience and decor may not affect the clinical outcomes – although there is evidence to suggest it may have an effect on recovery rates (Ulrich, 2004) – it certainly contributes to comfort. While the general decor and environment were not particularly high priorities in the questionnaire, findings in Phase 1 of this study showed noise and light as being contributory factors towards the overall experience because they made sleep difficult at night. Neither featured in the focus groups or interviews with staff. One reason for this is likely to be that the service users in Phase 2 of the study may have placed more emphasis on community services, while the hospital staff that were interviewed simply did not recognise it as a particular issue.

Nutrition is crucial to helping patients in their recovery and to rebuilding their strength. There was little indication within existing literature that this is seen as a component element of service quality in the health care sector. Out of those interviews held with service providers, only two identified food and nutrition as being important and both of these represented the same major teaching hospital. Meanwhile, results from the questionnaire also suggested that this element was not the highest priority with only one (appetising and tasty meals) being seen as a high priority.

6.1.1.2 Heterogeneity

Inherent in health care is the fact that every patient is different. From a medical stance, two patients may have similar conditions, but with differing responses to treatments, or they may have other complex needs which may affect the course of treatment. Almost as significant is the fact that patients (and family) are often at a vulnerable time of their lives: they will react in different ways to what may be difficult situations. As such, the way in which staff conduct themselves can have a major influence on the overall experience: understanding patients and their relatives and what anxieties they may have can help build rapport. It can manifest itself as a form of respect, and as responsiveness to their individual needs and empathy, all of which are antecedents to trust.

Unfortunately, recent priorities placed on targets and performance-related measures have ignored these dimensions. Nevertheless, the results of each phase of this study support the importance of measuring service quality rather than performance. Open coding within Phase 1 showed how communications and attitude were dimensions which registered with service users as being particularly weak. As one respondent stated:

> *"Overall the information you get before admission is all very general. There is nothing specific to you. I want to be treated more as an individual ... They need to be a bit more personal".*

At a later stage of her hospital stay the same respondent was able to appreciate the way in which her anaesthetist came for a chat when he heard how nervous she was. The fact that someone was reacting to her anxieties helped her.

> *"He was really nice and wanted to know why I was so nervous. I explained it was because of a previous experience. He said they would give me a sedative before I went to theatre."*

A similar reaction came from another respondent who was having an operation:

> *"Between 8.00 and 8.30 a nurse came to get me to take me to the ward. I got changed and the staff seemed very nice. They helped to calm me as I was nervous".*

Those dimensions identified as contributing towards the heterogeneous nature of health services received considerable discussion during the focus groups and interviews comprising Phase 2. ‘Knowing the customer’; ‘communications’; ‘attitude’; and ‘respect/dignity’ were all seen as significant in their contribution to health care (although ‘respect/dignity’ did not feature as frequently among the service providers, despite this dimension being constantly referred to in all government policy). Each of these is a component that, to be effective, must recognise the diverse nature of patients, relatives and carers. Each can also be seen as an antecedent to trust.

Data taken from the questionnaire in Phase 3 also points to the priority being placed on those items that focus on the individuality of patients:

- ‘The professional to show interest in me as a person, not a set of symptoms.’
- ‘The professional understands me as a person and my needs.'
- ‘My needs to be assessed and appropriate action taken if I have a problem.'
- ‘The professional has all relevant information about me to hand'.
- ‘To feel the professional listens to what I say.'
- ‘The doctor to have my full medical history to hand.'
- ‘To feel the professional knows me well enough to understand my needs.'
- ‘Nurses to be aware of my personal needs/concerns/fears.'

The evidence supports the notion of heterogeneity in terms of health care. While interventions and procedures may be standardised and evidence based, the diverse nature of individual people must be reflected in the overall delivery of the service.

6.1.1.3 Inseparability

Inseparability and heterogeneity are inextricably linked within the health care sector. The fact that patients should be equal partners in the service delivery, together with their diverse needs, makes for complex service experiences on both the part of the patient and the provider. Government policy constantly refers to patients, family and carers being involved in the process, from the design of services to the treatment which is given. Indeed, often the patient is

required to take personal actions to help in their own recovery: improving their lifestyle, dieting, administering their own medication, etc. At this level, trust plays a key role since, the more a patient trusts the professional and feels a part of the process, the more likely they are to take the advice that is proffered (Baron-Epel, 2001). While some of the tangible elements of service in health care, particularly in relation to cleanliness and working equipment, are inherent in building trust in health care, the building of appropriate professional relationships is also crucial. It is a two-way process where the patient plays as important a role as the professional.

Section 3.6 discussed literature about service dimensionality and identified human interactions as being the key antecedents to trust. A further characteristic lies in familiarity between the service provider and user (Macintosh, 2009), which helps build confidence that the provider knows what is required. It can only be achieved in continuously rendered services and comes with time. In a sector where determining the expertise of the professional is extremely difficult, the patient or other service user must look for other cues to build their trust. Inevitably the professional relationship between the actors will be a contributory factor towards the perception of the service. Health care differs from most other services since not only the patients but often their families are in a vulnerable state. They look for reassurance and empathy. Participants of the focus groups in Phase 2 of this study raised a number of items that they felt played a role in building this and reflect the literature around human interaction (inseparability) and ultimately the building of trust. These were included in the questionnaire within Phase 3, most of them scoring as particularly important priorities:

- ‘The professional to show respect towards me.'
- ‘The doctor to understand me as a person and my needs.'
- ‘To feel that I am an equal partner with the health care professional’
- ‘To feel the doctor trusts what I say.'
- ‘Where possible, to see the same professional.'
- ‘To feel the professional knows me well enough to understand my needs.'
- ‘To know my doctor.'
- ‘Nurses to be aware of my personal needs/concerns/fears'.

There is some correlation between these and dimensions recognised as contributing towards heterogeneity, as discussed in section 6.1.1.2. Ultimately both of these involve two-way processes.

One participant who contributed to the critical incident process is quoted as saying:

> "*I was (also) extremely friendly and courteous to them so they responded."* Respondent 6

Meanwhile, a father who was complaining about the attitude of staff towards his wife and baby was told by the consultant:

> *"You are making things more difficult for yourself ... The staff can hold grudges."* Respondent 10

Both examples demonstrate the way in which the experience is based on reciprocal interaction: not only do staff have a responsibility to develop the relationship, there is an onus on the patient to play their part.

The importance of continuity and the professional knowing the patient was highlighted by a number of other respondents. The following quotes are just a small sample:

> *"A different junior doctor came each day. There was no continuity there and none of them knew me."* Quote taken from group 2

> *"You are a person in your own right and you should be treated as such. Not someone with a bad back or broken elbow, they should treat you as a whole with dignity and with respect."* Quote taken from group 5

As previously quoted in section 5.3.3.7, a particularly poignant example of how important this element can be is highlighted by the following example:

> *"The last three years my husband has had testicular cancer. We went to hospitals, both inpatient and outpatient. He had to go as an inpatient for chemo. My husband is completely blind. They made sure on the ward he had the same bed, so he knew exactly where he was. Those small things helped. If he was due in, they would shift someone out of the bed and stick him in it. The same hospital, the consultants always say who they are. He had to go to X-ray and the consultant said 'Oh come on, I'll take you'. Trots off and … you know. It's lovely."* Quote taken from group 5

The respondent making these comments is herself almost blind. It demonstrates just how crucial it is for her and her husband that their frequent experiences with health care professionals have continuity and that their needs are understood and taken on board.

While it is accepted that trust in the professional should be inherent in the overall experience, it was interesting to note that the question of the professional's trust in the patient was raised, a factor which again supports the notion of inseparability and responsibility on the part of both parties, as reflected by the following comments:

> *"They don't trust you when you are ill. Are you really ill?"* Quote taken from group 2

> *"You should always have the same GP and they should have respect. That person knows you well enough to trust your judgment. They know you know your own body. A GP can diagnose much better if they know that person. They know you are truthful about your body."* Quote take from group 2

The focus groups gave rise to a number of items supporting the concept of an equal partnership between professional and patient. These were also included in the questionnaire in the following statements:

- 'To be given my options and be involved in deciding appropriate treatment.'
- 'To be able to choose where I am treated.'
- 'To be able to choose who treats me.'
- 'Equipment to be available for me to take my own cholesterol and blood pressure.'
- 'To feel I am an equal partner with the health care professional.'
- 'My records are available to me on request.'

Choice has become a feature of health care that has had increasing priority placed on it by government policy. Initially this may seem a strange element to include, since it is the professional who has the expertise to judge what treatment is necessary and which services are likely to be available at a limited number of facilities. Where particularly high levels of specialism in terms of expertise and equipment are required, then choice may be restricted. Increasingly, the emphasis is moving away from local general hospitals providing all services to larger hospitals offering specialist services.

Nevertheless, there are still occasions when patients are offered a number of options in terms of treatment or where they receive it, especially for routine conditions. Hospital consultants are being encouraged to publish records of their activity so that patients are able to select who they go to for treatment, although controversy remains around how effective the data is in helping people make informed decisions. As discussed in, section 3. 6.1.2 it is difficult for a layperson to evaluate a professional service. The fact that so many external factors, such as levels of deprivation, age and other demographics, can affect outcomes makes published statistical data difficult for the non-expert to assimilate.

Data from the questionnaire suggested that choice was not the highest priority in general but it was still seen as contributing to the overall experience.

6.1.1.4 Perishability

The perishability of the service is yet another unresolved point. When considered alongside intangibility, there remains a school of thought that some of the elements of a service are non-perishable. Some argue that a person's memory is tangible through a continued awareness of experiences, as has been discussed in section 3.2.2.1. While the aim of the clinical outcomes of the service is for them to be permanent, or at least semi-permanent, this study relates to processes rather than outcomes of service and most of the elements are perishable. Attitude, communications, reliability, comfort, respect, etc. are transient yet, crucially, they often affect the overall recovery of the patient as demonstrated by the experiences of a number of respondents.

A combination of breakdowns in communications between staff resulted in confusion over dietary requirements for the father of respondent 7:

> *"On more than one occasion there was a question mark over what sort of diet my father should have been on. I found staff giving him a meal which was a normal diet, when I understood it should have been a soft diet... There were laminated signs to indicate whether patients should be 'Nil by Mouth' or 'Soft Diet', etc. in the ward but for some reason most of the time these were not used for my father, which raised the uncertainty over the type of diet he should have been on - something I would imagine would be very important."*

The same respondent explained how, not only had her father's dignity been compromised, but there were potentially issues with lack of nutrition, due to failures in responding to problems:

> *"About this time my father's teeth go missing, which makes eating a greater problem at a time when staff are concerned he isn't eating. It also makes it difficult to hear what he says, which frustrates him as well as being an issue of patient dignity. We raised this issue and were told that he would be referred for new teeth and told that it is a common problem. It would take a couple of weeks. There was absolutely no sense of urgency."*

While there were no claims that these experience actually contributed to the death of her father, the respondent felt that this could potentially have been the case.

Respondent 2 felt that failure in communicating with the family of the patient was directly related to the death of her father:

> *"Dad was sick and could not see. All the symptoms were told to the doctor. Family were not told what the tests were for or what they were doing. If they had known what the test was for they would have probably mentioned that both his older brothers had had similar symptoms."*

Poor attitude and lack of responsiveness were also raised by yet another respondent, who was concerned that her mother was not being helped in taking medication, again affecting her recovery:

> *"Tablets she had been given were left in front of her and she wasn't taking them. We found tablets on the floor."* Respondent 13

In general, the perishability of a service will differ from the stance of the provider and that of the consumer, where the provider will see it through its relationship with the capacity of resources. Most often, it is not something that is of concern to the service user. In health care this aspect of perishability manifests itself in access, particularly through elements such as the availability of appointments, waiting times or being able to see the right person. It is central to the overall service experience. To some extent, inseparability comes into play again where patients waste resources through failing to attend appointments or misuse of service, such as inappropriate attendance at accident and emergency. The demands on health care are such that this

aspect of perishability creates far-reaching challenges for management in attempts to improve access for patients. While some of these problems are insurmountable, others may be less so: opening hours of local surgeries and clinics, being able to speak to the right person, being able to get through on the telephone. Each of these reflect perishability or access and may be addressed by looking at improved systems, as suggested by one respondent from group 5 who said:

> *"As soon as I walk through the door I am bristling. There is an empty reception desk and I said, 'Why don't you put a volunteer on it?'"*

6.1.2 Testing against Extant Service Quality Dimensions

Two key assertions were made about service quality dimensions in, section 3.6.2:

- That the dimensions being evaluated are of relevance to the service user.
- That more emphasis should be placed on the human elements of services, especially professional services.

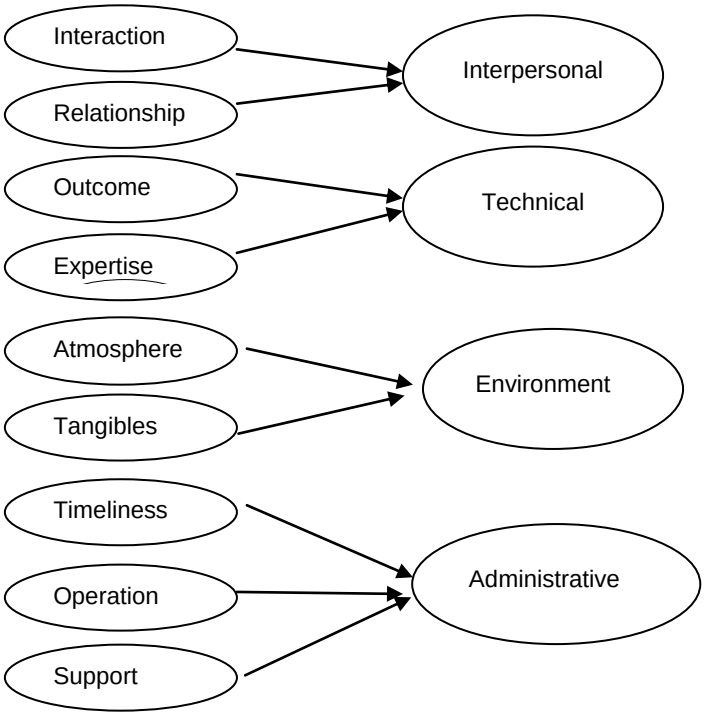
This study has attempted to identify those dimensions that the general public see as key to enhancing experiences within the health care sector. Although recognising that professional expertise cannot always be taken as a given, it also takes into account those dimensions that the Nordic School of thought describes as 'functional'. In doing this it has steered away from the performance-related measures most often associated with the 'technical' elements of service.

Despite relentless debate, there remains no conclusive agreement concerning the key determinants of service quality. Of those that were cited in Table 3.9, the closest fit to the findings of this study are represented by:

- Interpersonal, technical, environmental, administrative (Dagger et al., 2007).
- Process, design, outcome, relationship (Rhee and Rha, 2009).
- Outcome, interaction, environment (Brady and Cronin, 2001).
- Intrinsic – reliability, responsiveness, assurance, empathy
  Extrinsic – technical, tangibles (Mels et al., 1997).
- Customer/employee interaction (function or process quality)
  Service environment outcome (technical quality) (Rust and Oliver, 1994).

The two SERVQUAL models will be discussed in the next section. Of these, the model which has the closest resemblance to health service dimensions is that proposed by Dagger et al., as illustrated in Figure 6.1. Although conceptually simpler than the model for health care (section 5.4.1, Fig. 5.5), it fails to acknowledge the real complexities and significance of the interrelational elements of service..

Figure 6.1 Conceptual Framework for Service Quality



(Adapted from Dagger et al., 2007)

There was no theory which discussed respect as a quality dimension in a non-service-specific context as illustrated in Table 3.9 in section 3.6. Nevertheless, it was scored highly by respondents of the questionnaire in this study.

6.1.3 Review of the SERVQUAL Models

As SERVQUAL remains the most recognised and widely used model in the evaluation of service quality, this section considers its relevance in the health sector as defined by the findings of this study.

6.1.3.1 Expectations

One of the criticisms which SERVQUAL faces is its reliance on expectations, a complex construct which varies from situation to situation and individual to individual. There is plenty of evidence to suggest that public expectations have grown hugely since the NHS was founded in 1948. Advances in medicine and technology as well as government promises have fuelled that growth and there is little to suggest the tide will turn (Rankin, 2006). The evidence from the questionnaire endorses the assumption that the public place considerable importance on almost all items. Out of a potential score of 7, the mean for most of them was 5.75 and above. Theory distinguishes between different types of expectations offering a range of definitions including: what will happen or should happen, what is ideal and what is adequate? These are discussed in more detail in section 3.4.3.2. Only qualitative evaluation can determine how individuals define their own expectations. It is likely that these high-priority scores could be translated into expectation scores.

For this reason, SERVQUAL leaves itself vulnerable in attempting to evaluate a construct that is uncertain and is likely to result in measuring a service against unreasonable expectations. This is further exacerbated by the fact that expectations can be influenced by moods or emotions, a consideration that would need to be factored in if using disconfirmation as an evaluation technique since patients often experiencing stressful events in their lives due to illness.

6.1.3.2 Dimensionality

The dimensionality of the two SERVQUAL models is also questioned in relation to health care. The closer of the two versions is the original ten-item model. Indeed at first sight it appears to be case that this is more relevant than

the model drawn out of factor analysis in this study and illustrated in Tables 5.11 and 5.12 in section 5.4.2.

Table 6.1 Comparison of Theoretical Models in the Evaluation of Health Care

SERVQUAL 10 ITEMS	SERVQUAL 5 ITEMS	HEALTH-CARE-SPECIFIC MODEL
Security	Assurance	Trust
Understanding the customer	Empathy	Caring
Communications		Professionalism
Access		Access
Tangibles	Tangibles	
Reliability	Reliability	
Responsiveness	Responsiveness	
Courtesy		
Competence		
Credibility		

(Compiled by the author)

However, closer analysis suggests that a number of the items within SERVQUAL rely on the evaluation of processes and fail to acknowledge the interpersonal elements which are so crucial to delivering high-quality health care. Communication is particularly flawed. While the original model does recognise the need for clear and simple language, it lacks substance:

SERVQUAL – Explaining the service
How much it will cost?
Explaining trade-offs between service and cost
Assuring the consumer that a problem will be handled.

The adapted five-item model does not include it at all as a dimension in its own right.

Furthermore, there is considerable emphasis on processes and performance rather than quality:

Reliability: *"Consistency of performance and dependability. It means that the firm performs the service right for the first time. It also means that the firm honours its promises. Specifically, it involves:*

- *Accuracy in billing.*
- *Keeping records correctly.*
- *Performing the service at the designated time."*

Responsiveness: *"Willingness or readiness of employees to provide service. It involves timeliness of service:*

- *Mailing a transaction slip immediately.*
- *Calling the customer back quickly.*
- *Giving prompt service (e.g. setting up appointments quickly)."*

Courtesy: *"Politeness, respect, consideration and friendliness of contact personnel (including receptionists, telephone operators, etc.). It includes:*

- *Consideration of the consumer's property (e.g. no muddy shoes on the carpet).*
- *Clean and neat appearance of public contact personnel."*

(Parasuraman et al., 1985, pg. 47)

After communications, the biggest omission was around human elements of quality: in particular, rapport, respect and empathy, all of which are antecedents of trust and as such central to quality in health care. Although one of the items in the original SERVQUAL model takes into account understanding/knowing the customer, it is quite limited and skirts around the emotional aspects of health care dimensions, defining the item as:

"- Learning the customer's specific requirements.
- *Providing individualised attention.*
- *Recognising the regular customer."*

(Parasuraman et al., 1985, pg. 47)

Respect is, again, missing.

Interestingly, the tangible dimension of the original SERVQUAL model included the term *"other customers in the service facility"* (Parasuraman et al., 1985, pg. 47). Although this was not included in the questionnaire, it was raised in one of the focus groups by participants who said they did not like to attend walk-in centres, and by some pharmacists, from whose demeanour it was apparent that a number of other patients were there to get their methadone.

It is naive to suggest that SERVQUAL stands alone in failing to acknowledge the influence of emotions and an argument exists for qualitative work to be conducted alongside the use of questionnaires.

6.1.3.3 Customer Satisfaction versus Service Quality

Critics of SERVQUAL have argued that SERVQUAL fails to address the long-term construct of service quality, merely focusing on the individual service encounters reflected in customer satisfaction. With so much emphasis being placed on quality in health care in the UK, this is a key point. Increased efforts are being made to focus on longitudinal studies to gain a greater understanding of what service quality means to the patient. This has been discussed at some length in Chapter 2.

Health care represents a sector where strong emotions often exist in a service encounter. In such situations, the experience associated with just one dimension (whether good or bad), is likely to influence the perceptions of all aspects of a service (Dabholkar, 1995). This assumption means that it is especially important to take a long-term view in order to take account of where perceptions might be exaggerated due to the anxieties of respondents. The stronger the emotional experience, the more likely the patient is to use these in their evaluation of customer satisfaction. However, the accumulation of several experiences of service will allow the patient to take a more objective view through a cognitive approach, leading to an evaluation of service quality. The same theory can be applied in bringing together the perceptions of a number of patients over a period of time. Where one patient may have had several poor encounters during a period of treatment it is unlikely their evaluation will change over time but, if taken in context with other patients where experiences may have been positive, the longer-term construct of service quality may be improved and vice versa.

Management should be mindful that risks exist where corporate reputation is poor and patients are likely to use their prior knowledge or understanding of service levels in forming their perceptions.

6.2 OBJECTIVE 2: IDENTIFY AND EVALUATE EXISTING SERVICE QUALITY APPROACHES IN HEALTH CARE

Chapter 3 suggested that there was little agreement in the dimensionality of health care. This section considers the existing theory with the findings of this study. It also contextualises the results with the plethora of measures currently used in the sector.

6.2.1 Test Extant Theoretical Health Care Dimensions

There is a range of proposed approaches to dimensionality in health care, most of which take the technical elements to be an intrinsic part of the service encounter; surprisingly few take dignity or privacy to be independent factors, despite respect being entrenched in the quality construct as defined by the WHO and despite it being a constituent part of all UK government policy concerning health.

Although respect does not appear within the items identified by factor analysis in this study, data from the questionnaire identified it as having a high mean score against importance. It was also an element which was discussed with considerable frequency during focus groups and interviews.

Similarly, communications do not appear with any regularity in extant models, which contradicts the complexity of the dimension and the priority placed on it both by respondents representing the public and by service providers.

Communications has been defined as:

- Eliciting and understanding patient concerns, ideals, expectations, feelings.
- Understanding the patient in their psychosocial context.
- Reaching a shared understanding of the patient's condition and required treatment that meets with the patient's values.
- Empowering patients and giving them responsibility through involvement in their choices.

(Epstein et al., 2005)

This conceptualisation acknowledges the complexities of communications associated with health care, yet the construct does not appear with any frequency as an independent dimension in theoretical models.

The definition also adopts the concept of choice and partnerships between patient and clinician. Choice has become increasingly apparent in recent years in the UK health care system and is something which the WHO includes in its list of service dimensions. It does not, however, appear in any extant service quality model for health care. Although items falling within the construct of choice did not register as being among the highest scoring priorities in this study, they did account for mean scores of 5.5 to 6 out of a possible 7. This may be explained by the fact that choice is a relatively new concept, only really appearing on the agenda since the early part of this century. It may be that for people with little experience of health care (including some of those who have responded to the questionnaire) this is not an area which they have given much thought to.

6.2.2 Existing Approaches in Health Care Evaluation

The effectiveness of service evaluation in health care is the focus of much attention and is shifting from a target-driven, performance-related stance to one which is far more quality related. Around the time of completing this study, one trust saw its chief executive resign after years of criticism from local patient groups and national media coverage for poor service quality. The trust had relied on performance-related tools to achieve national targets but at the expense of measures based on quality. The resignation of the outgoing chief executive was announced after she finalised plans for a 'listening exercise' to hear what local people and groups such as GPs had to say about services. There remain some NHS trusts that remain entrenched in depending on purely performance-related measures, most often those implemented at a national level, although this is fast changing.

Chapter 2 discussed the wealth of programmes the Department of Health has imposed on health trusts and local general practice services, some of which are quality based and others performance based. The five, which may be argued to be particularly influential, focus quite heavily on performance:

- Monitor concentrates entirely on performance measures in scrutinising hospital foundation trusts.
- The QOF is performance and process based for the most part and largely target driven.
- Dr Foster is mainly performance based.

- The patient survey was more quality driven with questions relating to communications and respect, although there is also some reference to processes and performance.
- The CQC scrutinises quality as well as processes. The evaluation this body adopts is wide-reaching and exploits a range of means in obtaining data, both qualitative and quantitative. Nevertheless, this is a regulatory body and its efficacy is outside the scope of this research.

The tendency over the last decade to concentrate on target-driven measures using dashboards and balanced scorecards reflects the argument that there has been a gap, in that traditionally service evaluation concentrates on price or cost, backstage issues and expertise while customers (patients and family) are more concerned with timeliness, service and tangibles (Iacobucci et al., 1995a).

However, there have been step changes in UK health care. April 2013 saw the launch of a radically new NHS structure which requires all NHS organisations to place service quality high on board agendas. This extends to private-sector companies which are contracted to provide services on behalf of the NHS, a phenomenon which is growing. It is still too early to say how this is being addressed by individual organisations, many of them still in the process of setting up systems. Commissioning consortia will require provider services to demonstrate how they address and monitor service quality. While there is a swing towards providers taking the evaluation of service quality more seriously and placing it at board level, there is considerable scope to develop service-specific tools to help them achieve this.

6.3. OBJECTIVE 3: UNDERSTANDING THE MEANING OF QUALITY IN HEALTH CARE

This section discussions in some depth the meaning of quality for service users, comparing their perceptions with those of managers before reflecting on the findings of each phase of the study. It goes on to consider the effectiveness of using questionnaires in service evaluation in this sector.

6.3.1 What Quality Means to Users and Managers

While SERVQUAL has its flaws, it acknowledges the importance of management understanding what the customer wants. Putting this into context, it is crucial that management and clinicians understand the priorities patients and family place on

individual service elements. Reliance on national targets has diverted their attention away from this.

While the results from this study, as illustrated in Chapter 5, suggest some similarities in the perception of managers/clinicians and the way in which service users prioritise service dimensions, there are variances in some dimensions.

While many existing models fail to reflect the significance of communications as a dimension in its own right (section 3.7.3), some commentators do recognise it as a critical element of service quality in health care. This gap is mirrored by the findings of this research where service providers failed to put the same priority on it as the public did.

Fig 3.4 draws from extant literature to demonstrate the hierarchy of constructs that contribute towards building trust. Of the first level elements that form the basis of the model, communication is inherent in three: rapport, respect and empathy. The complex nature of the construct must be represented in any attempt to measure and manage service quality in health care.

The human elements of trust featured with lower frequency in interviews with service providers compared to the public where it was the highest priority. This may appear to contradict the theory that recipients of professional services in general seek prompts other than professional competence and credence to evaluate a service of which they have little understanding. This may be the case due to the outcomes of health care having a potentially profound effect on the quality of life or even, in more extreme cases, literally the likelihood of survival. However, the manner in which they have defined the antecedents of trust has meant this is not quite so much the case. Their reference to cleanliness of facilities, agreement and consistency between professionals, knowing the doctor, time taken for examination and the reputation of the hospital makes the dimension relatively simple to assimilate.

The frequency with which tangibles and staff occurred saw a reverse pattern, where providers discussed these at more length than the public did. The fact that staff was more of a focus for attention with providers supports the theory that management will

look at backstage issues, so leadership, staffing levels, training, etc. will be more in their consciousness (Crick and Spencer, 2011). These will be far more apparent to the organisation than to patients.

Although tangibles registered less frequently during focus groups with service users than was the case with trust, it was still relatively high. The main input concerning tangibles came from the large teaching hospital and local general hospital. The chair and director of facilities of the former of these were keen to explain their strategy towards food and nutrition, which are factored into the tangible dimension. As a major contributor to recovery, nutrition is fundamental to health care in hospital, yet it failed to attract much interest in the focus groups or high scores in the quantitative data. Meanwhile the medical director of the local trust similarly accounted for raising the profile of tangibles, comparing the reception/waiting room facilities of the newly built part of the hospital with those of an airport. Public respondents placed more importance on relational factors than on tangibles.

The relatively low level of regularity with which privacy and respect/dignity arose in both focus groups (patients and family) and interviews (providers) was quite surprising, and in contrast both to the high profile it receives in the media, where standards have been heavily criticised over recent years, and to the fact that it appears in all government policy.

6.3.2 A Comparison of Focus Group/Critical Incident and Questionnaire Data

The fact that the paths of both positive and negative critical incidents are not parallel with those of the comments arising from the focus groups and interviews raises a number of interesting questions. It is reassuring to see that there are comparatively few negative experiences of trust, although this may be explained by the fact that some incidents were not explicitly within the area of trust, but accounted for in other dimensions, for example communications, as illustrated by the comments of the mother of a young boy about their experience:

> *"The hospital said they had told me it was pneumonia. But even the A and E nurse had written asthma... When we got to the ward, again and again they*

did not seem to know why we were there. The communication was very bad and we were waiting for about half an hour."

Although not one of the most prolific dimensions in terms of negative incidents, there were 41 occasions when communications was perceived as failing and only five when it was viewed positively. The fact that the public placed such high priority on it during the focus groups, compared to interviews with service providers, suggests a discrepancy where more effort to understand the construct would be beneficial to the overall service experience and, potentially, outcomes.

Communications is a complex dimension, accounting for numerous individual items as well as having considerable potential for cross-coding with other dimensions. Its prominence was high both as a priority for the public as well as in the way in which it featured as a poorly performing in terms of experience.
It may be process driven:

> *"A junior doctor said he would speak to a senior doctor. We waited for another 45–60 minutes before the senior doctor came. It was an Asian lady and her English was not great. I had to go through the whole thing yet again as the junior doctor was not with her."* Respondent 18

> *"When I did arrive at the ward I wanted more information about what was going to happen, but they always assumed that you knew, so you always had to ask questions."* Respondent 15

> *"It wasn't a bad experience except for some poor communication: nobody told me what was going on at the beginning but I was given all necessary information on discharge."* Respondent 15

> *"Some of the communication at discharge between what I had been given and what had been given to the district nurses was different. I had been told I could have a shower. The district nurse said I shouldn't have had a shower. The district nurse also found a stitch in the wound which was not mentioned in the discharge letter. At another appointment it was a different district nurse who did not know why she was there. I told her it was to have a stitch removed. The nurse said she was told the stitch was due to come out the following Monday."* Respondent 14

It can also be relational:

> *"Mum asked if they would do their best to explain what was going on. All the doctors did but mum was hard of hearing so she didn't always catch what they were saying. They seemed to think she was not completely there and talked across her to us which was annoying."* Respondent 3

> *"Mum was sitting next to a slightly older lady called Annie. They were talking to her like a child."* Respondent 13

Greater emphasis is needed to prioritise this dimension from a managerial point of view. Improved processes to support staff are required. While relational aspects might be enhanced by better training, this may be simplistic in that this element of communications can partly be attributed to attitude, and ultimately individual staff personalities and moods. Indeed, attitude is yet another example of prominence in critical incidents (both positively and negatively), as well as having received considerable discussion during focus groups. Yet service providers did not give it much mention.

While access also showed major discrepancies between focus groups (public), where it was a source of considerable discussion, and interviews (providers), it was another dimension that was represented by relatively high numbers of incidents, both positive and negative. This contradicted the low profile given to it during the interviews.

The most significant gap between experience and management focus was with reliability, which manifested itself in different ways:

> *"The GP said always go to the hospital because they will have his records but I saw no evidence of this. I lost all confidence and did not want to go back there. Everything was fragmented."* Respondent 18

> *"My father was not so good. He had not received the chest massage he needed."* Respondent 7

> *"The tissue viability nurse was supposed to have come to sort out the discharge but she never came."* Respondent 8

> *"There was some mix-up about the list. I was supposed to be first on the list but another person knew someone in theatre and asked if another patient could go first because she was very nervous. So I found myself waiting and nobody had said what was happening."* Respondent 17

These quotes taken, from interviews with four different participants during the critical incident phase of the work, demonstrate the complexities of coding. Each of these

were coded as reliability and cross-coded with other items such as communications, attitude, trust and responsiveness. Nevertheless, this ambiguity does not explain the considerable discrepancy in the fact that it was mentioned 129 times as failing compared to the fact that it was brought out at a relatively low level during interviews with providers. It is only fair to note that it was also one of the highest-scoring dimensions for positive experiences. The data suggests a gap needs to be narrowed between management's perception of reliability and that of patient experience. More emphasis is required from a management perspective, despite the fact that it also accounted for a significant rating in terms of positive experiences.

The use of questionnaires to generalise the data proved to be less conclusive in cases where there was little to distinguish between the scores of each dimension. Nevertheless, the results did not replicate the findings from the qualitative work in every case.

Those that were identified as having the highest priority were respect, trust and responsiveness respectively, none of which reflected the profile received from the provider interviews. The fact that the quantitative data showed trust as once again receiving one of the highest score supports the findings from the public focus groups. The results imply that, although literature suggests trust is not something that patients feel they are able to evaluate, it is something that managers must give more regard to than seems to be the case.

Neither respect nor responsiveness was among the higher-profile dimensions in the qualitative work. Literature identifies respect as an antecedent of trust. This fact, alongside its high score in the questionnaire data and its prominence in all government policy, means that local managers must raise awareness of its importance in all service quality strategy.

Tangibles was at the other end of the scale, refuting the importance placed on it by both the public and service providers. It also contradicts extant literature which places emphasis on the tangible elements of quality in health care.

6.3.3 The Use of Questionnaires in the Evaluation of Health Care

The critical incident phase of this study exposed participants to recall a miscellany of mainly negative experiences which were of a sensitive nature. It was apparent that feelings were, not surprisingly, raw for some of them, especially where the death of a loved one was involved. Inevitably such experiences are likely to influence perceptions, raising doubt over the use of questionnaires as a sole means of measuring quality.

Theory about customer satisfaction and service quality has expounded on the fact that moods and emotions affect the way in which individuals may evaluate service encounters where one poor experience is at risk of influencing perceptions of other parts of the overall experience.

Questionnaires are often used to obtain feedback from one-off encounters. This points to the fact that it is customer satisfaction being monitored rather than service quality. Responses in terms of health care are open to merely offering the immediate reaction of a person after what may have been a difficult, emotional or even painful encounter. They rarely give the opportunity for an individual to go away and reflect on the questions being asked.

The current NHS inpatient survey includes communications, dignity, access, safety, food, reliability, involvement, dignity and trust in its evaluation of services. While the questions are quite extensive and include a number of those elements identified by respondents to this study as being key to service delivery, there remain many questions that are process driven. They fail to consider more relational aspects such as rapport and empathy. Nor does the questionnaire recognise the different environments within a hospital. As a receptionist working in accident and emergency pointed out:

> **"***It is difficult to generalise because departments in individual hospitals have different needs."*

The GP survey questions have many similarities with those which evolved from the factor analysis of this survey covering access, trust, seeing the same person,

communications (listening, explanations given), respect/empathy (care/concern) and time given for the appointment.

Figures 6.2 and 6.3 set out suggested questionnaires for both inpatients and general practice, both of which have been designed from the results of this study.

Figure 6.2 Proposed Inpatient Questionnaire

	1	2	3	4	5
Trust					
I had trust in the doctor treating me					
I had trust in the nurses caring for me					
I had trust in other professionals involved in my care					
Relevant information about me was passed to other departments/agencies when necessary					
Examinations/treatment/tests did not feel rushed					
Any call I made for assistance was answered in a timely manner					
Where relevant my full medical history was used in diagnosis					
I did not feel a nuisance when asking for help in hospital					
Professionals had all relevant information about me to hand					
Information given by different staff/departments was consistent					
Appropriate information was given to me at all times					
Professionals had all relevant information about me to hand					
Staff understood my needs and took appropriate action if a problem occurred					
I felt that I was listened to					
Staff were willing to help					
I felt the doctor trusted me					
Staff did what they said they would do when they said they would					
Staff were aware of my fears					
If I had a complaints it was addressed in a timely manner					
I knew who to speak to if I had concerns					
Access					
I did not spend lengthy periods in waiting rooms prior to treatment/having tests					
There were no delays in receiving treatment/tests					
In the case of any delays explanations were given					
Caring approach					
I was helped to relax					
The staff were friendly					
Local clinics/surgeries to be visually pleasing					
The hospital ward was bright and welcoming					
I was shown respect					
The staff had ‘people skills’					
Professionalism					
The professional knew me and understood my needs					
The hospital’s records on cleanliness/MRSA/C. diff/E. coli are displayed					
To know my doctor					
The hospital has a good reputation					

(Compiled by the author)

Figure 6.3 Proposed Local Clinic/Surgery Questionnaire

	1	2	3	4	5
Trust					
I have trust in the doctor					
I have trust in the nurses					
I have trust in other professionals caring for me					
Relevant information about me is passed to hospitals and other departments/agencies when necessary					
Examinations/treatment/tests do not feel rushed					
Where relevant my full medical history is used in diagnosis					
The doctor/nurse has all relevant information about me to hand					
Information given by different doctors/staff is consistent					
Appropriate information was given to me at all times					
Professionals have all relevant information about me to hand					
I feel that I am listened to					
Staff are willing to help					
I feel the doctor trusts me					
I feel the doctor/nurse is aware of any concerns or fears I may have					
If I have a complaint I feel it would be addressed in a timely manner					
Access					
I do not have to spend lengthy periods in waiting rooms					
Appointments do not run late					
Explanations are given if appointments run late					
Plenty of notice is given for cancelled appointments					
Caring approach					
I was helped to relax					
The practice staff are friendly					
The clinics/surgery is visually pleasing					
I am shown respect					
The staff have ‘people skills’					
Professionalism					
The professional knows me and understands my needs					
I know my doctor					
The surgery/clinic has a good reputation					

(Compiled by the author)

Increasingly, the use of questionnaires as stand-alone tools is being seen as insufficient. They are too simplistic in such a complex and dynamic sector. The use of

questionnaires at local level runs the risk of weakness in design, resulting in poor data. Figure 6.4 shows a questionnaire taken from a dentist's surgery. It is an example of how NHS providers are placing more importance on obtaining data regarding service quality. It also demonstrates how easily they can be flawed if the necessary skills are not available.

Figure 6.4 Existing Local Dentist Questionnaire

	1	2	3	4	5
1. General service					
The practice opening hours					
The practice layout and accessibility					
Patient information such as leaflets, brochures and signs					
The supply of retail products such as toothbrushes					
Cleanliness and tidiness of the practice					
2. Our practice arrangements					
The entrance of the practice					
The layout of reception					
The patients' toilet					
The treatment room					
The overall impression of the practice					
3. Customer care					
Staff professionalism					
Our telephone manner					
Staff uniforms and general appearance					
How welcomed you felt					
How friendly the staff were					
4. Our orthodontist					
Did you feel confident with the orthodontist?					
How clearly were treatment choices explained?					
How relaxed did you feel during treatment?					
How comfortable was the treatment?					
How clearly were the treatment choices explained to you?					
5. Administration and finance					
How clear was the treatment plan given before treatment started?					
Was the treatment good value for money?					
How do you rate our recall arrangements?					
How easy was it to make or change appointments?					

(Glebe Street Dental Practice, 2013)

While it includes items across a number of dimensions identified as important by theory and service users, such as trust, tangibles and communications, to a limited extent, there are a number of anomalies. There is nothing relating to access in terms of how easy it is to get an appointment or the reliability of appointments in keeping to time. The communications dimension was only represented by the one-way provision of information provided by the practice, rather than two-way communications which would be represented by interaction between the patient and the professional.

More specifically:

- General service:
  The question relating to patient information needs to be more specific – is it asking about how easy it is to understand, whether it is relevant or how visually appealing it is?

- Customer care:
  What is meant by 'staff professionalism'?

- Orthodontist:
  Two questions were the same.
  Is the use of the word 'comfortable' appropriate when seeking to evaluate something where discomfort may be unavoidable?

- Administration and finance:
  Is it possible for a patient to judge if treatment is good value for money? If it frees them from pain they are likely to have a positive perception of this, no matter how expensive. What is meant by recall arrangements?

Research is becoming more prevalent around service evaluation in health care, not only in the UK but globally. This study has shown evidence of organisations adopting more creative approaches in service evaluation. Shadowing patients and family through the patient journey has been adopted by some to get insight into the wider experience. First adopted in America, this is now being piloted by some hospitals in the UK.

This shift endorses the views of critics who have described the use of questionnaires as no more than a troubleshooting exercise (Murray et al., 2001; Dougall et al., 1999). It also supports the view that clinicians are more likely to take notice of more detailed personal accounts than of statistics via questionnaires (Dougall et al., 1999).

The results of the factor analysis carried out for this study have demonstrated the difficulties in designing a questionnaire. It removed a number of items which had scored highly as priorities. The definitions of some factors were a little vague in terms of the items they comprised, suggesting a level of uncertainty around their effectiveness. This was particularly the case with trust. Nevertheless, items were included which have not shown up on other surveys currently in use, particularly in relation to communications.

Questionnaires, however, should not be seen as having no value but rather as an intrinsic part of a wider evaluation methodology which includes qualitative techniques such as interviews, focus groups or even shadowing. They can be adapted for use in a hospital setting or local clinic, as well as to compare perceptions of patients/carers/family with those of staff.

6.4. OBJECTIVE 4: PROPOSE A CONSTRUCT OF SERVICE QUALITY RELEVANT TO HEALTH CARE IN THE UK

This section considers not only the dimensionality of service quality but also how practice relates to theory in a wider sense. It discusses the impact of the changes implemented in 2013 when the NHS experienced a completely new way of working, with far more autonomy placed at local level, and the fact that competition has been a driver for new ways of working. It also takes into account the implications of measuring service quality as opposed to customer satisfaction, as well as the way in which the service-dominant logic should be applied to practice.
It is broken down into two sections:

6.4.1 Contributions to theory:

6.4.1.1 The Use of Expectations in Evaluating Service Quality.
6.4.1.2 Dimensionality.
6.4.1.3 SERVQUAL - Relevant or Irrelevant to Health Care.

6.4.2 Contributions to practice:

6.4.2.1. Implications for Management:

How the changing health economy affects quality.
Changing the emphasis from performance to quality.
Measuring customer satisfaction or service quality.

The importance of regular monitoring.
Providing resources.
General practice and community services.

6.4.2.2 Implications for policy:

Applying the service dominant logic.
The role of organisational development.
Using questionnaires.
Dimensionality.

6.4.2.3 Implications for practice:

The use of questionnaires.
Using qualitative techniques.
Developing longitudinal studies.
The differing needs of departments.

6.4.1 Contributions to Theory

6.4.1.1 The Use of Expectations in Evaluating Service Quality

The use of expectations in evaluating service is examined in some depth in section 3.4.3. Theory debates the nature of the constructs, which can vary according to what they are based on and when they are made. The variables that affect the influence of expectations in service quality are many and this makes their effectiveness problematic. They may be assimilated against what the individual sees as ideal, what they forecast will happen or what they believe should happen. The difficulties associated with the use of expectations are exacerbated in professional services where the service user does not know what to expect. They may find it difficult to define their problem (Ojasalo, 2001) and consequently do not understand what outcomes might be expected.

The extent of negative media coverage relating to the NHS in the years running up to 2013, and beyond, is likely to be a major influencer which leads to lower expectations. This, in turn, creates low disconfirmation scores where the level of service is perceived quite well against low expectation, although caution should be used in relation to this. Although expectations are likely to have been reduced over recent years with the publication of reports into poor practice and continued media interest, the experiences of most respondents in

the critical incident phase of this study generated a feeling of considerable dissatisfaction with services.

Timing, moods/emotions and managing expectations can also be influencing factors. This is particularly the case in health care, whose services are often delivered during stressful times in a person's life and in emotional circumstances. It is not unusual for patients to have long-term associations with their health professional, during which their expectations may change as they become more familiar with their care and they get to know the doctor or other key staff they encounter. As the relationship progresses and they gain more trust, their satisfaction levels tend to increase. The moods and emotions of a patient are especially important since any stress they feel can have a considerable effect on how they perceive the quality of service against expectation.

Managing expectations can also be a challenge within the sector, against a backdrop of continual medical advances with the potential to both improve quality of life and, often, to extend it. At the same time patients are becoming more educated and live in a consumer-driven world where excellence is continually sought.

Table 3.5 sets out the range of definitions for expectations, including the use of the words 'desired', 'ideal' and 'should'. Care is needed in the wording of questionnaires to take account of this. It is too vague to merely ask what expectations respondents have. In this study, respondents had been asked what service elements they deemed important. In other words, it was clearly asking what they wanted to see. There does, however, remain a risk in that most of the items were routinely scored as having very high priority which raises the issue of unrealistic expectations.

The feedback from the focus groups illustrates the further complexities around expectations in health care. The following quote from group 5 demonstrated how expectations, in terms of what is seen as will happen, can vary according to the service:

> *“It is interesting what you say about expectations, isn’t it, because I think for me there seems to be a hierarchy of health. Things like cancer are seen as very important and they are but if you look at how older people are treated and the care they get, and we have all seen documentaries. Because they are not seen as useful anymore but in Eastern societies they are revered and it would be different [sic]. But resources I think are given to ‘sexy’ services.”* Quote taken from group 5

This suggests that a person is likely to believe that experiences of care when using cancer services will be superior to those for the elderly. Similarly, the care provided by high-dependency units is perceived to be of a higher standard than that in general wards.

> *"My overall conclusion is that it seems to be the more concentrated the treatment the better. But maybe this is because there are more staff in these cases. Unfortunately, in cases where the patient is older, once they are transferred to a general ward, the care appeared to us to be lacking compared to that given to younger people*." Respondent 5

> *“I think so. Again it is trust. You know you have gone somewhere they can help.”* Quote taken from group 5

This latter comment was in response to being asked if the environment was important. The fact that it was referred to as leading to trust can be translated as meaning you can ‘expect’ to be helped.

Another respondent raised the issue about patients not knowing what to expect, which supports theory about many not having any real expectations prior to experience (Devlin et al., 2001; Yuksel and Yuksel, 2001):

> *“People don’t understand the medical profession. I do. Who is who and what is done. I am comfortable with it. If I go into a hospital I’m not frightened because I work in one. That is not normal to a lot of people. You don’t feel comfortable. I know who to ask. If you aren’t familiar you haven’t a clue.”* Quote taken from group 2

These are just three examples taken from transcriptions that demonstrate how closely expectation and desires are linked.

It is argued that the uncertainty in defining expectations makes it too nebulous a construct to be effective in the evaluation of service.

6.4.1.2 Dimensionality

Dimensionality is the principal contribution to theory, where the evidence from both the qualitative and quantitative phases in this research confirms the importance of relational service dimensions in health care. While a number of problems described in the critical incident interviews did arise due to procedural failings, those elements that performed most poorly were communications and attitude. Focus groups reflected the same trend, where four out of the six most prominent elements were trust, knowing the customer, communications, and attitude. Of the other two – tangibles and access – access comprised some items which were based on the two-way interface between patients and the professional, such as being able to speak to the right person and not feeling rushed.

The model set out in Figure 5.5 in section 5.4.2 identifies four factors: trust, access, caring approach and professionalism. Although cross loading with other indicators such as process, environment and technical, with the exception of access, each factor comprises items primarily based on interrelations and communications between the professional and the patient .

6.4.1.3 SERVQUAL – Relevant or Irrelevant to Health Care?

Section 2.5 discusses in some depth SERVQUAL, which is recognised as the seminal model used to evaluate service quality, and raises concerns about its relevance in high-contact services. The findings of this study support those concerns.

The model was based on research in four sectors: retail banking, credit card, securities brokerage and product repair and maintenance. None of these represent the complex and high-contact nature of health care.

SERVQUAL Dimensionality

While the original model with ten items did include the factors ‘communications’ and ‘understanding/knowing the customer’, the former did not reflect the intricate nature of these dimensions which have both been identified as important to quality by the findings of this study.

SERVQUAL describes communications as:

> *"Keeping customers informed in language they can understand and listening to them. It may mean that the company has to adjust its language for different consumers – increasing the level of sophistication with a well-educated customer and speaking simply and plainly with a novice. It involves:*
>
> - *Explaining the service itself;*
> - *Explaining how much the service will cost;*
> - *Explaining the trade-offs between service and costly;*
> - *Assuring the consumer that a problem will be handled."*

(Parasuraman et al., 1985, pg. 47)

It fails to acknowledge a number of dimensions, some of which are unique to the health sector and have been identified through the focus groups in Phase 2 as being important:

- Information is passed to other departments/agencies if necessary.
- My full medical history is used when necessary in making a diagnosis.
- Not to feel a nuisance when asking for help in hospital.
- Professionals have all relevant information about me to hand.
- Information given by different staff/departments is consistent.
- I know who to speak to if I have concerns.
- To feel comfortable asking questions.
- Not to be asked for personal/medical information in a public area.
- To be sure my personal/medical history will not be passed on in error.

Together these contribute to the constructs of trust and respect. Although the last three of these dimensions were removed by factor analysis, they were identified as priorities by the public as discussed in, section 5.2.

There is nothing in the model to represent rapport or empathy as suggested by the items:

- The professional helps me to relax.
- The professional is friendly and informal.
- To be shown respect.
- Staff to have 'people skills'.
- Staff are aware of my fears.

In comparison, the adapted SERVQUAL model with five items defined empathy as an independent factor including:

- Knowing the needs of the customer.
- Having their best interests at heart.
- Staff to give personal attention.

- Staff to give individual attention.
- Convenient opening hours.

(Parasuraman et al., 1988)

It also listed the customer having trust in staff, describing it as follows:

- Customers can trust staff.
- Customers feel safe.
- Polite staff.
- Staff get support from firm.

(Parasuraman et al., 1988)

Having trust in the context of the relatively simple and low-contact services on which SERVQUAL is based differs significantly from the case of the health care sector, where it not only includes trust in the professional (through rapport, empathy and respect) but also in tangibles (cleanliness) and in the organisation (reputation).

The model also failed to acknowledge the importance and complexity of communications.

The basis of the SERVQUAL model is the use of user expectation in its evaluation of service quality. This adds yet another weakness in its application to health care, as discussed in section 3.5 and in section 6.4.1.1 of this chapter, where the term 'expectation' is deemed to be too complex to have real meaning in the evaluation of quality.

6.4.2 Contributions to Practice

6.4.2.1 Implications for Management

How the changing health economy affects quality

There is no lack of evidence to demonstrate the increased emphasis which is being placed on service quality at all levels of health care. As choice has become a key part of the Government agenda, service providers are facing up to the reality of competition. In a sector where NHS organisations saw themselves as almost a monopoly, recent years have seen increased use of private-sector businesses to provide health care on behalf of the NHS,

although still free for the end user. This is particularly the case for more routine procedures and treatments traditionally carried out at local general hospitals but which can now be commissioned from alternative NHS providers or from the private sector. In 2012 more than 200,000 patients were opting to access services provided by the independent sector on behalf of the NHS, with significant numbers exercising their right to choice of NHS providers (Department of Health, 2012).

The Health and Social Care Act 2012 has reinforced this shift in direction, requiring NHS trusts to respond to the concept of competition, which has been alien to them in the past. While there remains an emphasis on outcomes, the Act has pushed service quality to the fore regarding contracts including a requirement that the construct and its evaluation are key priorities. There is a need to be mindful of who the 'customer' is. Is it the commissioner or is it the patient? Each will have their own perspective on what is required. As a senior nurse at the large teaching hospital cited in this study pointed out, doctors, managers and patients all require different types and levels of information. While doctors and managers at commissioning bodies are interested in clinical outcomes and finances respectively, the patient is concerned with both outcomes and the functional service elements.

Competition must not be, and is not, the only driver behind the need for increased focus on service quality. The continued high profile of incidences of poor care has shot the issue onto the Government's agenda as well as more local agencies. The report into 14 trusts with abnormally high death rates showed that factors such as doctors and nurses having poor English skills, wards being unclean, patients feeling afraid to complain, and machines not working were among those that were seen as being partly responsible (Keogh, 2013). Each of these was raised as an issue in the focus groups. Stories told during the critical incident interviews carried out as part of this study support the continued tendency of failings to appear in the media. Management needs to ensure that they have processes in place to minimise the risk of patients receiving poor care which affects their dignity and comfort, and potentially their recovery rates.

Despite the argument that patients need prompts other than the technical aspects of health care, consultants are now required to publish their results to help patients make an informed choice about whom they wish to go to and where. This helps the patient have trust in their health care professional against a backdrop where trust should be inherent in care, but where there is evidence suggesting that has not been the case over recent years. The results of this study agree with extant theory that patients use interrelational prompts to build trust. Nevertheless, the publication of outcomes can help them in making informed choices.

The motivation to improve services must not only be to reflect the statutory requirements of providing information but must demonstrate a genuine desire to understand what the patient wants and act on it accordingly where this does not compromise their treatment. In a sector as complex as health care, this means working at multiple levels with patients, family/carers, clinicians and managers across a variety of disciplines. To be effective it needs resourcing both financially and with the appropriate skills. It should be seen as an investment rather than an expenditure.

Changing the emphasis from performance to quality

The early 21st century has seen an overwhelming propensity towards a target-driven health service based on objective measures set nationally. These have relied on balanced scorecards which were originally designed for manufacturing. While their use in health care has seen improvements in some areas, most notably the reduction of waiting lists for surgery and waiting times in accident and emergency departments, this approach has sometimes been at the expense of local needs and has manifested itself in poorer quality. Using the Nordic model of technical and functional service elements, the former have been ruthlessly monitored while the latter has received very little attention. The Keogh Report has evidenced the fact that targets are not always the most appropriate measure and that interrelational factors increasingly must be focused upon (Keogh, 2013), again supporting the findings of this thesis.

The recent change in focus means a very different approach is required by managers. Far greater understanding of what the patient (or family) wants is needed, as well as an appreciation of how staff perceive service quality. While the use of expectations in the gap model SERVQUAL is not seen as appropriate due to the complexities of the concept, comparing the perceptions of service users and staff will help in the construction of a framework for service evaluation. If staff believe certain service elements to be of importance while patients prioritise others, there will inevitably be a gap in the monitoring process. Although management has a mandatory responsibility to facilitate national patient surveys, they must not lose sight of the need to focus on local priorities as well. All surveys must be supported by qualitative market research.

Measuring customer satisfaction or service quality

Management must also be aware of the implications of measuring customer satisfaction versus that of service quality. If taken in isolation, questionnaires measure the short-term orientation of customer satisfaction as opposed to the longer-term service quality. The fact that questionnaires relating to health care are often completed during or immediately after a period of anxiety means that respondents, albeit unintentionally, may often allow emotions to shape their perceptions sufficiently strongly that just one encounter can impinge on their perceptions of other parts of service quality. An experience of poor communication with one member of staff or at one appointment can result in the patient judging all other service elements or appointments as being similarly poor, albeit inappropriately. In some interviews during Phase 1 (critical incidents), respondents seemed to use the experience as a cathartic exercise, reflecting on where things had gone wrong. At times incidents were mentioned which, when taken alone, would have been relatively insignificant but when taken in context with everything else became far more important.

This is a reality which must be taken into account when designing service evaluation strategies.

The importance of regular monitoring

In order to measure service quality as opposed to customer satisfaction, it is necessary to take data from questionnaires over a period of time, allowing it to be used to give regular snapshots of patient perceptions. The data can then be used at a strategic level or within individual disciplines or departments in the organisation. Periodically, qualitative methods should be used to support quantitative measures to create a wider, more in-depth picture. Not only does this help in getting a better understanding of patient perceptions, it also ensures that the items being measured on the questionnaire remain relevant over time. Again, the process should be hierarchical, involving clinicians at all levels, managers and support staff. It should also include representatives across all stakeholders including patients, family/carers and members of the general public (since they are likely to require access to services at some point in their lives).

Regular monitoring will highlight trends in patient priorities which may fluctuate over time. It will also keep management abreast of where services are either performing well or are slipping. In the latter case, actions can be taken on these before they become a problem.

The existing national patient surveys allow hospitals and general practices to benchmark themselves against others. Locally employed questionnaires can promote benchmarking across departments and disciplines. Consistency in service quality across an organisation did register as important in the questionnaire data (although not so much from the interviews and focus groups) and good management should strive to ensure that services are of a high standard throughout an organisation.

Where individual service elements are strong in one part of the hospital or clinic these can be replicated in other areas. It is accepted that departments – and even hospitals, depending on their areas of specialism – have assorted demands placed on them which can result in fluctuations for some service items. Nevertheless, trust, relational, tangible and caring elements should remain fundamental to the patient experience throughout.

Providing resources

At the most basic level, quality must be seen as an essential component of the overall care package to ensure the well-being and comfort of patients during illness. To address this there must be recognition at board level that strategy aimed at improving service quality needs resourcing. In an environment where demands are high and budgets limited, this presents a considerable challenge but to ignore it can prove to be a false economy or, at worst (as the Keogh Report suggests), it can have tragic consequences.

While choice did not feature as a main priority in this study, it is now an embedded feature of health care in the UK which sees funding follow the patient. If hospitals fail to generate public trust, then their very existence might be in jeopardy. In early 2013 Hinchinbrook Hospital Healthcare NHS Trust in Huntingdon saw the private sector company Circle take over its management and, in September 2013, a similar approach was being considered for Peterborough and Stamford Hospitals Foundation Trust. Both of these have been as a result of debts being accrued. Yet another trust, which was the focus of attention in the Keogh Report, saw its chief executive forced to resign in August 2013 and a team from another local NHS Trust being brought in to correct serious failings in service quality.

Providing resources in terms of financing and time to allow staff to take part in developing and implementing strategies is not an optional extra. It is a strategy that must include time to work with patients and the public to understand quality. It must recognise the need to provide and develop skills in managing service evaluation as well as acting to improve areas of weakness.

General practice and community services

While the main focus of this section has been very much on acute (hospital) services, similar approaches must be adopted in general practice and community services. These services may not have been under the same scrutiny or the subject of highly critical reports; nor is their existence under threat through competition. Nevertheless, they still have a basic responsibility to ensure their services meet the needs of their population and, since the Health and Social Care Act 2013, GPs are required to ensure high levels of quality in the services they commission on behalf of patients through Clinical Commissioning Groups.

6.4.2.2 Implications for Policy

Closely related to management implications is the setting of policy. While managers are responsible for implementing policy, it is generally the Board who will set and oversee such policy and it is at this level that service enhancement should begin.

Applying the Service-Dominant Logic

Ideally the policy set to enhance service quality should reflect the theory behind a service-dominant logic, where every individual member of staff, whether back room or front office, must understand their contribution to service delivery. This includes clinicians, administrative staff and management. It also extends to external agencies, a fact that is particularly resonant in health care where a range of bodies, particularly local authorities, can be part of the service provision. Health services are no different from other professional services in that there is a danger that the clinicians often do not understand the nature of the service-level construct from the patient's perspective. They are task orientated, where technical outcomes outweigh the functional elements of service. Meanwhile, there is a danger that back-office and support staff do not always appreciate the full effect of their own contribution in the service encounter. Although evidence from government policy and clinicians participating in this study does suggest that this is changing, there is still a great deal of work to be done.

In the conceptualisation of health services as having high levels of customer contact and customisation of care, the relational aspects of the service hold particular importance (Lewis and Brown, 2012). This is endorsed by the findings from all three phases of this study.

Fundamental to the theory is the fact that the service user (in the case of health care, the patient or family/carers) is a key player in service provision. There has been a shift from the patient being an operand resource, where the clinician takes control of the treatment plan, to one where the patient becomes an operant resource: a key player in the process. This is reflected in the Government's agenda, which has set patient involvement both in the decision-making process and at service encounter level as a high priority. Although participants in the study did not raise the concept of choice and involvement in discussion very much, they did rate interrelational elements as important and policy should echo theory to drive practice.

The involvement of patients in the encounter is mirrored in the relational dimensions of quality where rapport, empathy and communications are so important and where relationships are antecedents to trust. Evidence suggests that if the patient feels listened to and part of the process, they are more likely to follow the advice of the professional (Pajinkihar, 2008) and policy should take account of this fact.

The role of organisational development

Organisational development is the way in which an organisation plans to make improvements in the way it works. It helps staff to understand and embrace the beliefs and attitudes of the organisation and to look at the ways in which improvements can be made on a continuous basis. In doing this staff at all levels and from all disciplines must feel involved in the process to help them understand where their contribution fits in with the overall mission. This thesis does not attempt to discuss organisational development other than to suggest that it is central to helping staff to understand the concept of service quality and its place in helping patients during stressful times of their lives. It supports them in recognising the role they can play in enhancing the

construct. In doing this, communications, involving staff, and training are three major influencers.

In the health care sector we see an immense diversity of staff, each with their own role which contributes to the patient's perception of service quality. A 360-degree course of action can help in promoting the concept of improving service quality, where staff are encouraged to work with patients to understand patients' perceptions of quality compared to their own. Once areas for improvement have been established, staff are able to play their part in implementing an improvement strategy.

It is a fact that some groups of staff will be more instinctively engaged than others. The nature of patient care often depends on multidisciplinary teams where each member has a specific role. They work together to ensure the highest level of care. This should be at both the technical and functional level. However, consultants, who are accustomed to working autonomously, may feel that the measures are not relevant to them since they may see their focus as being on the technical outcomes rather than the functional elements. Instances from the critical incidents suggested they do need to be more aware. One issue that came to light on several occasions was the difficulty in accessing senior clinical staff for information.

Similarly, back-room staff may believe that as they are removed from the direct patient interface they are not in a position to influence the perception of quality. They are often responsible for supporting processes and, while much of the impetus is placed on relational elements of front-line service, the service-dominant logic suggests that all staff have a role to play.

Communications

Effective internal communications strategies should be a building block to draw everyone into the process. With messages and communications channels tailored to individual staff groups, they can be a motivational tool to explain how roles affect service quality and how individuals can influence the process of improvement. They might also be used to demonstrate how those

areas that patients rank as being weak can be improved through new ways of working.

Senior consultants, who have considerable power in the organisation and are highly skilled in the technical aspects of service, are more likely to have a false impression of service quality, especially where patients may feel intimidated (Brown and Swartz, 1989). Since mid-2013 they have been required to publish their success rates. This generates a risk that they may become even less orientated towards improving dimensions that they see as being peripheral to the core service of clinical interventions. Communications strategies must take account of this in the aim of winning their support.

Staff Involvement

Section 6.4.2.1 has identified the need for resources to allow staff to help develop strategy. To maximise the potential of service enhancement, staff should be encouraged to be a part of the process, giving them a sense of ownership. This will help them understand the importance of the work along with how it can help the patient experience and where and why improvements are needed. It will motivate them to learn more about what patients want and how they can work towards delivering this.

Training

Training is likely to be an essential element regarding two platforms.

The first of these is giving staff the skills to conduct service evaluation programmes. Measuring service quality requires an element of expertise. Too often it is delegated to people as a responsibility extra to their core job and in cases where they do not have the necessary skills or experience to generate effective evaluation programmes. They will also feel impelled to prioritise data for national targets which will inevitably distract them from more local issues. The skills needed for measuring outcomes against targets are performance and process driven rather than quality driven and require a different skill set. Arguably these should be set aside from quality initiatives.

While support may be bought in from expert consultants to facilitate the initial stages of designing service evaluation packages, training of key staff in their implementation is essential. This is not only to advise in developing and using questionnaires but also to carry out qualitative work and the analysis of data. To encourage ownership and motivation, staff selected for training should represent a wide cross section of the organisation, including back-room personnel. Again, section 6.4.2.1 has stated the need for resources to be made available.

Secondly, training should be available to help them to make improvements where items are scoring poorly.

Once the data has identified areas for improvement, training in the most effective ways to strengthen those elements of service may be beneficial. While training in 'customer care' in a health care setting (particularly hospitals) is not unusual, this most often involves courses lasting a matter of hours which staff are required to attend very infrequently. They are rarely tailored to specific needs of the organisation or department. Opportunities exist to develop training which helps build awareness of those dimensions where services are not of a sufficiently high quality. Benchmarking between departments, disciplines and wards mean that different parts of the organisation can learn from one another on how to implement best practice in a hospital setting. In community services such as general practice or dentistry, training times are an established part of working which provides the setting for organisations to learn from one another. The critical incident interviews provide initial evidence as to where training could be helpful, such as communications, attitude and reliability.

Using questionnaires

Questionnaires are the most commonly used tool in service evaluation and have the advantage that they are relatively inexpensive and simple to use. However, the findings of this study suggest that, while questionnaires are useful, they are insufficient as a stand-alone tool.

One author summed up the intricate nature of his health care after he had experienced 17 hospital admissions over a 50-year period:

> *"If you are just treating bodies then you do not have the whole story. You need to drop your ideas about patients and just treat that glorious creature the whole human being ... Do not be a 'nurse' or a 'doctor', just be yourself...."(Brophy, 2005)*

The fact that the provision of care is so largely based on human interrelations between the provider and patient suggests that questionnaires alone can be over-simplistic. The findings from the critical incidents alongside the public focus groups and interviews with professionals demonstrated the wide range of items which health care comprises. The data from the questionnaire showed that the public find it difficult to prioritise these items, most of them scoring almost all items as being highly important. Only very lengthy questionnaires could capture each item.

The literature review provided evidence to support these findings – two patients completing a questionnaire rated sigmoidoscopy services highly but, when interviewed, described where some elements had failed.

In evaluating quality, consideration must also be given to who will be using the results. Professionals are often suspicious of data from questionnaires. (Dougall et al., 1999). Senior clinicians are more interested in using their own clinical judgement rather than targets, and patients see statistical data as being manipulated by managers. The chair of the teaching hospital cited in this study claimed that:

> *"National surveys are a waste of time. Management have to walk the walk and talk the talk."*

In other words, managers must talk to patients and staff to get a wider understanding of the quality of services they provide. Questionnaires cannot do that alone.

The results of factor analysis supported the fact that quantitative data should be supplemented with qualitative work. While the process did provide clear patterns regarding relational elements of quality, it also excluded a number of

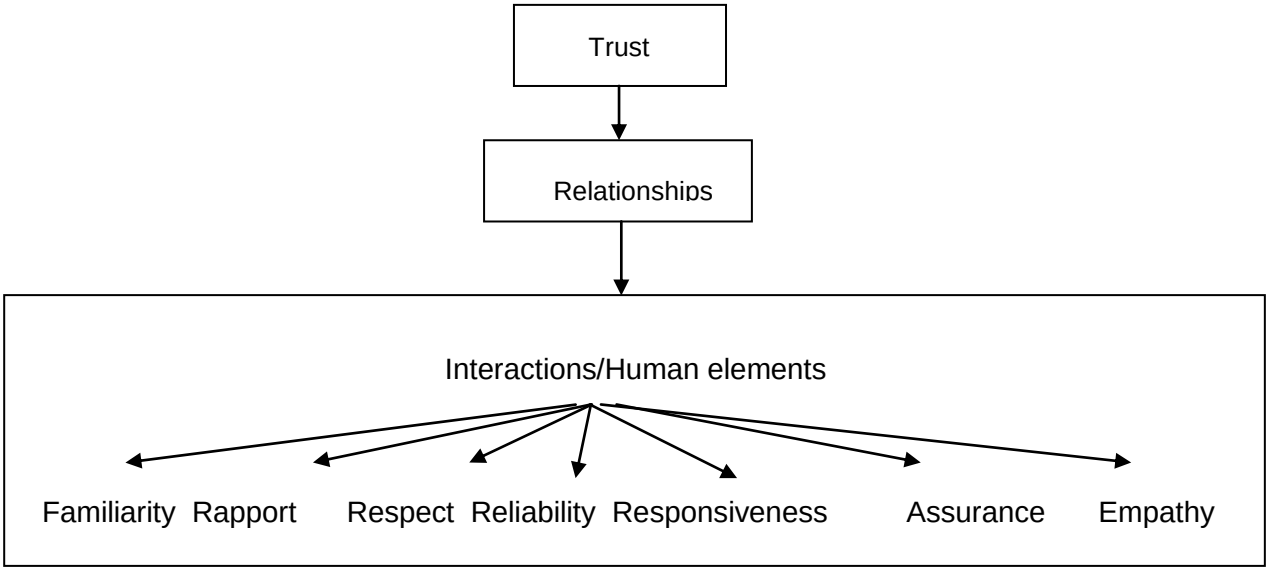
items that had received high-priority scores from the public, suggesting more work is required to understand the most effective way of designing a sector-specific questionnaire for use at local level.

Dimensionality

Although dimensionality has been mentioned in relation to SERVQUAL, as a key component of this study it deserves more discussion.

Extant theory suggests that a hierarchy exists which leads to trust. Since recipients of professional services often find it difficult to evaluate professional competency and look for other prompts, this structure is particularly relevant. Figure 3.4 identifies this as being:

Hierarchy of Constructs



(Compiled by the author)

The data from each phase of this study goes some way to supporting this proposition. Open coding identified communications and knowing the customer as being extremely important to the public, although in interviews with representatives from the providers, these were not raised in discussion as often. One of the items within communications is rapport, while empathy is a constituent of knowing the customer. Meanwhile, reliability and responsiveness were not rated as being of the highest importance to the

public or staff, yet reliability accounted for the largest number of negative critical incidents of any dimension. Surprisingly, respect and responsiveness did not feature with any significance. Respect is closely associated with attitude and empathy which may have affected the results. Similarly, responsiveness also correlates with attitude. The highest rating dimension was trust.

The results support the theory that relational dimensions are crucial in the delivery of professional service, and most particularly in health care, where patients may feel anxious or vulnerable and uncertain of what to expect. Priority must be given by management in understanding these dimensions.

6.4.2.3 Implications for Practice

The first stage in developing a strategy for service evaluation is commitment at board level. Once that has been assured, the strategy should determine the tactics that will be employed to conduct the work.

Broadly speaking, the outcomes of this study can be broken down into six categories where dimensionality underpins each:

- The use of questionnaires.
- The use of qualitative techniques.
- Developing longitudinal studies.
- Differing needs of departments.
- Service quality in hospitals.
- Comparing patient perceptions with staff perceptions.

The use of questionnaires

Questionnaires are cheap and relatively simple to use. Nevertheless, to be effective, they must be professionally designed to ensure they are relevant and easy to answer. Time is needed to analyse the data and feed it into improvement plans. The use of factor analysis has produced a four-factor model that has a reasonably generic application through health care, although it may require slight adaptation to take account of hospital environments compared to the community (see Figures 6.2 and 6.3 in section 6.3).

Relatively little training is required in applying questionnaires, although some expertise is needed in the analysis of results.

Ethical approval from the North West Ethics Committee required the study to include people from what are known as ‘hard to reach groups’. Among others, these include individuals who have serious disabilities, the elderly, and people with mental health problems or learning difficulties. While not every group was represented, those that were required some help in completing questionnaires. Resources in terms of training and extra time need to be taken into account for providing this support.

Using qualitative techniques

While the model which has evolved from the factor analysis is fairly generic and focuses very strongly on relational aspects of service quality, a number of items which participants of focus groups and respondents to the questionnaire deemed as very important were omitted by factor analysis To take account of this, qualitative techniques should be used periodically to ensure that all aspects of quality are taken into account in the evaluation process.

The use of qualitative techniques also counteracts the risk that respondents simply score everything highly, since theory suggests that interviews and discussion groups can raise concerns which questionnaires fail to. The fact that some dimensions produced large numbers of negative experiences during the critical incident interviews that were obviously seen to be significant enough to mention, yet were not seen as particularly important in the quantitative research, supports this potential risk.

The design of such techniques may require external professional facilitation but, once established, can be conducted internally.

Developing longitudinal studies

To maximise the potential of evaluation, surveys and qualitative research should be carried out longitudinally where trends can be established and

benchmarking employed across departments and disciplines. In trusts with responsibility for more than one hospital, this is particularly useful where management teams, who are geographically remote, can compare results. Benchmarking can facilitate learning opportunities where methods of best practice are evident in some areas and others are weak.

Longitudinal work also captures changing themes where the priorities of patients may alter over a period of time as services develop.

The differing needs of departments

The critical incident interviews identified concerns that service quality was poorer where the elderly were concerned. This was summed up by one respondent who was referring to three experiences – two with his elderly parents and one with a younger friend. One parent and the friend had been in intensive care for a period of time. He concluded that:

> *"It seems to be the more concentrated the treatment the better. But maybe this is because there are more staff in these cases. Unfortunately in cases where the patient is older once they are transferred to a general ward, the care appeared to us to be lacking compared to that given to younger people."*

This was not an isolated case in these interviews and was supported by the accident and emergency receptionist who referred to the different demands on her department from other parts of the hospital. It demonstrates that service dimensions must reflect these needs and that the model developed in this piece of research as shown in Tables 6.2 and 6.3, while including many generic questions, will benefit from adaptation according to where it is used.

Service quality in hospitals versus community

As with the variety of hospital settings, consideration must be given to dimensionality in relation to the overall hospital environment as compared to services in the community. These include general practice, district nursing, dentistry, walk-in centres and other allied professionals such as occupational therapists and physiotherapists. Again, there is considerable diversity which makes it difficult to replicate exactly the same dimensions across the

spectrum. While many items on a questionnaire may be applicable throughout, several will not. It is likely that, although the interrelational dimensions are equally important for all settings, their component items may vary according to the type of relationships that exist. General practitioners may have a longer-term relationship with patients where items such as ‘seeing the same doctor’ or ‘knowing my doctor’ may be more important than in a hospital.

Comparing patient perceptions with staff perceptions

While this paper does not endorse the use of a gap model in terms of experience, it does support the fact that it is necessary to understand the perceptions of patients compared to those of staff. If there is a mismatch, then it is likely that the opportunity for appropriate improvements will be missed. The results from Phases 1, 2 and 3 of this study do suggest a degree of disparity as discussed in section 6.3, most notably around trust, which received a far higher profile among the public than the service providers while tangibles and staff issues reflected the opposite. Since trust largely occurs as a result of interrelational elements, this suggests that staff should place greater focus on these than they currently do.

When designing evaluation strategies, managers must take this into consideration and make provision for techniques to gain a greater awareness of comparing the perceptions of staff and patients.

6.5 LIMITATIONS

The scope of this study meant that it was almost impossible to obtain a representative sample, as every member of society is relevant since we are all potential patients. Efforts were made to include as diverse a population as possible, with Phase 1 of the study covering an age group from 21 to 89 (because many of these were known to the researcher, ages were known) and a cross section of respondents from socioeconomic groups B, C1 and C2.

Phase 2 of the study included focus groups representing the elderly, young mothers, those people who have a range of complex needs, and a cross section of profiles

taken from snowballing. Together these included age groups from 20s to 80s and across socioeconomic groups B, C1, C2, D and E. Nevertheless, the majority of participants were in the older age brackets. Phase 1 focused on those who had experience of services; consequently, it was likely they would be older. Phase 2, however, did reach a wider group although, again, older people were in the majority. There was no representation from socioeconomic group A and, interestingly, there was only one respondent in Phases 1 and 2 who was of a group other than white British. This was despite the fact that the research concentrated on an area with large pockets of different ethnic groups, either of a non-white ethnicity or Eastern European.

Participants representing service users in these phases were also restricted to the Greater Manchester area; service providers represented a slightly wider geodemographic covering the North West of England, but it was still relatively restrictive.

Although there was the opportunity to remain anonymous, respondents were able to provide their name and contact details to be entered for a draw. Many did and from this it was possible to note that, although one of the recipient mailing lists comprised a range of community groups representing a large number of ethnic groups, most of the questionnaires returned were from white British people. A second mailing list was far wider, based on the electoral register. While this provided a more extensive geodemographic than the qualitative work, it also failed to attract responses from a wide range of ethnic backgrounds.

The research did not reach people with learning difficulties due to access difficulties, and, for ethical reasons, no children were included.

The objectives of the study were quite general and not sufficiently wide to take account of the potential differences in responses between diverse groups. This may be something which could be achieved through further research.

Although the Likert scale on the questionnaire provided ratings between 1 (not so important) and 7 (very important), most respondents placed high priority on almost all

the 104 items. A few marked every one as being 7. This may have been a result of there being so many statements to score against that it became easier to mark them all the same, or indicated that they were emphasising that all service elements should have priority placed on them. A relatively large number left some statements out. Again, the reason for this could be one of two possibilities: either they did not know how to score the item, or it was simply an error. There were one or two instances where whole sections were omitted.

While piloting the questionnaire raised no concerns about the rankings of 1–7, to reduce these to 1–5 may have helped respondents to clearly distinguish between the rating of priorities by reducing the opportunity to score all items very highly. Only further qualitative work can give a clearer picture regarding this phenomenon.

One of the difficulties in conducting research such as this in a service sector as complex as health care is that it is necessary to cover a wide range of services (e.g. community facilities such as general practice, district nursing, dentistry, walk-in centres, local general hospitals, large teaching hospitals with particular specialties or tertiary hospitals such as those providing expertise in cancer or coronary care, etc.). While this study included community services, local general hospitals and a teaching hospital, it did not include tertiary care other than a local hospice.

In Phase 2 of the research, service providers were interviewed to get their view of service quality and what is important to them. These interviews reached a range of personnel from management and front-line clinical staff; however, only one non-clinical staff member took part. A larger sample would have helped to give a wider perspective from the providers' point of view since many of these have daily dealings with patients and their families, making their views just as pertinent as any other group.

The purpose of the research was to consider the unique features of health care compared to other service sectors. The limitations listed here go a long way to demonstrating just how diverse the sector is and that it may even be considered that health care is too complex on its own to justify easy generalisation.

6.6 FURTHER RESEARCH

Quality in health care in the UK has been thrown into the spotlight as concerns have grown over recent years; most recently this has culminated in recommendations for change. A need to place less emphasis on targets and more on quality means that hospitals, in particular, must focus on understanding the patient experience from a wider lens than clinical interventions and outcomes. At the time of writing this thesis, health care organisations are having pressure put on them to provide means of evaluating patient and family perceptions and to act on them.

The findings of this study offer a foundation for the development of an evaluation tool but at the same time point the way for further research into what is an emotive sector.

The construct that has been developed is a useful starting point for use in health care, albeit with some adaptation for different settings. However, the findings do imply that more qualitative work would help in understanding it in greater detail and in different situations.

The fact that health care touches everyone makes it a sector where it is particularly difficult to understand the perceptions and expectations of its users. Its users cover all age ranges, socioeconomic groups and geographical coverage, and, most significantly, people with a hugely diverse range of needs. This study has not attempted to look at one target group in depth but has endeavoured to cover as wide a sample population as possible. There are, however, specific groups where a greater understanding would be beneficial. Not least of these is the elderly, which represents by far the largest segment which accesses health services and is likely to grow significantly over the coming years. The critical incident interviews suggested that it is the services for the elderly that are most prone to poor service. They are the group who are least able or less willing to express their wants and perceptions. A number of the interviewees in Phase 1 were speaking on behalf of their elderly relations about incidents where they had had to speak up for them. The focus group that included those over the age of 75 in a residential home was the one where participants were least willing to speak. Research into quality for the elderly would

potentially make a huge contribution into improving services in an area which has received considerable criticism.

An opportunity also presents itself in endeavouring to understand the differing priorities and environments which individual departments and specialities have. Accident and emergency departments have their own particular challenges which would distinguish their quality elements from other hospital departments or wards. The changing face of health care is seeing more services delivered in the community, such as general practice, dentistry, district nursing, etc. In parallel there is an increasing trend towards large, highly specialised hospitals. Such distinct types of service provision will inevitably lead to more marked dimensions in service quality according to the setting. This requires further research to understand them more accurately.

The fact that the findings discussed in Chapters 5 and 6 of this thesis present evidence of a gap between the perceptions of service users and service providers advocates additional work to learn more about the causes of the gap and how this could be closed. Again, this may vary according to the setting.

6.7 CONCLUSIONS

While recognising the limitations of the work and the need for further research as set out in section 6.6 the results of each phase of this research support much of the extant literature about the evaluation of service quality in professional services. Contextualising it against health care, the evidence suggests that the functional elements of services in the sector have been viewed as subordinate to the technical outcomes. Government policy is demonstrating a shift in this, in that they are now seen as more integral to the overall encounter, but more work is needed to support health care providers in this.

6.7.1 Review of Extant Models and Measures of Service Quality

Service quality is an elusive construct and, despite years of debate, scholars have been unable to agree on a common definition, making it difficult to measure. One of the most widely acknowledged concepts is the service-dominant logic, where all

members of an organisation are responsible for service quality and where the service user is an equal partner in the service encounter. While some services can be standardised to some degree – and even in health care, clinical interventions may be – the nature of the sector, where each patient is unique and a principal part of the process, means that the experience should be heterogeneous. The heterogeneity and separability are represented in the dimensions around trust, relationships and human interactions, which are fundamental to the service encounter.

The study has demonstrated that while SERVQUAL remains the most influential model in measuring service quality, a new direction is needed. Its use of expectations is inconclusive, since these may be formed at various stages of the process and service users may define the concept in a number of ways. Although the authors claim that the model was designed following research into high-contact services, it does not mirror the highly complex and interactive nature of health care in its dimensions. Although the original ten-item model was a closer fit than the later adapted model with five items, it still failed to reflect the emotional implications of health care where some dimensions were too process related and, in particular, it did not address the intricacies of communications.

Among other concerns is that fact that SERVQUAL measures customer service rather than service quality. The findings of reports into poor service quality in health care have stressed the need to understand the construct and to identify trends in poor performance allowing management to focus on reversing those trends.

6.7.2 Identify and Evaluate Existing Service Quality Approaches in Health Care

Former US Secretary of Defence Robert McNamara reportedly said, *"We have to find a way of making the important measurable, instead of making the measurable important".* This quotation resonates in respect of the way in which targets and performance have been the focus in health care, rather than quality. Trusts have used balanced scorecards to measure performance against nationally and politically set targets at the expense of quality and local needs. While targets have their place in monitoring outcomes and waiting times, etc., there has long been a need to focus more on quality. Although recognised as hugely influential and designed to link action with objectives and targets, balanced scorecards ignore the softer elements of real

service quality such as communications, rapport, empathy and responsiveness (among others) that come together to deliver the caring part of health care.

The Francis Report and the Keogh Report both found the hospitals under review failing not only in clinical interventions and outcomes but also in quality factors. The local general hospital included in this study saw two respondents, who were family of patients, express serious concern over a number of quality items which were both procedural and related to quality. Communications had failed, addressing patient needs to maximise comfort had not been considered and treatment had not been provided. An interview with the medical director of the same hospital showed that the only measures used were against the national targets. Although anecdotal, it does suggest that performance measures are insufficient and that failings in other quality items can have serious consequences.

One of the major difficulties in its evaluation is defining what service quality actually means and unless managers understand this it cannot be measured effectively.

While a cornucopia of measures are used in UK health care, there has been little in the way of a common understanding aside from the target-driven elements. However, a step change is happening in response to the backlash against too many examples of failing services. Greater emphasis is now being placed on patient experience and involvement. Boards are also being forced to provide the leadership in this, where previously responsibility was often tacked on to a person's job description. Nevertheless, there is currently no universally accepted tool that exists for use at local level. Once more robust techniques and greater levels of continuity are established alongside boards taking ownership, then service quality should experience significant improvements.

6.7.3 Understand the Meaning of Quality to Health Care Users and Managers

One of the weaknesses the Department of Health has been guilty of in recent years is failing to understand what factors are important to patients and their families. This has been apparent in the use of balanced scorecards in what became a target-driven environment. Although national surveys have included quality measures as opposed

to process measures, they have been criticised for being designed to satisfy political criteria rather than local needs. While individual trusts have been given the option to add some of their own questions, there have been risks that the questionnaires have become too lengthy.

The findings of this piece of research do point to some synergy between what the public see as important and the perceptions of service providers. There are, however, some anomalies, particularly around trust, tangibles and staff. While trust has the highest priority for the public it only scored third in provider interviews. A possible explanation for this is that managers wrongly assume trust is inherent in all they do. Although tangibles scored relatively highly for service users, for the providers it rated the highest. It was interesting to note that staff were the second-highest-scoring element for providers. This may be because they see what is going on behind the scenes and the effect this has on the service encounter.

Although communications was one of the higher-scoring elements for both groups there was little similarity in how the component items scored, suggesting that a greater understanding of the dimension is needed, especially as the critical incident interviews showed it as being the element which failed most often.

Management also needs to be aware of attitude, which, again, was seen as being of concern among the interviewees for critical incidents, yet did not attract much discussion for service providers.

The findings support the importance of the interrelational elements of services in determining quality from the perspective of users, which is not entirely replicated with service providers. However, in the rapidly changing environment of health care in the UK during 2013, the emphasis may shift due to the publication of two highly critical reports and the prominence that is being accorded to these elements in order to rebuild trust.

6.7.4 Propose a Construct of Service Quality Relevant to Health Care

The ultimate aim of this work was to validate a construct of service quality in health care. The study has produced four main outcomes:

- The findings have proposed a conceptual model for health care (Figure 5.5) which identifies four indicators for health care: process, relational, environment and technical . These are based on four factors: trust, access, caring approach and professionalism. With the exception of access, each relies to a considerable extent on relational elements..

- There has been too much emphasis on target-driven measures as opposed to the service elements that centre on human interactions, which are key to promoting service quality in health care. The findings have produced a four-factor model which largely reflects this premise.

  Trust:

  - *Having trust in the clinical ability of the professional.*
  - *Information is passed to other departments/agencies if necessary.*
  - *Professional takes time to conduct examination/ treatment/tests.*
  - *Calls for assistance are answered in a timely manner.*
  - *My full medical history is used when necessary in making a diagnosis.*
  - *Not to feel a nuisance when asking for help in hospital.*
  - *Professionals have all relevant information about me to hand.*
  - *Information given by different staff/departments is consistent.*
  - *Appropriate information is given to me at all times.*
  - *Needs are assessed and appropriate action taken if there is a problem.*
  - *Feeling the professional listens to what I say.*
  - *Staff show a willingness to help.*
  - *To feel the doctor trusts me.*
  - *Staff do what they say when they say.*
  - *Staff are aware of my fears.*
  - *Complaints are addressed in a timely manner.*
  - *I know who to speak to if I have concerns.*

  Access:

  - *Not to spend lengthy periods in waiting rooms.*
  - *Appointments not to run late.*
  - *Explanations to be given if appointments run late.*
  - *Plenty of notice given for cancelled appointments.*

Caring Approach:

- *Professional helps me to relax.*
- *Professional to be friendly and informal.*
- *Local clinics/surgeries to be visually pleasing.*
- *Hospital wards to be bright and welcoming.*
- *To be shown respect.*
- *Staff to have 'people skills'.*

Professionalism:

- *The professional knows me and understands my needs.*
- *Hospital's records on cleanliness/MRSA/ C. diff/E. coli are available.*
- *To know my doctor.*
- *The hospital has a good reputation.*

The model requires slight adaptation to reflect the individual needs of community services and the hospital environment.

- Questionnaires are a useful tool in the evaluation of service quality at a local level if appropriately designed. They are simple and cheap to administer. However, factor analysis removed a number of items that had received high scores from respondents. This leads to the supposition that questionnaires alone are insufficiently robust to provide an in-depth picture of service quality rather than customer satisfaction and need to be supported by periodic qualitative research techniques to generate deeper understanding of issues. Adopting these complementary methods ensures that trends and themes are monitored to ensure that patient priorities are reflected while generalising them across a wide population of patients.

- Staff at all levels of the organisation should be included in the process, not only in taking responsibility for service quality as assumed by the service-dominant logic, but also as respondents so that any gaps between their perceptions and those of patients and family are identified and closed as soon as possible.

6.7.5 In Conclusion

The time is ripe for driving forward the effective evaluation of the non-clinical side of service quality in health care. Failures have been seen to contribute to tragic consequences, which has caused the Government to place the issue high on the agenda. All service providers are required to adopt it at board level and to demonstrate how they are promoting quality. While much research is being done in this area, there is still a lack of a generally accepted model for use at local level, and it is doubtful whether many trusts have the required levels of expertise and even less likely that community services do. There is a massive window of opportunity to develop further research in the field with a view to supporting the improvement in service quality for all.

6.8 PERSONAL REFLECTIONS

This study has been truly iterative, where the process has developed as the research progressed and my skills have matured. Coming into the work with some experience of qualitative research in a previous role working with public consultations in the health service, I had some basic skills in interview techniques and conducting focus groups, though very little in terms of quantitative research.

6.8.1 Reflections on the Qualitative Process

The first phase of this research was purely qualitative, using storytelling to identify critical incidents. The unstructured nature of the work allowed participants to reflect on some very sensitive events of their lives, for which a background in health care was valuable as it gave me some understanding of the issues coming out of what was being explained from a professional point of view. It was also an emotional challenge at times as I had experienced similar personal encounters in the recent past. These professional and personal experiences required a level of caution in that there was a danger they could influence the way in which interviews were conducted, with potential leading questions as well as the way the feedback was interpreted. It was important to put personal perceptions to one side. Although I could relate to what some participants were saying, I was conscious of the potential conflict in interest and I did feel that I was able to separate myself from what they were saying. This applied to both the critical incident process in Phase 1 and Phase 2, which involved the focus groups and interviews.

Interestingly, it was during the interviews with service providers that it was most difficult for me to remain emotionally unattached, as it was tempting to refer to past experience of being a close family member of a patient who received poor care. It would have been easy to direct questions which reflected where different service elements had failed. This was especially true in the case of interviewing the medical director of a local general hospital. Nevertheless, this was one of the last interviews and by this stage I was able to place it in context with the research as a whole and with previous feedback.

My professional background undoubtedly helped in the interviews with service providers, as I was able to lead the conversation in a knowledgeable manner, at a time when the NHS was undergoing perhaps the most significant changes in its history. I understood the background to these, their aims and the challenges they were going to bring with them. I also understood how the changes would affect structures. Not least was my appreciation of contemporary issues around service quality and the ways in which they had been addressed in the past and how they were being placed as a high priority in the new NHS structure.

There were particular challenges with the focus groups involving older people and those with complex needs. The former group were wary of the purpose of the meeting and tended to get away from the point of the discussion. Some spoke very quietly and there was a level of background noise (this group was held in the dining room of a residential home). This was a case where my professional NHS background in consultations helped. I felt I was able to build their trust through starting off the meeting in a very chatty way which, in turn, built their confidence. A similar approach was adopted with the group who had complex needs, although there were added challenges here where some members of the group had serious communication difficulties. I felt embarrassed at times when I was unable to understand what they were saying and had to rely on one of their helpers. I felt this was a little disrespectful on my part, although unavoidable.
Transcription of the feedback was a lengthy process ,which required listening very closely to the digital recordings to hear exactly what was being said when either the participants had communication difficulties, there was background noise, or several

people were speaking simultaneously. It was also necessary to ensure I understood exactly what was being conveyed where some statements were ambiguous. As I became more accustomed to this, it did become easier.

Coding the transcripts was equally lengthy and required several attempts. With each reading it was possible to see different ways in which individual pieces of text could be coded. There were no clear-cut rules and it supported the argument that results cannot be generalised. It was a valuable learning curve and one which again became easier as I gained increasing familiarity with the information.

6.8.2 Reflecting on the Quantitative Process

Having no previous experience in quantitative research, I found this part of the study the most arduous. The design of the questionnaire was relatively straightforward using the results of the qualitative work, although some interesting and useful comments were made during the piloting stage, which proved invaluable as part of the learning process. I was overwhelmed with the response rate of 20%, which demonstrated the importance the general public places on health services.

While entering data from over 1,100 responses was onerous, it was not difficult. The use of factor analysis, however, was not quite so straightforward for someone with little knowledge of statistical techniques. After extensive reading round the technique and with support from supervisors, numerous iterations were carried out. The interpretation of the results was made more difficult because the patterns emanating from the analysis were not particularly strong. It took some time before meaningful results were achieved that could be robustly justified. It also took time for me to acknowledge the way in which the results of the factor analysis failed to reflect the ratings respondents of the questionnaire placed on items. The factor analysis reduced the items considerably, removing a number of those that respondents had said were important. The fact that it is not possible to consolidate these did cause some problems, until I came to understand that the process was demonstrating that the use of questionnaires alone is insufficient to evaluate service quality in health care. Qualitative work is needed to augment these.

The progression from a complete lack of knowledge and skill in the use of factor analysis to a level where I could legitimately argue the validity of the results has given me a new competence which can be applied to later work.

6.8.3 Reflections on the Methodology

Prior to undertaking the research, I had no appreciation of the philosophy behind differing approaches. After struggling with the different paradigms and concepts, I realised that my practical standpoint fitted with the more recently recognised philosophical school of pragmatism. Research into health care must take into account the complexities of professional relationships, involvement of different disciplines and agencies and the multitude of different service elements which interrelate, all of which necessitate the acquisition of rich and detailed qualitative data to understand the construct. This, however, does not provide the necessary generalisability required in a sector which touches every member of society at some part of their lives. Only quantitative research can attempt this. On reflection I believe that the use of complementary methods in this research was the correct approach to take. The focus groups and interviews represented a reasonably wide cross section of participants and have left open an opportunity for more detailed studies to compare the varying perceptions of different socioeconomic and age groups.
The work has taken me from a raw student of research with a steep learning process ahead to a reasonably able practitioner with the potential to develop my research skills for future studies.

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APPENDICES

APPENDIX 1

NHS HOSPITAL INPATIENT SURVEY

INPATIENT QUESTIONNAIRE

What is the survey about?

This survey is about your **most recent** experience as an **inpatient** at the National Health Service hospital named in the letter enclosed with this questionnaire.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his / her point of view – not the point of view of the person who is helping.

Completing the questionnaire

For each question please cross ☒ clearly inside one box using a black or blue pen. For some questions you will be instructed that you may cross more than one box.

Sometimes you will find the box you have crossed has an instruction to go to another question. By following the instructions carefully you will miss out questions that do not apply to you.

Don't worry if you make a mistake; simply fill in the box ■ and put a cross ☒ in the correct box.

Please **do not** write your name or address anywhere on the questionnaire.

Questions or help?

If you have any queries about the questionnaire, please call the helpline number given in the letter enclosed with this questionnaire.

Taking part in this survey is voluntary. **Your answers will be treated in confidence.**

Please remember, this questionnaire is about your **most recent** stay at the hospital named in the accompanying letter.

ADMISSION TO HOSPITAL

1. Was your most recent hospital stay planned in advance or an emergency?

1 ☐ Emergency or urgent → **Go to 2**

2 ☐ Waiting list or planned in advance → **Go to 5**

3 ☐ Something else → **Go to 2**

THE ACCIDENT & EMERGENCY DEPARTMENT

2. When you arrived at the hospital, did you go to the A&E Department (also known as the Emergency Department, Casualty, Medical or Surgical Admissions unit)?

1 ☐ Yes → **Go to 3**

2 ☐ No → **Go to 5**

3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

1 ☐ Not enough

2 ☐ Right amount

3 ☐ Too much

4 ☐ I was not given any information about my treatment or condition

5 ☐ Don't know / can't remember

4. Were you given enough privacy when being examined or treated in the A&E Department?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ Don't know / can't remember

EMERGENCY & URGENTLY ADMITTED PATIENTS, now please go to Question 9

WAITING LIST & PLANNED ADMISSION PATIENTS, please continue to Question 5

WAITING LIST OR PLANNED ADMISSION

5. When you were referred to see a specialist, were you offered a choice of hospital for your **first hospital appointment?**

1 ☐ Yes

2 ☐ No, but I would have liked a choice

3 ☐ No, but I did not mind

4 ☐ Don't know / can't remember

6. How do you feel about the length of time you were on the waiting list before your admission to hospital?

1 ☐ I was admitted as soon as I thought was necessary

2 ☐ I should have been admitted a bit sooner

3 ☐ I should have been admitted a lot sooner

7. Was your admission date changed by the hospital?

1 ☐ No
2 ☐ Yes, once
3 ☐ Yes, 2 or 3 times
4 ☐ Yes, 4 times or more

8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ Don't know / can't remember

ALL TYPES OF ADMISSION

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No

THE HOSPITAL & WARD

10. While in hospital, did you ever stay in a critical care area (e.g. Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know / can't remember

11. When you were **first** admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?

1 ☐ Yes
2 ☐ No

12. During your stay in hospital, how many wards did you stay in?

1 ☐ 1 → **Go to 14**
2 ☐ 2 → **Go to 13**
3 ☐ 3 or more → **Go to 13**
4 ☐ Don't know / can't remember → **Go to 14**

13. **After you moved** to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

1 ☐ Yes
2 ☐ No

14. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

1 ☐ Yes
2 ☐ Yes, because it had special bathing equipment that I needed
3 ☐ No
4 ☐ I did not use a bathroom or shower
5 ☐ Don't know / can't remember

15. Were you ever bothered by noise **at night** from **other patients**?

1 ☐ Yes
2 ☐ No

16. Were you ever bothered by noise **at night** from **hospital staff**?

1 ☐ Yes

2 ☐ No

17. In your opinion, how clean was the hospital room or ward that **you** were in?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

18. How clean were the toilets and bathrooms that **you** used in hospital?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ I did not use a toilet or bathroom

19. Did you feel threatened during your stay in hospital by other patients or visitors?

1 ☐ Yes

2 ☐ No

20. Were hand-wash gels available for patients and visitors to use?

1 ☐ Yes

2 ☐ Yes, but they were empty

3 ☐ I did not see any hand-wash gels

4 ☐ Don't know / can't remember

21. How would you rate the hospital food?

1 ☐ Very good

2 ☐ Good

3 ☐ Fair

4 ☐ Poor

5 ☐ I did not have any hospital food

22. Were you offered a choice of food?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

23. Did you get enough help from staff to eat your meals?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I did not need help to eat meals

DOCTORS

24. When you had important questions to ask a doctor, did you get answers that you could understand?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I had no need to ask

25. Did you have confidence and trust in the doctors treating you?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

26. Did doctors talk in front of you as if you weren't there?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

NURSES

27. When you had important questions to ask a nurse, did you get answers that you could understand?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I had no need to ask

28. Did you have confidence and trust in the nurses treating you?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

29. Did nurses talk in front of you as if you weren't there?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

30. In your opinion, were there enough nurses on duty to care for **you** in hospital?

1 ☐ There were always or nearly always enough nurses

2 ☐ There were sometimes enough nurses

3 ☐ There were rarely or never enough nurses

YOUR CARE & TREATMENT

31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

32. Were you involved as much as you wanted to be in decisions about your care and treatment?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

33. How much information about your condition or treatment was given to **you**?

1 ☐ Not enough

2 ☐ The right amount

3 ☐ Too much

34. Did you find someone on the hospital staff to talk to about your worries and fears?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I had no worries or fears

35. Do you feel you got enough emotional support from hospital staff during your stay?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I did not need any emotional support

36. Were you given enough privacy when discussing your condition or treatment?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

37. Were you given enough privacy when being examined or treated?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

38. Were you ever in any pain?

1 ☐ Yes → **Go to 39**

2 ☐ No → **Go to 40**

39. Do you think the hospital staff did everything they could to help control your pain?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

40. How many minutes after you used the call button did it usually take before you got the help you needed?

1 ☐ 0 minutes / right away

2 ☐ 1-2 minutes

3 ☐ 3-5 minutes

4 ☐ More than 5 minutes

5 ☐ I never got help when I used the call button

6 ☐ I never used the call button

OPERATIONS & PROCEDURES

41. During your stay in hospital, did you have an operation or procedure?

1 ☐ Yes → **Go to 42**

2 ☐ No → **Go to 49**

42. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not want an explanation

43. Beforehand, did a member of staff explain what would be done during the operation or procedure?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not want an explanation

44. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not have any questions

45. Beforehand, were you told how you could expect to feel after you had the operation or procedure?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

46. Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?

1 ☐ Yes → **Go to 47**

2 ☐ No → **Go to 48**

47. Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

48. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

LEAVING HOSPITAL

49. Did you feel you were involved in decisions about your discharge from hospital?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not want to be involved

50. Were you given enough notice about when you were going to be discharged?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

51. On the day you left hospital, was your discharge delayed for any reason?

1 ☐ Yes → **Go to 52**

2 ☐ No → **Go to 54**

52. What was the **MAIN** reason for the delay? (**Cross ONE box only**)

1 ☐ I had to wait for **medicines**

2 ☐ I had to wait to **see the doctor**

3 ☐ I had to wait for an **ambulance**

4 ☐ Something else

53. How long was the delay?

1 ☐ Up to 1 hour

2 ☐ Longer than 1 hour but no longer than 2 hours

3 ☐ Longer than 2 hours but no longer than 4 hours

4 ☐ Longer than 4 hours

54. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

1 ☐ Yes

2 ☐ No

55. Did a member of staff explain the **purpose** of the medicines you were to take at home in a way you could understand?

1 ☐ Yes, completely → **Go to 56**

2 ☐ Yes, to some extent → **Go to 56**

3 ☐ No → **Go to 56**

4 ☐ I did not need an explanation → **Go to 56**

5 ☐ I had no medicines → **Go to 59**

56. Did a member of staff tell you about medication **side effects** to watch for when you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

57. Were you told how to **take** your medication in a way you could understand?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need to be told how to take my medication

58. Were you given clear written or printed information about your medicines?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this

5 ☐ Don't know / can't remember

59. Did a member of staff tell you about any danger signals you should watch for after you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ It was not necessary

60. Did hospital staff take your family or home situation into account when planning your discharge?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ It was not necessary

5 ☐ Don't know / can't remember

61. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ No family or friends were involved

5 ☐ My family or friends did not want or need information

62. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / can't remember

63. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?

1 ☐ Yes

2 ☐ No, but I would have liked them to

3 ☐ No, it was not necessary to discuss it

64. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)

1 ☐ Yes

2 ☐ No, but I would have liked them to

3 ☐ No, it was not necessary to discuss it

65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

1 ☐ Yes, I received copies → **Go to 66**

2 ☐ No, I did not receive copies → **Go to 67**

3 ☐ Not sure / don't know → **Go to 67**

66. Were the letters written in a way that you could understand?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ Not sure / don't know

OVERALL

67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

68. Overall... (**Please circle a number**)

I had a very poor experience — I had a very good experience

0 1 2 3 4 5 6 7 8 9 10

69. During your hospital stay, were you ever asked to give your views on the quality of your care?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / can't remember

70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

1 ☐ Yes

2 ☐ No

3 ☐ Not sure / don't know

ABOUT YOU

71. Who was the main person or people that filled in this questionnaire?

1 ☐ The **patient** (named on the front of the envelope)

2 ☐ A **friend or relative** of the patient

3 ☐ **Both** patient and friend/relative together

4 ☐ The patient with the help of a health professional

Reminder: All the questions should be answered from the point of view of the person named on the envelope. This includes the following background questions.

72. Are you male or female?

1 ☐ Male

2 ☐ Female

73. What was your **year** of birth?

(**Please write in**) e.g. | 1 | 9 | 3 | 4 |

1	9	Y	Y

74. Do you have any of the following long-standing conditions? (**Cross ALL boxes that apply**)

1 ☐ Deafness or severe hearing impairment → **Go to 75**

2 ☐ Blindness or partially sighted → **Go to 75**

3 ☐ A long-standing physical condition → **Go to 75**

4 ☐ A learning disability → **Go to 75**

5 ☐ A mental health condition → **Go to 75**

6 ☐ A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy → **Go to 75**

7 ☐ No, I do not have a long-standing condition → **Go to 76**

75. Does this condition(s) cause you difficulty with any of the following? (**Cross ALL boxes that apply**)

1 ☐ Everyday activities that people your age can usually do

2 ☐ At work, in education, or training

3 ☐ Access to buildings, streets, or vehicles

4 ☐ Reading or writing

5 ☐ People's attitudes to you because of your condition

6 ☐ Communicating, mixing with others, or socialising

7 ☐ Any other activity

8 ☐ No difficulty with any of these

76. What is your ethnic group? (**Cross ONE box only**)

a. WHITE

1 ☐ English / Welsh / Scottish / Northern Irish / British

2 ☐ Irish

3 ☐ Gypsy or Irish Traveller

4 ☐ Any other White background, **write in.....**

b. MIXED / MULTIPLE ETHNIC GROUPS

5 ☐ White and Black Caribbean

6 ☐ White and Black African

7 ☐ White and Asian

8 ☐ Any other Mixed / multiple ethnic background, **write in.....**

c. ASIAN / ASIAN BRITISH

9 ☐ Indian

10 ☐ Pakistani

11 ☐ Bangladeshi

12 ☐ Chinese

13 ☐ Any other Asian background, **write in....**

d. BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH

14 ☐ African

15 ☐ Caribbean

16 ☐ Any other Black / African / Caribbean background, **write in.....**

e. OTHER ETHNIC GROUP

17 ☐ Arab

18 ☐ Any other ethnic group, **write in.....**

77. What is your religion?

1 ☐ No religion

2 ☐ Buddhist

3 ☐ Christian (including Church of England, Catholic, Protestant, and other Christian denominations)

4 ☐ Hindu

5 ☐ Jewish

6 ☐ Muslim

7 ☐ Sikh

8 ☐ Other

9 ☐ I would prefer not to say

78. Which of the following best describes how you think of yourself?

1 ☐ Heterosexual / straight

2 ☐ Gay / lesbian

3 ☐ Bisexual

4 ☐ Other

5 ☐ I would prefer not to say

APPENDIX 2

NHS GP PATIENT SURVEY

Ipsos MORI

NHS

THE GP PATIENT SURVEY

Please answer the questions below by putting an ✘ in ONE BOX for each question unless more than one answer is allowed (these questions are clearly marked). We will keep your answers completely confidential.

If you would prefer to **complete the survey online**, please go to **www.gp-patient.co.uk**

Reference: **1234567890** Online password: **ABCDE** BSL

ACCESSING YOUR GP SERVICES

Q1 When did you last see or speak to a GP from your GP surgery?

- ☐ In the past 3 months
- ☐ Between 3 and 6 months ago
- ☐ Between 6 and 12 months ago
- ☐ More than 12 months ago
- ☐ I have never seen a GP from my GP surgery

Q2 When did you last see or speak to a nurse from your GP surgery?

- ☐ In the past 3 months
- ☐ Between 3 and 6 months ago
- ☐ Between 6 and 12 months ago
- ☐ More than 12 months ago
- ☐ I have never seen a nurse from my GP surgery

Q3 Generally, how easy is it to get through to someone at your GP surgery on the phone?

- ☐ Very easy
- ☐ Fairly easy
- ☐ Not very easy
- ☐ Not at all easy
- ☐ Haven't tried

Q4 How helpful do you find the receptionists at your GP surgery?

- ☐ Very helpful
- ☐ Fairly helpful
- ☐ Not very helpful
- ☐ Not at all helpful
- ☐ Don't know

Q5 In the reception area, can other patients overhear what you say to the receptionist?

- ☐ Yes, but I don't mind
- ☐ Yes, and I'm not happy about it
- ☐ No, other patients can't overhear

Q6 How do you normally book your appointments to see a GP or nurse at your GP surgery?

Please ✘ all the boxes that apply to you

- ☐ In person
- ☐ By phone
- ☐ By fax machine
- ☐ Online
- ☐ Doesn't apply

Q7 Which of the following methods would you prefer to use to book appointments at your GP surgery?

Please ✘ all the boxes that apply to you

- ☐ In person
- ☐ By phone
- ☐ By fax machine
- ☐ Online
- ☐ No preference

Q8 Is there a particular GP you usually prefer to see or speak to?

- ☐ Yes
- ☐ No ..... Go to Q10
- ☐ There is usually only one GP in my GP surgery ..... Go to Q10

Q9 How often do you see or speak to the GP you prefer?

- ☐ Always or almost always
- ☐ A lot of the time
- ☐ Some of the time
- ☐ Never or almost never
- ☐ Not tried at this GP surgery

MAKING AN APPOINTMENT

Q10 **Last time you wanted to see or speak to a GP or nurse from your GP surgery:**

What did you want to do?

- ☐ See a GP at the surgery
- ☐ See a nurse at the surgery
- ☐ Speak to a GP on the phone
- ☐ Speak to a nurse on the phone
- ☐ Have someone visit me at my home
- ☐ I didn't mind / wasn't sure what I wanted

Q11 **And when did you want to see or speak to them?**

- ☐ On the same day
- ☐ On the next working day
- ☐ A few days later
- ☐ A week or more later
- ☐ I didn't have a specific day in mind
- ☐ Can't remember

Q12 **Were you able to get an appointment to see or speak to someone?**

- ☐ Yes
- ☐ Yes, but I had to call back closer to or on the day I wanted the appointment
- ☐ No ..... Go to Q16
- ☐ Can't remember ..... Go to Q18

Q13 **What type of appointment did you get?**

I got an appointment...

- ☐ ...to see a GP at the surgery
- ☐ ...to see a nurse at the surgery
- ☐ ...to speak to a GP on the phone
- ☐ ...to speak to a nurse on the phone
- ☐ ...for someone to visit me at my home

Q14 **How long after initially contacting the surgery did you actually see or speak to them?**

- ☐ On the same day
- ☐ On the next working day
- ☐ A few days later
- ☐ A week or more later
- ☐ Can't remember

Q15 **How convenient was the appointment you were able to get?**

- ☐ Very convenient ..... Go to Q18
- ☐ Fairly convenient ..... Go to Q18
- ☐ Not very convenient
- ☐ Not at all convenient

Q16 **If you weren't able to get an appointment or the appointment you were offered wasn't convenient, why was that?**

- ☐ There weren't any appointments for the day I wanted
- ☐ There weren't any appointments for the time I wanted
- ☐ I couldn't see my preferred GP
- ☐ I couldn't book ahead at my GP surgery
- ☐ Another reason

Q17 **What did you do on that occasion?**

- ☐ Went to the appointment I was offered
- ☐ Got an appointment for a different day
- ☐ Had a consultation over the phone
- ☐ Went to A&E / a walk-in centre
- ☐ Saw a pharmacist
- ☐ Decided to contact my surgery another time
- ☐ Didn't see or speak to anyone

Q18 **Overall, how would you describe your experience of making an appointment?**

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor

WAITING TIMES

Q19 **How long after your appointment time do you normally wait to be seen?**

- ☐ I don't normally have appointments at a particular time
- ☐ Less than 5 minutes
- ☐ 5 to 15 minutes
- ☐ More than 15 minutes
- ☐ Can't remember

Q20 **How do you feel about how long you normally have to wait to be seen?**

- ☐ I don't normally have to wait too long
- ☐ I have to wait a bit too long
- ☐ I have to wait far too long
- ☐ No opinion / doesn't apply

LAST GP APPOINTMENT

Q21 **Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following?**

Giving you enough time

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Listening to you

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Explaining tests and treatments

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Involving you in decisions about your care

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Treating you with care and concern

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Q22 **Did you have confidence and trust in the GP you saw or spoke to?**

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No, not at all
- ☐ Don't know / can't say

LAST NURSE APPOINTMENT

Q23 **Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at each of the following?**

Giving you enough time

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Listening to you

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Explaining tests and treatments

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Involving you in decisions about your care

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Treating you with care and concern

- ☐ Very good
- ☐ Good
- ☐ Neither good nor poor
- ☐ Poor
- ☐ Very poor
- ☐ Doesn't apply

Q24 **Did you have confidence and trust in the nurse you saw or spoke to?**

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No, not at all
- ☐ Don't know / can't say

OPENING HOURS

Q25 **How satisfied are you with the hours that your GP surgery is open?**

- ☐ Very satisfied
- ☐ Fairly satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Fairly dissatisfied
- ☐ Very dissatisfied
- ☐ I'm not sure when my GP surgery is open

Q26 **Is your GP surgery currently open at times that are convenient for you?**

- ☐ Yes ..... Go to Q28
- ☐ No
- ☐ Don't know

Q27 **Which of the following additional opening times would make it easier for you to see or speak to someone?**

Please ✗ all the boxes that apply to you

- ☐ Before 8am
- ☐ At lunchtime
- ☐ After 6.30pm
- ☐ On a Saturday
- ☐ On a Sunday
- ☐ None of these

OVERALL EXPERIENCE

Q28 **Overall, how would you describe your experience of your GP surgery?**

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor

Q29 **Would you recommend your GP surgery to someone who has just moved to your local area?**

- ☐ Yes, would definitely recommend
- ☐ Yes, would probably recommend
- ☐ Not sure
- ☐ No, would probably not recommend
- ☐ No, would definitely not recommend
- ☐ Don't know

MANAGING YOUR HEALTH

Q30 **Do you have a long-standing health condition?**

- ☐ Yes
- ☐ No
- ☐ Don't know / can't say

Q31 **Which, if any, of the following medical conditions do you have?**

Please ✗ all the boxes that apply to you

- ☐ Alzheimer's disease or dementia
- ☐ Angina or long-term heart problem
- ☐ Arthritis or long-term joint problem
- ☐ Asthma or long-term chest problem
- ☐ Blindness or severe visual impairment
- ☐ Cancer in the last 5 years
- ☐ Deafness or severe hearing impairment
- ☐ Diabetes
- ☐ Epilepsy
- ☐ High blood pressure
- ☐ Kidney or liver disease
- ☐ Learning difficulty
- ☐ Long-term back problem
- ☐ Long-term mental health problem
- ☐ Long-term neurological problem
- ☐ Another long-term condition
- ☐ None of these conditions ..... Go to Q33
- ☐ I would prefer not to say ..... Go to Q33

Q32 **In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?**

Please think about all services and organisations, not just health services

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No
- ☐ I haven't needed such support
- ☐ Don't know / can't say

Q33 **How confident are you that you can manage your own health?**

- ☐ Very confident
- ☐ Fairly confident
- ☐ Not very confident
- ☐ Not at all confident

YOUR STATE OF HEALTH TODAY

Q34 **By placing an ✗ in one box in each group below, please indicate which statements best describe your own health state <u>today</u>.**

Mobility

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

Self-Care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

Pain / Discomfort

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety / Depression

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

Q35 **Have your activities been limited <u>today</u> because you have recently become unwell or been injured?**

By 'unwell or injured' we mean anything that only lasts for a few days or weeks, e.g. a bad cold or broken leg

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No

PLANNING YOUR CARE

The next few questions are about care plans.

A care plan is an agreement between you and your health professional(s) to help you manage your health day-to-day.

It is usually a written document you carry with you to appointments and use at home. It can include information about your medicine, an eating or exercise plan, or goals you want to work toward, like returning to work.

Q36 **Do you have a written care plan?**

- ☐ Yes
- ☐ No ..... Go to Q40
- ☐ Don't know ..... Go to Q40

Q37 **Did you help put your written care plan together?**

By 'helping' we mean setting goals for yourself or choosing how you want to manage your health

- ☐ Yes
- ☐ No

Q38 **Do you use your written care plan to help you manage your health day-to-day?**

- ☐ Yes
- ☐ No

Q39 **Does your GP, nurse or other health professional review your written care plan with you regularly?**

- ☐ Yes
- ☐ No
- ☐ Don't know

OUT OF HOURS

These questions are about contacting an out-of-hours GP service when your GP surgery is closed.

Don't include NHS Direct, NHS walk-in centres or A&E.

Q40 **Do you know how to contact an out-of-hours GP service when the surgery is closed?**

- ☐ Yes
- ☐ No

Q41 **In the past 6 months, have you tried to call an out-of-hours GP service when the surgery was closed?**

- ☐ Yes, for myself
- ☐ Yes, for someone else
- ☐ No ..... Go to Q46

Q42 **How easy was it to contact the out-of-hours GP service by telephone?**

- ☐ Very easy
- ☐ Fairly easy
- ☐ Not very easy
- ☐ Not at all easy
- ☐ Don't know / didn't make contact

Q43 **How do you feel about how quickly you received care from the out-of-hours GP service?**

- ☐ It was about right
- ☐ It took too long
- ☐ Don't know / doesn't apply

Q44 **Did you have confidence and trust in the out-of-hours clinician you saw or spoke to?**

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No, not at all
- ☐ Don't know / can't say

Q45 **Overall, how would you describe your experience of out-of-hours GP services?**

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor

NHS DENTISTRY

Q46 **When did you last try to get an NHS dental appointment for yourself?**

- ☐ In the last 3 months
- ☐ Between 3 and 6 months ago
- ☐ Between 6 months and a year ago
- ☐ Between 1 and 2 years ago
- ☐ More than 2 years ago ..... Go to Q50
- ☐ I have never tried to get an NHS dental appointment..... Go to Q50

Q47 **Last time you tried to get an NHS dental appointment, was it with a dental practice you had been to before for NHS dental care?**

- ☐ Yes
- ☐ No
- ☐ Can't remember

Q48 **Were you successful in getting an NHS dental appointment?**

- ☐ Yes
- ☐ No
- ☐ Can't remember

Q49 **Overall, how would you describe your experience of NHS dental services?**

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor

Please go to Q51

Q50 **Why haven't you tried to get an NHS dental appointment in the last two years?**

If more than one of these applies to you, please X the main ONE only

- ☐ I haven't needed to visit a dentist
- ☐ I no longer have any natural teeth
- ☐ I haven't had time to visit a dentist
- ☐ I don't like going to the dentist
- ☐ I didn't think I could get an NHS dentist
- ☐ I'm on a waiting list for an NHS dentist
- ☐ I stayed with my dentist when they changed from NHS to private
- ☐ I prefer to go to a private dentist
- ☐ NHS dental care is too expensive
- ☐ Another reason

SOME QUESTIONS ABOUT YOU

The following questions will help us to see how experiences vary between different groups of the population. We will keep your answers completely confidential.

Q51 **Are you male or female?**

- ☐ Male
- ☐ Female

Q52 **How old are you?**

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 to 84
- ☐ 85 or over

Q53 **What is your ethnic group?**

A. White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background

Please write in ☐

B. Mixed / multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed / multiple ethnic background

Please write in ☐

C. Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Please write in ☐

D. Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black / African / Caribbean background

Please write in ☐

E. Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group

Please write in ☐

Q54 **Which of these best describes what you are doing at present?**

If more than one of these applies to you, please ✗ the main ONE only

- ☐ Full-time paid work (30 hours or more each week)
- ☐ Part-time paid work (under 30 hours each week)
- ☐ Full-time education at school, college or university
- ☐ Unemployed
- ☐ Permanently sick or disabled
- ☐ Fully retired from work
- ☐ Looking after the home
- ☐ Doing something else

Please go to Q57

Q55 **In general, how long does your journey take from home to work (door to door)?**

- ☐ Up to 30 minutes
- ☐ 31 minutes to 1 hour
- ☐ More than 1 hour
- ☐ I live on site

Q56 **If you need to see a GP at your GP surgery during your typical working hours, can you take time away from your work to do this?**

- ☐ Yes
- ☐ No

Q57 **Are you a parent or a legal guardian for any children aged under 16 living in your home?**

- ☐ Yes
- ☐ No

Q58 **Are you a deaf person who uses sign language?**

- ☐ Yes
- ☐ No

Q59 **Which of the following best describes your smoking habits?**

- ☐ Never smoked
- ☐ Former smoker
- ☐ Occasional smoker
- ☐ Regular smoker

Q60 **Do you look after, or give any help or support to family members, friends, neighbours or others because of either:**

- **long-term physical or mental ill health / disability, or**
- **problems related to old age?**

Don't count anything you do as part of your paid employment

- ☐ No
- ☐ Yes, 1-9 hours a week
- ☐ Yes, 10-19 hours a week
- ☐ Yes, 20-34 hours a week
- ☐ Yes, 35-49 hours a week
- ☐ Yes, 50+ hours a week

Q61 **Which of the following best describes how you think of yourself?**

- ☐ Heterosexual / straight
- ☐ Gay / Lesbian
- ☐ Bisexual
- ☐ Other
- ☐ I would prefer not to say

Q62 **Which, if any, of the following best describes your religion?**

- ☐ No religion
- ☐ Buddhist
- ☐ Christian (including Church of England, Catholic, Protestant, and other Christian denominations)
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Other
- ☐ I would prefer not to say

Thank you for your time.
Please return this questionnaire in the reply paid envelope provided or send it in an envelope marked only FREEPOST GP PATIENT SURVEY (no stamp is needed).

Developed with University of Exeter Medical School | University of Cambridge

OTHER COMMENTS

If there is anything else you would like to tell us about your experiences in the hospital, please do so here.

Was there anything particularly good about your hospital care?

Was there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you.

Please post this questionnaire back in the FREEPOST envelope provided.
No stamp is needed.

APPENDIX 3

SAMPLE TRANSCRIPT

(PARTICIPANTS WITH COMPLEX MEDICAL NEEDS)

NOTES:

M represents the group leader

There were six participants with very diverse needs. Two helpers were also present due to the communication problems some of the participants had. For the purposes of anonymity, particpants are identified by numbers.

Items round SERVQUAL were not included as it was felt that some members of the group would have

M. I am looking at what is important to you in terms of health care. But first I want to ask you as what do you see as health care. Is it the hospital, your local doctor?

1. The local doctor. He is the first person you see. Your GP.

2. The dentist, the optician and the doctor.

3. It is the whole health set. The NHS and this centre for me is the social side.

1. And the dentist and that type of thing.

M. How many of you agree that it is the local doctor.

4. Yes the doctor

1. He is the first one you see.

5. Here it is the personal contact. *(Reference is made to the community centre where the focus group is taking place)*

M. This facility is more of the social side. So we will speak a little more on the health side of it. So if you think about your local doctor what is it that is important to you when you visit your doctor?

6. Sitting down. The wait.

3. Yes.

2. Getting through to the receptionists.

3. Trying to get through to make an appointment if you are really ill. I also had a 45 minute wait just to see the asthma nurse. I know there were a lot. But when your appointment is at a certain time you expect to be seen.

M. Getting through to the receptionist and the wait. Do you mean picking the phone up and getting through or the fact that you have to go through why you want to see the doctor? They don't automatically give you an appointment

3. If you are really ill they understand. Sometimes it is really difficult to get through to them why you want to see the doctor. But if I am really ill I do get through.

2. You can't get to see your own doctor so you have to see different doctors.

M. Right. Is that important to you?

1. I don't get on as well with some doctors as I do with my own doctor.

2. At our practice there are 6 or 7 different doctors and to make an appointment I have to take a chance. My doctor knows I have epilepsy. I ring up to seea particular doctor and they say no you can't see them at the moment.

M. Seeing your own doctor means he knows what your needs are.

2. Yes, that is right.

5. I don't go to the doctor's that often but when I do go it is always a different one. So I don't really know them. I don't really like that.

M. Are there any other aspects that are important to you? Do you automatically trust what the doctor says is correct?

4. They don't give you enough time.

6. I always see the same doctor and have done for five years. Sometimes you have to wait 20 minutes but that is OK. I trust the doctor.

M. Is that important to you?

6. I wouldn't want to see another GP.

M. Going back to the idea of trust. Do you think if you see the same GP all the time that makes you feel more able to trust them?

2. Yes.

6. I trust the GP better.

4. Yes it is better.

1. Yes, you do trust them better

2. I was bad one day here and when I went home I asked to GP to come. He said you are alright. I went to bed and I was foaming at the mouth and then had to go to hospital with meningitis. I was in six weeks. So I don't trust them now.

M. There is a tendency that we all do treat what the doctors says is gospel, but I get the feeling that is beginning to change a bit. Are there any other aspects for

example do you feel that the actual physical appearance of a surgery contributes anything?.

5. No

2. You want to be able to get in, to have access don't you.

M. Access, yes. You would think at a doctors' surgery that would be automatic to get access.

2. No. They put automatic doors on.

4. I have to go round the back. My wife pushes me

3. I have to have somebody to help me to get in.

5. Mine has automatic doors. Access is alright.

M. What about the waiting room? Sometimes the receptionist is asking you questions. Do you feel that sometimes you don't want to answer that in public?

Helper. I question my GP. I think you have to build that trust. I have had experiences where I have had to question the decisions and that has not been welcomed by the GP. But from your past experience it leads you to be more cautious around your treatment and whether it is the right treatment. I have had tests, they have all come back negative and I have been felt belittled by the language that some GPs and doctors use.

M. Have any others of you experienced that, where a doctor talks to you in a patronising manner? Is it important to you the way they talk to you?

1. They talk to you as though they know you and make sure you understand. They don't patronise you.

M. So your doctor is OK

1. Yes

3. In our surgery it has been done up. In the past in the same surgery it said anybody who is physically abusive or nasty will be struck off. But I have never had any problems like that.

M. I think that most surgeries now have posters about abuse given to staff. How do you find that doctors or receptionists talk to you? Do they speak to you on an equal level? How would you like them to speak to you?

2. They talk to you as though you are children.

5. My old GP when I was first diagnosed, I went to see a neurologist and he told the GP not to tell me about the diagnosis. *(This participant is referring to her diagnosis of multiple schlerosis).*

M. Had you suggested that you didn't want to know the results?

5. No, I wanted to know. When I approached her and said I want to know she then let me see the results. That should be my choice. Having children makes MS worse. I carried on without knowing.

M. As a result of that, how do you feel about the doctor?

5. I can't always tell what is being said.

M. Do you feel that you they keep you informed now.

5. That doctor's left now. It is someone different.

M. Does who you see now talk to you on an equal level

5. Yes, yes.

M. Communication can be broken down in the way that people speak to you. Do any of you have comments on the type of information you are given. That is a classic example where you are not being given the information . *(This refers to the diagnosis of multiple schlerosis)*.

5. At the time people said to me that I should have seen it. But I was stressed. *(This also refers to the diagnosis of multiple schlerosis)*.

M. Have the rest of you got any thoughts on communication. Do you understand what is being said to you. How important is this?

1. They should give you all the information.

3. Sometimes the patients can be nasty so what else can they expect back. But I've never had any problems. I have a wheelchair but the doctor has never seen me in it.

M. Are you comfortable with your GP?

3. Yes. There were two and one retired a few months ago.

M. If you were going to a hospital what kind of things would be important to you in a hospital setting?

4. I go three or four times a week.

M. What is your experience like?

1. They are good.

4. It is Manchester Royal. The doctor I have is very good.

1. The doctor I see is very good.

M . In what way is he very good?

1. He knows how to speak to you. He treats everyone the same. Some doctors think they are clever.

M. Sometimes they have a god like auras don't they.

1. Yes

Helper. I think when you go for an appointment you know the procedure, you know where to go.

M. So signposting is important?

Helper. Yes signposting. I think that is important in your letter. If you arrive at the front door and it says go to the green clinic you have to follow signs and some people are not good at following signs.

M. Also peoplea re nervous so you want it to be easy.

6. My doctor is very good. I have a relationship with him.

4. I have the same doctor

M. You like that?

4. Yes

M. It is coming out that it is important to see the same doctor. Is there anything else in a hospital that is important as well as signage?

3. Well I have no sense of direction anyway. My husband says, the car parking at the hospital is diabolical

1. It is the same at ours.

3. Now they have changed it at Tamesisde. It is backwards.

M. It is practically a new hospital Tameside.

2. It is good

M. It is refreshing to hear someone say that. Why is it good?

5. It is pleasant surroundings now.

2. You want to walk in and have a feel. You feel better.

M. Really and that is because of the environment?

5. Yes.

2. Yes. It's good.

M. So that gives you a better feeling of going to hospital?

2. Yes

Helper. And when you go in they have a new Costa Coffee.

6. Yes, I liked it. The light and furniture.

M. So that makes a big difference to you.

2. Yes. It used to be dark when you walked in. Now it is light. You walk in its great.

5. Yes

4. Nice bright colours. The facilities seem a lot better.

2. Yes

M. What about at the hospital and you are seeing different people. How do you feel the staff is in a hospital setting? What would be important to you?

5 . Friendly

3. Cleanliness

M. That is another factor that should be a given

1. They should be interested

M. Interested in you as a person?

4. When I go to the GP you go in there is a machine to check in and I can't see it. (this gentleman has sight problems) There is a machine to take your blood pressure. I can't do that.

5. Mine has as well.

M. You don't use it so it's not that important?

2. A lot of people have that ready. You walk in he has got it there.

M Going back to the idea of staff is there anything else that comes to mind with staff?

4. *It is not possible to transcribe this comment due to background noise.*

M. So you think they are influenced on whether they have had a good day or a bad day.

Helper. A friendly, caring attitude.

3. One of our nurses is a friend of mine and every time she says to my husband I am seeing Joyce *(the participant is referring to herself here)* first before your husband.

M. But that is a personal touch

3. Yes it is nice. My husband has a phobia of needles; his blood pressure goes up through the ceiling. She talks to him about football and then he doesn't know that she has done it.

M. How do you feel about the way staff in a hospital are dressed. Does the uniform make you feel they are professional? Does it matter to you?

4. I like to see them smarter.

5. I think sometimes it can distract you from the person you just see the uniform and you don't look at the person's face. I recently went for an X-ray and the nurse was in her room and I didn't look at her face right away. I just saw the uniform. But then I started having a conversation with her.

M. I suppose there are two ways of looking at it. You say it distracts you from the person. But then there is the fact that the uniform tells you what their role is.

2. Yes.

Helper. Yes and I think that is the recognition that you would expect that they have been through some training.

4. The registrar had a white coat and a name badge on

M. So it gives a feeling of professionalism

4. Yes

3. In my husband's case he had a lot of operations because he suffered from polio when he was born. He still has a phobia about needles and when he has to

have his blood pressure taken it goes through the ceiling. It's known as white coat syndrome.

M. Yes, so the way someone talks to him is important?

3. Yes.

M. This is more difficult question. What is the most important thing to you? We talked about environment, communications, accessibility, trust etc. Whether it is at the GPs or in a hospital, what would be the most important thing to you?

4. Feeling better. Knowing what they are doing to you.

1. That you are getting somewhere. You end up with what you need.

5. Your GP respects your views.

M. We'll come back to that in a minute if that is OK.

3. When you go to the surgery and you think to yourself have you forgotten anything? Once you have been to the surgery and tell them whatever it is troubling you it makes you feel better because that is the start.

M. That you are feeling you are at the start of the journey?

3. With my husband even though he knows the nurse very well it was very brave of him to say what was troubling him

M. So the relationship is important. It means that your husband can be more open.

3. He has always been terrified of anything to do with hospitals.

M. I think a lot of people are so that relationship is important.

4. You go in the doctors and they don't know what is wrong with you. In 1968 when I first had brain damage and I lost my sight and then I had meningitis in 2004

Helper. For me it is one appointment one problem. That didn't used to happen years ago. If you had something to discuss you went whether it was one or three problems. Now they won't let you do that unless you have a double appointment.

5. I don't have that.

Helper. I went with one problem but I had something else I wanted to ask about that. She said no. So I said well I'll go away and make another appointment. She said oh no.

M. You mentioned about respecting your views. One of the things that I think happens more is your own involvement in decision-making. The doctor gives you

information about what your options are and you are part of the process of making decisions. Is that something that is important to you or would you rather just leave it with the doctor?

4. Yes. Especially when it comes to choosing which hospital.

1. *It is not possible to transcribe this comment due to background noise and difficulties with communication on the part of the participant.*

M. You welcome the opportunity to have a choice of which hospital to go to.

4. The nearest hospital to me is Tameside but when I go they mention Salford.

M. Do you think that is because of what they specialise in. I suppose sometimes you are governed by what your condition is and which hospital offers what you need.

4. Salford offers the same as Tameside.

M. Is this important to the rest of you? Being involved?

1. To be told what I can do

M. You can't make a decision without the right information.

3. I have never been in that situation but I remember when many years ago my mum always wanted to see if they could make me walk better. This doctor said we can always chop her legs off and give her false ones. I was born with cerebral palsy. That was at North Manchester General.

M. I think attitudes have changed a bit since then.

4. Some people said Tameside is not what it should be. They botched my operation.

3. Another problem when I go to the doctors is the step to the pharmacy is very high so if my husband isn't with me I have to ask the nurse. There is no ramp. It is very high. Even when I go to the dentist the step is a bit high. With me walking on sticks polished floors is a problem. In the chemist as well.

4. When I go to the dentists there are two steps.

Helper. My dentist is bad for that.

(The session comes to a natural end at this point)

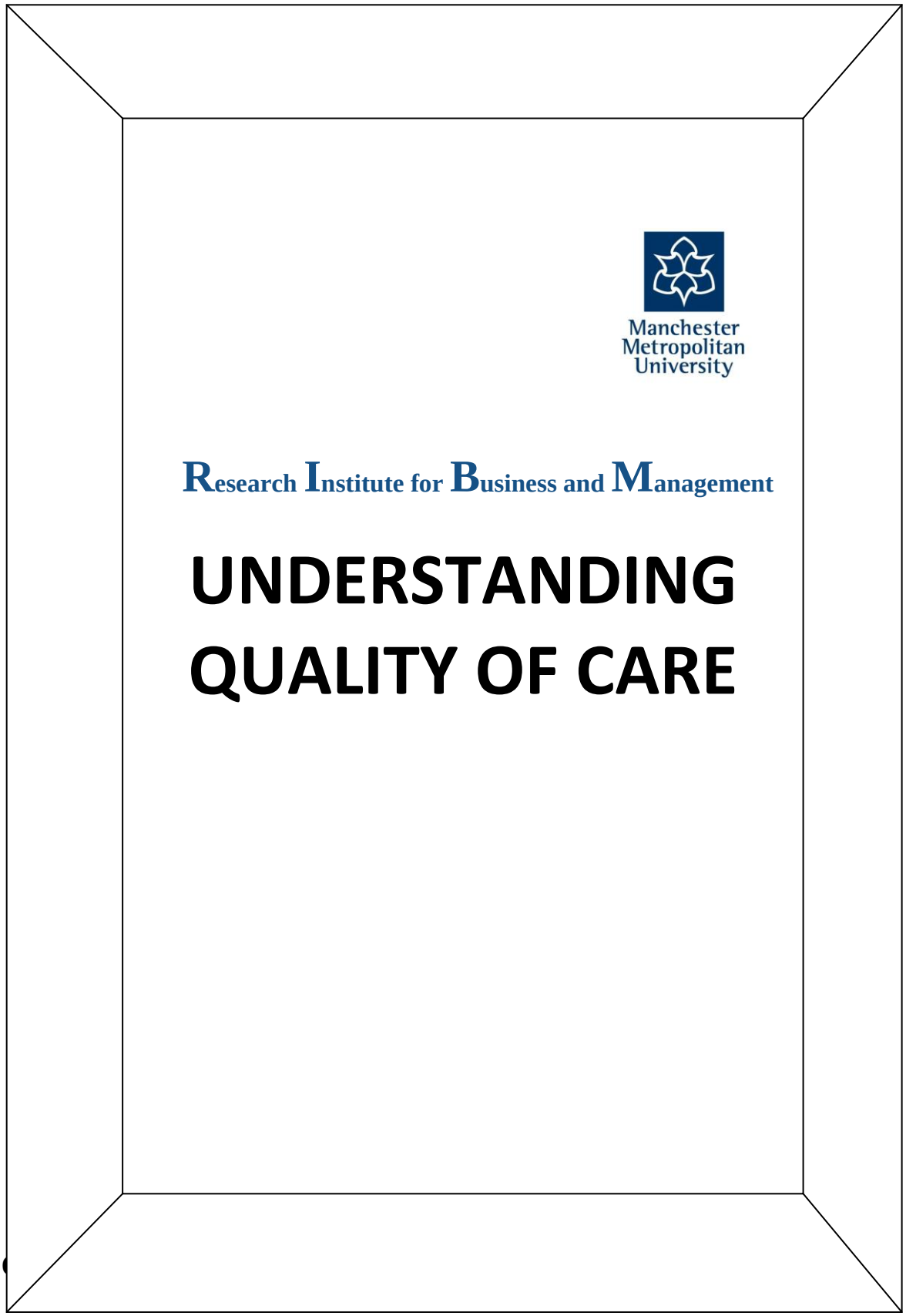
M . Does anyone else have anything else have anything else they would like to say?
(Nobody does)

M. In that case can I say thank you for letting me interrupt your session this morning. It really is appreciated.

APPENDIX 4

PHASE 3

THESIS QUESTIONNAIRE


Manchester
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UNDERSTANDING
QUALITY OF CARE

There is currently much interest in the quality of health care and we are trying to understand more about what are the most important elements for patients, their family/friends or carers. We would appreciate your time in completing this questionnaire. It should take approximately 15 minutes to complete. Please place a cross in the most appropriate boxes that reflect your own opinion about the priorities you give to different elements of care. **Your answers should reflect the type of care you would like to receive rather than the level of care you feel you do receive.** Please return completed forms to **healthstudy@hotmail.co.uk**.

Your replies are totally confidential. The information we gather from this questionnaire may be shared with appropriate health and associated professionals to help improve the services offered at NHS surgeries, clinics and hospitals.'
A version in larger print is available on request to **healthstudy@hotmail.co.uk or 07847557672**

All completed forms will be entered into a draw for £25 gift token for Marks and Spencer or Argos, depending on the choice of the winner.

If you wish to enter the draw please give your contact details here. This may be an e-mail address, phone number or mailing address. These will be kept confidential.

Name

Contact details

THE ENVIRONMENT IN WHICH I AM CARED FOR							
I want ...	**Not so Important**						**Very Important**
	1	**2**	**3**	**4**	**5**	**6**	**7**
staff to be smart							
hospital signposting to be clear							
hospital waiting areas to have things to do							
staff to wear badges providing their name and job role							
decor in a hospital ward to be bright, cheerful and welcoming							
staff to wear uniforms which help identify their position and seniority							
local clinics/doctors' surgeries to be bright and well decorated							
equipment to appear to be modern							
staff not to wear uniforms							
efforts to be made to make hospital environments as relaxing as possible							
good bedside entertainment such as TV/radio to be available if confined to hospital							
equipment to be undamaged and works first time							
there to be sufficient comfortable seating in waiting rooms							

A CARING APPROACH							
I want ...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
the receptionist to be friendly and courteous							
not to be asked for medical information by the receptionist							
to be asked what name I should be addressed by							
the professional to show interest in me as a person, not a set of symptoms							
the professional to show respect towards me							
the professional to help me to relax during a consultation							
the professional to be friendly and informal							
the doctor to understand me as a person and my needs							
all wards/departments to offer similar standards of service							
staff to have 'people skills'							

COMMUNICATIONS/INVOLVEMENT IN MY OWN CARE knowing what's going on							
I want ...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
to feel comfortable in asking questions							
to choose where I am treated							
professionals to have all the relevant information about me to hand							
information to always be given in simple, jargon-free terms							
to be given appropriate information at all times during my care							
to choose who treats me							
to receive important information face to face rather than by letter							
my records to be made available to me on request							
not to have to repeat information to different professionals							
professionals to ask if I understand what they have said in case of accents or terminology							
to feel my doctor or other health care professional listens to what I say							
to feel assured information is passed to other departments/agencies if necessary							
staff to refer to notes about concerns I have, my dislikes/likes etc							
information given by different staff/departments to be consistent							
to be given my options and involved in deciding the appropriate treatment							
to feel that I am an equal partner with the health care professional is important							
equipment to be available to allow me to take my own cholesterol and blood pressure							
staff to be aware of patients who are hard of hearing and speak accordingly							
staff not to speak to me in a patronising manner							

RESPONDING TO MY NEEDS							
I want...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
not to feel a nuisance if I ask for help when in hospital							
nurses/assistants in hospital to answer calls for assistance in a timely manner							
complaints to be handled in a timely manner							
not to be moved from a ward with no notice							
someone to be available to reassure me during uncomfortable/painful procedures							
any complaint I may make to be addressed appropriately							
staff to show a willingness to be helpful							
to know who to speak to if I have concerns							
to not be transferred between wards during the night or at mealtimes							
my needs to be assessed and appropriate action is taken if I have a problem							
nurses to be aware of my personal needs/concerns/fears							
not to feel uncomfortable if I have to make a complaint							
staff to have time to cater for my needs and to make me feel comfortable							

HAVING TRUST IN MY CARE							
I want ...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
to see the environment at the local doctor/clinic is clean							
to feel that the doctor trusts what I tell him/her							
the doctor to refer to a book/website if unsure about something							
the professional to take time to conduct an examination, treatment and/or tests							
to have trust in the clinical ability of the person treating me							
information about the professional history of my specialist to be available to me							
not to be asked for personal/medical information in a public area/waiting room							
where possible, to see the same professional							
the hospital to look clean							
the doctor to be sufficiently competent to not have to refer to a book/website							
the hospital I attend to have a good reputation/be free from public criticism							
to feel the professional knows me well enough to understand my needs							
there to be co-ordination between staff/departments providing my care In hospital							
to know my doctor							
the doctor to have my full medical history to hand							
the doctor to take into account my medical history where diagnosis is difficult							
to be sure my personal/medical history will not be passed on in error							
access to wards to be controlled							
there to be general agreement between professionals about my treatment							
to feel there is no danger of accidents when in hospital							
to know the doctor is competent even if he/she is not friendly							
strong leadership to be apparent and reflected in the level of care							
to see the hospital's record on cleanliness, e-coli and MRSA clearly displayed							

EASE OF ACCESS TO AND RELIABILITY OF SERVICES							
I want...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
it to be easy to get timely appointments with my local doctor/clinic							
appointments not to run late							
to be able to easily get through on the phone to the local surgery or hospitals							
opening hours of local surgeries/clinics to extend beyond normal office hours							
the location of services to be convenient							
an explanation if appointment times are not kept to							
to have the option to see a GP who specialises in my needs							
not to have to spend lengthy periods in waiting rooms							
not to have to pay to get a faster or more convenient appointment							
physical access to premises to take account of people with disabilities							
home visits to be easily available when needed especially for children/elderly							
it to be easy to speak to the right person							
it to be easy to speak to a member of the ward staff if I am in hospital							
to feel unrushed when I see a doctor or other professional							
to have plenty of notice and reasons given if my appointment is cancelled							
to be able to discuss more than one problem at one appointment							
staff to do what they say they will when they say they will do it							
plenty of car parking to be available							
be able to get timely appointments for specialist services							
a choice of dates in the case of needing inpatient treatment							
car parking to be free of charge							

FOOD							
I want...	**Not so Important 1**	**2**	**3**	**4**	**5**	**6**	**Very Important 7**
volunteers to be on duty to help patients eat							
light snacks such as toast, teacakes, fruit, ice cream to be readily available							
no activities (except emergencies) to take place during mealtime to allow staff to help patients							
not to have to decide the day before what I want to eat the following day							
food to be appetising and tasty							

ABOUT ME
Please place a cross by the appropriate category I am: (a) Retired (b) A homemaker (c) Not employed (d) In full time employment (e) In part time employment
If (a) please state what your occupation was
If (d) or (e), please state your occupation
Do you have qualifications? **Yes** **No** If so to what level? **GCSE** **A level** **NVQ** **HND/HNC** **Degree** **Post Graduate** **Professional** (or equivalent) Other (please state)
Please place a cross by your age group I am aged: **18-35** **36-50** **51-65** **66-75** **76+**

Please return your completed form to healthstudy@hotmail.co.uk.

THANK YOU VERY MUCH FOR YOUR TIME

APPENDIX 5

LETTER ACCOMPANYING THE QUESTIONNAIRE

Faculty of Business and Law

Business School

Manchester Metropolitan University

November 2012

Dear Respondent,

There is currently much interest in the quality of health care. Happily, much of the care we receive is of the highest standard, but of course there is always room to make improvements.

The purpose of this study is to provide an opportunity for you, as a potential or current service user, to state what you believe can make your experience as comfortable as possible at what can be a difficult time. It refers to those non-clinical elements such as the environment, rapport, appointment times etc., all of which can be major contributors to your overall care. It may be in hospital as either an in-patient or out-patient; it may be at your local doctor's surgery or even in your own home. We are not asking you to evaluate services you have received, merely to state what you would like to experience.

Your comments will be used to develop a means by which service providers can see how they measure up to what you say is important, rather than what they consider to be significant.

If you wish to be entered for the draw, then please put your name and contact details on the front of the questionnaire. This is optional, but please be assured that this will remain confidential.

It would be helpful if responses could be returned in the stamped addressed envelope by the 18th January 2013.

Thank you for your help.

Margaret Hyde
Doctoral Researcher
Health Quality Research Group
Manchester Metropolitan University

Professor Gill Wright
Director of Research
Research Institute of Business and Management
Manchester Metropolitan University

Business School
All Saints Campus
Oxford Road
Manchester
M15 6BY
United Kingdom

Telephone
+44 (0)161-247

Fax
+44 (0)161-247

E-mail

@mmu.ac.uk

NOTE: All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Committee North West – Preston.

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions.
The contact is Margaret Hyde at healthstudy@hotmail.co.uk.

APPENDIX 6

INFORMATION LEAFLETS FOR FOCUS GROUPS

AND

INTERVIEWS

Manchester Metropolitan University

PATIENT INFORMATION LEAFLET
UNDERSTANDING SERVICE QUALITY IN YOUR HEALTH CARE

We would like to invite you to take part in our research study. The purpose of this work is primarily educational, but maybe used to inform health providers in the future. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Part 1 tells you the purpose of this study and what will be involved if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear. Contact details are at the bottom of the leaflet.

Part 1

At some time in our lives we are all likely to need the services of the NHS or other health care provider. Every one of us is either an existing or future patient so whether it is relating to our own care, or to that of a loved one. The way that care is delivered is key.

Health care is delivered on two levels:

- The clinical aspects – that is the treatment that we receive;
- The non-clinical aspects – how we are treated as people: respect; empathy; environment; attitude etc.

It is the second of these that this work is looking at.

Much has been written in the media about the quality of health care in this country and whatever our own thoughts or experiences, there is a genuine desire by those who provide services to offer the highest level of services possible. Nevertheless, the nature of health care places heavy demands and pressures on services which means that on occasions, things may not be quite as we would like. Similarly as patients, when we use services, we are often feeling at our most vulnerable and need reassurance.

The purpose of this exercise is to provide an opportunity for you, the user of the service, to explain what it is that you see as important to ensuring that your experience is as comfortable as possible. This may be in hospital as either an inpatient or outpatient; it may be at your local doctors' surgery or even in your own home. Your perceptions will be compared with the views of health care professionals and managers in order to identify where gaps exist between what you feel service quality should be and what those who provide the service believe it should be.

The initial stage of the research will take the form of six group discussions, each comprising approximately eight people, the subject of which will be what participants would consider to be most important to them in the service they receive. The sessions are likely to last about one hour and will be recorded. It does not matter if you have not received health care in the past or had experience of a hospital. The groups will fall into two age groups: 40 – 64 and 65+ and will be tape recorded. Contributors to this part of the study have been approached either because they have registered their own interest, or through a third party who has suggested they may be happy to take part. Tea, coffee and biscuits will be provided and each meeting is expected to last about one and a half hours.
Any respondent may request to view the transcripts to ensure they reflect what was said. Should you wish to take this up simply tell the facilitator at the time of the group discussion and a transcript will be forwarded. Anonymised direct quotes will be used in the final thesis and any published academic papers.

Unfortunately, it is not possible to reimburse travel expenses.

A questionnaire will then be developed from the findings of these focus groups and you will be invited to complete these if you wish. Although the results will be published in an academic paper, your own individual contribution will be treated

sensitively and in confidence. All participants of the focus groups will be offered the opportunity to have a summary of the results by completing a slip which will be available at the focus groups.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

We will follow ethical and legal practice and all information about you will be handled in confidence. All information which is collected during the course of the research will be treated anonymously and your name and address removed from any data so that you cannot be recognised.

If a participant should find it difficult to reflect on certain issues, they will be given the option of withdrawing from the group and should they wish, the details of a qualified counsellor will be made available.

Participants have the right to check the accuracy of data held about them and correct any errors.

Although data may be seen by other researchers and published in international academic journals, this will be anonymous. It is up to you to decide whether you want to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Committee North West – Preston.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions.

The contact is Margaret Hyde at healthstudy@hotmail.co.uk. If you remain unhappy and wish to complain formally, you can do this through the Research, Enterprise and Development at Manchester Metropolitan University. Details are :

Professor Dave Raper,
Director of Research,
Research, Enterprise and Development Office,
Manchester Metropolitan University,
Ormond Building,
Ormond Street,
Manchester. M15 6BY

Tel: 0161 247 1025
e-mail: d.raper@mmu.ac.uk

If you would like to take part then please contact: Margaret Hyde at healthstudy@hotmail.co.uk or 07847557672. Thank you.

Manchester Metropolitan University

INFORMATION LEAFLET
UNDERSTANDING SERVICE QUALITY IN YOUR HEALTH CARE

We would like to invite you to take part in our research study. The purpose of this work is primarily educational, but maybe used to inform health providers in the future. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Part 1 tells you the purpose of this study and what will be involved if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear. Contact details are at the bottom of the leaflet.

Part 1

Much has been written in the media about the quality of health care in this country, but this should not work against the fact that there is a genuine desire by health care workers, be they clinicians, managers or other support staff, to provide the highest level of care possible. Unfortunately, as we all know, the nature of health care places heavy demands and pressures on staff, and things may not always be quite as we would like them to be.

This study recognises that health care is delivered on two levels:

- The clinical aspects – that is the treatment that we receive;
- The non-clinical aspects – how we are treated as people: respect; empathy; environment; attitude etc.

It is the second of these that this work is looking at.

The purpose of the study is to develop a greater understanding of what service providers see as important in service elements in order to deliver a high quality service for the patient and/or their families. This may be in hospital as either an inpatient or outpatient; it may be at the local doctors' surgery or even in the patient's own home. Your ideas will be compared with those of service users in order to identify where gaps exist between what you feel the important elements of service quality are and what those who use the services see them as. The study will also look at current methods used to measure service quality in a health setting.

The initial stage of the research will take the form of one to one interviews with clinicians, managers or other support workers, each lasting approximately one hour. Each interviewee will be asked what they would consider to be most important in non clinical service delivery. The sessions are likely to last about one hour and will be recorded. The findings from this stage will then be compared to the views of existing or potential future service users taken from a series of group discussions.
Any respondent may request to view the transcripts to ensure they reflect what was said. Anonymised direct quotes will be used in the final thesis and any published academic papers.
A questionnaire will then be developed from the findings and widely distributed to the public and to service users. The results will then be used to develop an easy to use framework which can be tailored to local needs and will provide an effective means by which to understand to patients/family perceptions of service quality. Although the results will be published in an academic paper, your own individual contribution will be treated sensitively and in confidence. All participants will be offered the opportunity to have a summary of the results.

Part 2

The study will follow ethical and legal practice. All information which is collected during the course of the research will be treated anonymously and your name and address removed from any data so that you cannot be recognised.
Participants have the right to check the accuracy of data held about them and correct any errors.
Although data may be seen by other researchers and published in international academic journals, this will be anonymous. It is up to you to decide whether you want to join the study. We will describe the study and go through this information sheet. If

you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.
The research has received ethical approval from the National Research Ethics Service Committee North West – Preston.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions.
The contact is Margaret Hyde on 07847 557672.. If you remain unhappy and wish to complain formally, you can do this through the Research, Enterprise and Development at Manchester Metropolitan University. Details are :

Professor Dave Raper,
Director of Research,
Research, Enterprise and Development Office,
Manchester Metropolitan University,
Ormond Building,
Ormond Street,
Manchester. M15 6BY
Tel: 0161 247 1025
e-mail: d.raper@mmu.ac.uk

If you would like to take part then please contact: Margaret Hyde at healthstudy@hotmail.co.uk or on 07847 557672. Thank you.

APPENDIX 7

CONSENT FORM FOR FOCUS GROUPS AND INTERVIEWS

Centre Number:
Study Number:
Participant Identification Number for this study:

CONSENT FORM

Title of Project: Understanding service quality in health care
Name of Researcher: Margaret Hyde
(please initial each box)

I confirm that I have read and understand the information sheet dated 5th December 2011 version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected ☐

I understand that the discussions during the focus groups will be audio recorded and notes taken. ☐

I understand that relevant sections of data collected during the study, may be looked at by individuals from Manchester Metropolitan University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data and to this being included in published future work, either of an academic nature or articles in professional magazines ☐

I agree to take part in the above study. ☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed: 1 for participant; 1 for researcher site file;

REQUEST TO SEE TRANSCRIPT OF DISCUSSION FROM FOCUS GROUP

I would like to receive a transcript of the discussion from the focus group I took part in order to ensure that my input has been accurately recorded.
Date of focus group
Name (Please print)

Address
Tel no.
E-mail address

REQUEST TO RECEIVE A SUMMARY OF THE RESEARCH FINDINGS
I would like to receive a summary of the research findings from the project Understanding Service Quality in Health Care. I understand this will be not be available until December 2013.
Name (Please print)

Address
Tel no.
E-mail address

Please hand to the facilitator at your focus group.
Alternatively requests for a summary of the findings can be made to healthstudy@hotmail.co.uk