ASSESSING SERVICE USER EXPERIENCE AS A COMPONENT OF SERVICE EXCELLENCE: IN NHS PRIMARY HEALTHCARE SETTINGS: A CASE STUDY OF SALFORD PCT

BASHIR ALI ABUSAID

Faculty of Business, Law and the Built Environment
School of the Built Environment University of Salford,
Salford, M5 4WT United Kingdom

Submitted in partial fulfilment of the requirements of the Degree of Doctor of Philosophy

February 2007

Bashir Ali Abusaid, PhD study was undertaken in the Research Institute of The Built and Human Environment (BuHu) in the School of the Built Environment, the University of Salford

GLOSSORY OF TERMS

Service user	Customer, client, consumer, Recipient or Patient
Service related elements	Factors associated directly with the delivery of healthcare
Environment related elements	Factors associated with the place where healthcare is delivered
Service user experience	A journey that service users go through to receive healthcare
SERVICE EXCELLENCE	An ongoing transformational process in operationally effective and continuously improving organisations with matching culture; that guarantees service is experienced by the service user in a valuable, enjoyable and memorable manner, delivered by delighted staff".

ABBREVIATIONS

NHS	National Health Service
PCT	Primary Healthcare Trust
FM	Facilities Management
DOH	Department Of Health
LIFT	Local improvement finance trust
CHI	Commission for Healthcare Improvement
PEAT	Patient Environment Action Team
WHO	World health organisation
EU	European Union

ABSTRACT

Given the importance of user experience in a knowledge economy, established models, concepts and methods of measuring quality and excellence, currently in use, lack direct service user input and involvement in the service planning and delivery process. Therefore, in the context of the knowledge economy, understanding how service users experience service delivery is vital to engaging and connecting intimately in order to capture the over all impressions of the service users and the interface between a service and their lives for creating the conditions for service user experience as a component of service excellence. Engaging service users does not happen through consultations at meetings, it needs to happen at very early stages of service delivery through conversation and dialogue rather than choice alone. The second half of the ten year NHS Plan (DOH 2000) which focuses on the service user and emphasises the role that Primary Care Trusts can play in bringing the health service to the community in order to achieve the UK vision for service user-centred healthcare - a service fitted round the service user, not the service user fitted round the service. Therefore, health service has been selected as a prime example to demonstrate that organisations should rely on service user experience for their reputation for excellence to shape service around interactions of their users.

The aims and objectives of the research presented in this thesis were to explore service user experience as a key element of the concept of service excellence in NHS Salford Primary Care Trust. The link between health and social deprivation is well established. Thus, service users in the City of Salford were selected because they experience some of the worst economic and social problems in Europe. A phenomenological approach was adopted in order to get to the roots of the service user's own understanding of excellent healthcare. The study undertook a

critical review of previous research into service concepts and instruments and their application in healthcare settings and identified current methods and techniques used in primary care. It has been shown that existing tools rely on previous work conducted in secondary care settings and do not have a basis in understanding of user experience.

The research identified five important dimensions for achieving service excellence, from their perspective, and developed a set of service user centred approach that should help NHS healthcare providers move from service quality stage to service excellence. The research focused on understanding the overall perceptions of satisfaction and experience amongst service users of healthcare settings. Empirical research consisted of a combination of both qualitative and quantitative methods, and triangulated sources of data. Qualitative methods included face to face interviews followed by focus groups to build a real understanding of issues that directly matter most to the service users. In order to confirm the findings of the first phase and furthermore, to recognise the impressions identified in the interviews and focus groups, a survey was carried out as a second part of the empirical study. The findings from surveys, focus groups and interviews, show levels of satisfaction and negative impressions. Data analysis shows no significant differences amongst gender, race, and age etc, to a service user experience assessment process within Salford PCT which depends on service users themselves. Further, Salford PCT has the responsibility for more to be done to reach a stage where most of the negative and average comments are changed to very positive ones which translate an urgent need for Salford PCT to react to these views in a more effective manner.

The research contributes a new knowledge for assessing potential service user experience of healthcare settings, a critical appraisal of the

assessment of service concepts, an adoption of a new methodology that could help service users address issues that directly matter to them and a proposal for a new tool to be employed for assessing service excellence. The concepts developed in this thesis provide both a point of departure for further research and the development of a practical tool with which to assess service user experience as a component of service excellence in service organisations.

DECLARATION

This thesis is submitted under the University of Salford regulations for the award of PhD degree by research. Some findings during the research together with details associated with the research process itself have been published in refereed conference proceedings prior to this submission and are detailed below:

Abusaid, B. and Alexander, K., (2002), Achieving Service Excellence in the Hotel Industry through the Guest Experience, in Proceedings of the 2nd International Conference of Postgraduate Research in the Built and Human Environment, Salford, England, April.

Abusaid, B. and Alexander, K., (2003), A Proposed Qualitative Case Study Methodology to Investigate the Impact of Service Excellence on Business Performance in the Hospitality Industry, in Proceedings of the 3rd International Conference of Postgraduate Research in the Built and Human Environment, Lisbon, Portugal, April.

Abusaid, B. and Alexander, K., (2004), The Development of an Instrument for Evaluating Service Excellence in Healthcare Settings, in Proceedings of the 4th International Conference of Postgraduate Research in the Built and Human Environment, Salford, England, April.

Abusaid, B. and Alexander, K., (2005), Methodology for Measuring Service Users Experience in a Healthcare Setting, in Proceedings of the 5th International Conference of Postgraduate Research in the Built and Human Environment, Salford, England, April.

Abusaid, B. Kaya,S .and Alexander, K., (2005), Service Excellence through Service User Experience, in Proceedings of the EUROFM

Research Symposium in Facilities Management, Frankfurt, Germany, April.

Abusaid, B. Nelson, M. Kaya, S. and Alexander, K., (2005), How do PCTs Measure Users experience?, In Proceedings of the ,EUROFM Research Symposium in Facilities Management, Helsinki, New zealand, June.

The researcher declares that no portion of the work referred to in the thesis has been submitted in support of an application for another degree qualification of this or any other university or other institute of learning.

ACKNOWLEDGEMENT

First of all, thanks and all the praise should go to Allah.

I would like to express my deepest gratitude to my supervisor, Professor Keith Alexander who has been so helpful and for his invaluable advice, generous support, guidance, encouragement, patience and the useful comments he provided me during my studies.

Special thanks must go to my Co supervisor Dr. Cal Douglas for his support during my research and provided me with true guidance and invaluable advice until the achievement of my studies.

Many warm thanks are reserved for my parents who have supported me and prayed for my success during my studies. Also many thanks will go to my lovely family: my wife Fatima who has been very supportive and encouraging all the way during my research journey and to my children, Sarra, Mohamed, Mouad, Malek and Musab for all their love and patience.

I would like to acknowledge the case study organisation and other contributors to this research thesis most especially Amanda Rafferty.

To all who inspired and motivated me when I thought I could not go on and most importantly "bullied" me to finish, some of you also spent time reading my thesis. For those I have not mentioned personally, it was not because you were any less important to me, but remember I pray and give thanks for you.

EXCELLENCE IS NOT AN ACT,

IT IS A HABIT "Aristotle"

TABLE OF CONTENTS

List of Figures

List of Tables

Chapter 1: Introduction

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

1.1 Background

The world has stretched beyond the industrial economy to a service-based economy. In the service economy goods are standardised and wrapped up, service users are more concerned with price than with who actually makes these goods. This has driven organisations to market their goods with services as a package to distinguish them from those of their competitors (Pine II and Gilmore, 1999). The economic change has led to both rapid expansion in the products and services available to service users and changes in the way service users and businesses behave and interact.

The emerging experience economy is wrapping up services so fast in the same way that a service economy wrapped up goods. As the process of wrapping up services is taking place rapidly, bankers, hoteliers, insurance organisations and other service providers have to think of a way to sustain the emerging experience economy. Further, in an economy driven by service users, service user experience has social dimensions, which must be recognised - in education, health, labour markets and elsewhere. It is the combination of services and environment that determines the ability of services to operate effectively in society, and for individuals to derive benefits from public services. These benefits need to be understood in terms of outcomes.

Good service cannot be reduced to nothing more than an efficient operation, its value lies in the less tangible sense that the service is supporting and meeting ones needs, working for and on behalf of every one. The real problem with service is that it is still treated as a commodity (Parker & Heapy 2006). Further, in their work, (Parker & Heapy 2006) argue that the challenge, facing all service organisations, leads to two major consequences. First, learning how to create deeper forms of satisfaction and wellbeing through service is the long-term

priority for public service reform. Second, a distinctive approach to what they called 'service design', which seeks to shape service organisations around the experiences, interactions, participation of their service users.

1.2 User Engagement

The measure of how much service user participation is 'enough' depends here on how much is needed to help them to achieve their goals (Birchal & Simmons, 2004). They suggest that some analysts often use the image of a 'ladder of participation' to summarise different levels of participation. They described the lowest step on the ladder as information giving and receiving, the next as consultation, and the highest step as a variety of processes – self-management, negotiation, and representation and so on.

According to Birchal & Simmons (2004), the ladder metaphor breaks down because, above the level of consultation, service user groups seem to select one of three strategies. There is a self-management strategy, which involves taking some control over the provision of a service such as tenant management organisations, self-help groups. There is also a negotiation strategy, which involves deliberately not taking over responsibility for a service but acting more like a trade union, using the group's collective power to force the opponent to come to terms such as tenants' federations and some disability groups. Then there is a representation strategy, which means sending some group members to sit on a committee where their voice can be heard and authority felt.

Public services are not exempt from this sense of frustration. Since 1997, the public sector has expanded. Public service jobs have grown, as have the levels of investment being poured into schools, hospitals,

cultural institutions and security infrastructure. NHS spending will be 90 per cent higher in 2007/08 when compared with 1996/97. Schools spending will be 65 per cent higher and transport will be 60 per cent higher (Parker& Heapy 2006).

1.3 Influential Factors within Health Service

The World Health Organisation (WHO) considers health as a state of complete physical, mental and social well-being, so that people may lead a socially and economically productive life. In Health 21, WHO promotes a policy of health for all, as a basic human right, and sets out strategies to ensure that scientific, economic, social and political sustainability drive its implementation.

Drawing on the factors that surround the external business environment, and the impact of each of these factors on the business (and their interplay with each other), it is possible to identify a whole range of factors that together combine to shape up the climate of healthcare delivery in the UK.

These factors are:

- **Political Factors**

When examining political factors, an eye must be kept out for any political changes that could affect the health service. Many issues should be considered such as laws that are being drafted, global changes that are occurring, Legislation on maternity rights, data protection, health & safety and environmental policy. Thus, the political arena has a huge influence upon the regulation of health service, and the service users as a whole.

Since the arrival of the Labour government in 1997, they adopted an approach termed as 'what matters is what works'. This practical approach seems to work at many levels. It seems that the new government policies are creating opportunities for support to be built into the structure of the service delivery. This move by the government proves that an essential change in relationships between service users and providers is inevitable.

The recognition by the government also extends to many local services such as housing, social care and leisure that should open up new opportunities for service users to take part in the decision making process. Therefore, the focus has been on the relationship between service users and service providers from a top-down perspective.

- **Economic Factors**

Often the political factors have a huge impact over economic factors. For example, tax is usually decided by politicians, based on a mixture of political and economic factors. Interest rates, in many countries are decided by a central bank, but political factors may still be important. Other economic factors include exchange rates, inflation levels, income growth, debt & saving levels (which impact available money) and service user and provider confidence.

Marketers need to consider the state of a trading economy in the short and long-terms. According to Campbell (1989) economic historians identified the importance of rising demand as a crucial factor initiating the service user revolution that accompanied the beginning of industrialisation in the eighteenth century in England and located its principle cause in a new tendency to consume. Further, Campbell (1989) states that new tendency to consume stems from changes in

values and attitudes being in some way related to changes in fashion. Additionally, Gorz (1988) argues that since there is no limit to the quantity of money that can be earned and spent, there will no longer be any limits to the needs that money allows service users to have or to the need for money itself.

The UK software industry is currently complaining of a shortage of computer programmers - which is driving up wage costs. Again - the global picture can be important. Some companies are now using programmers in countries like India for software development. This helps them keep costs down - and leads to competitive advantage over companies with higher costs. Although some of these factors are global, but it is also important to look at factors affecting health service sector as it is a crucial economic measure.

- **Social Factors**

The social and cultural influences on any organisation differ from one country to another. Since the creation of the European Union (EU), the people of Europe are searching for a more socially responsible and sustainable approach to development and growth. Very often this involves a trade-off: a resolution of the conflict between the pursuit of wealth and the protection and improvement of health. EU health strategy focuses on improving the health of European citizens and increasing the competitiveness of European health-related industries and businesses, while addressing global health issues including emerging epidemics. Within this European context, the UK vision is for service user-centred healthcare - a service fitted round the service user, not the service user fitted round the service.

Social factors influence people's choices and include the beliefs, values and attitudes of service users. So understanding changes in this area

can be crucial. Typical issues to look at for each of these follow: - service user attitudes to healthcare delivery- the role of women in Society - attitudes to health - attitudes to wealth - attitudes to age (children, the elderly, etc.).

- **Technological Factors**

Technological factors are vital for competitive advantage, and are a major driver of change and efficiency. Technological; factors can for example lower barriers to entry, reduce minimum efficient health service levels, and influence outsourcing decisions. New technology is changing the way healthcare sector operates. The Internet is having a profound impact on the strategy of organisations. This technological revolution means a faster exchange of information beneficial for healthcare provider as they can react quickly to changes within their operating environment.

Advances in technology can have a major impact on healthcare delivery success - with providers that fail to keep up often going out of business. Technological change impacts on socio-cultural attitudes. For example, the way people are diagnosed has changed dramatically over the last 30 or so years. Considerations must be paid to any technology that could make delivering healthcare easier. Technology is vital for competitive advantage, and is a major driver of globalisation.

The new approach to how education should be provided has been reconsidered, which is why England is building schools of the future to promote the use of IT in schools. While, effective healthcare plays a fundamental role in improving a person's overall health and wellbeing, and providing a good quality of life, healthcare services in England and Wales are complex and varied. The number and range of organisations involved in the provision of healthcare continues to grow. And as the

Government's agenda of greater choice for, and involvement of, service users begins to take shape, the lines between the NHS, independent sector and community-based organisations are becoming increasingly blurred. Therefore, the UK government has to overhaul the technology within the NHS in England and Wales, digitise service user records and create an advanced communications infrastructure in an attempt to improve healthcare delivery.

- **Environmental Factors**

Environmental factors within the NHS are internal influences that have a direct impact on the NHS. These include:

• Service users: NHS will survive on the basis of meeting the needs, wants and providing benefits for their service users.

• Employees: Employing the correct staff and keeping these staff trained and motivated is an essential part of the strategic planning process of NHS.

• Suppliers: A closer supplier relationship is one way of ensuring competitive and quality health service for the NHS.

• Stakeholders: Stakeholders expectation and perception are vital for the success of the NHS.

• Media: Positive or adverse media attention on the NHS service can in some cases make or break the NHS.

Those environmental issues have to be considered and closely monitored to be able to respond to any changes that may occur within the NHS working environment.

1.4 The need for new paradigm

With reference to the work under taken by Johnston, (2001) organisations live or die by their reputations. Although not discussed within the context of NHS, the consideration is applicable in positively improving the reputations of the health service in helping raise service user's expectations that could lead to higher benefits from health service delivery.

The National Health Service (NHS) sector in the UK will be undergoing dramatic changes in the next few years. This is due in part to changing service user requirements and the implementation of the Agenda for Change programme (D O H, 2004). Many healthcare providers within the NHS have lost track of the true needs of their service users and are trapped in outdated views of what healthcare delivery is all about. This is evidenced in the report by Nigel Crisp (NHS chief executive) in October 2002, published by the Department of Health. This report (D O H, 2002) clearly stated that the NHS needs to refocus its management efforts, engage with service users, staff and the public and build momentum to manage for excellence.

A review of PCT services to make them fit for purpose for staff and service users, rather than systems, has led inevitably to a radical rethink in the way that the PCTs' healthcare services are provided. This new way of thinking about primary healthcare has affected almost every area of the PCTs activities, as health and wellbeing cannot be separated from housing, employment, the environment and a thriving local economy.

User satisfaction within the UK NHS is based on assumptions about users needs from the NHS perspective. Many approaches deployed to measure user satisfaction neglected the impact that the process of

healthcare delivery may have on the user satisfaction. Therefore, measurement criteria should truly reflect user needs and requirements to ensure the measurement of user experience and create reputation for service excellence.

1.5 Why service user experience?

The introduction of the White paper in January (2006) termed as (our health, our care, our say) is indicative that the government is willing to build a new world class system of health and social care in England. The new initiative adopted by the government will allow the move towards the approach where service is designed around the service user rather than the needs of the service users being forced to fit around the service already provided.

The challenge for the NHS should maintain this development and make sure that GPs are capable of expanding their services and responding to changing service user's demands. The new initiatives will guarantee that GPs are allowed to acquire for their service users services within the NHS and private sector. This white paper looks to provide greater choice for service users so they can take full advantages of the new range of services provided. It also seeks to improve care, cut delays, make services more convenient, expand the role of practice nurses and local pharmacists and encourage GPs to offer longer surgery hours.

The purpose of this research was to explore how the service users of NHS PCTs experience healthcare delivery. A phenomenological approach was used, allowing the user's own interpretations to be discovered. Further, this study sought to explore key elements of user experience as an integral part of service excellence in NHS PCTs, initially through face

to face interviews, focus groups and subsequently through a questionnaire-based study.

An examination of previous work carried out on behalf of the Commission for Health Reviews (formerly CHI) has shown that the basis on which service user experience was interpreted cannot be traced back to their roots. From a research perspective, an understanding of the basis is important to ensure the reliability and validity of the outcomes. Many questions currently remain unanswered which impact on the reliability of current measures. Therefore, this research thesis examined the concept of service excellence in general and the service user experience as a key element of achieving and sustaining service excellence in great detail, because service user experience has not received adequate attention in the past due to misinterpretation and misunderstanding within NHS PCTs

Based on the researcher's personal interest and professional experiences, this research sought to solve a host of issues with regard to how the service users of NHS PCTs experience the healthcare delivery in pursuit of service excellence. A study such as this would examine aspects of the user experience as a key element of service excellence in NHS PCTs, allowing the user's own interpretations to be discovered.

1.6 Reasons for choosing PCTs

The NHS healthcare services are provided through a number of channels namely:

- Primary care trusts (PCTs) provide family healthcare services by family doctors, dentists, pharmacists, nurses, midwives,

health visitors, optometrists and ophthalmic medical practitioners. Primary care groups announced in the new NHS which brings together family doctors and community nurses. These groups will have the opportunity to Primary Care Trusts (PCT s). A Primary Care Trust is a new form of Trust for Primary Care Groups who seek to be freestanding (The New NHS, 1999).

- Acute and specialist services treat conditions which normally cannot be dealt with by primary care specialists or which are brought in as an emergency. It covers medical treatment or surgery that service users receive in hospital following a referral from a general practitioner (GP). Secondary care is made up of NHS, foundation, ambulance, children's and mental health trusts.

- Social care covers a wide range of services that can help people to carry on in their daily lives and is one of the major public services. They provide services that meet an individual's or an area's circumstances and needs. They also work closely with others including the NHS, voluntary and private organisations as well as with the education service, the probation service, the police and other agencies who share the responsibility to provide this care and support.

Primary Care Trusts (PCTs) are the most recent organisations to enter the NHS and are relatively unfamiliar to service users and the public. However, they have very important and wide ranging responsibilities, particularly as they are the key drivers for modernisation and improvement in the NHS; the weight of political expectations is on their shoulders. PCTs were established under the Health Act (1999) as

independent NHS bodies and embody the principle of devolving more control and decision making power to the frontline clinicians involved in delivering and arranging care for service users (such as GPs and community nurses). They bring together responsibility for primary and community care services within one organisation.

1.7 Case Study Organisation

Salford is the fourth most deprived local authority area in the North West of England, and 28th nationally. The city has considerable health inequalities as a consequence of lower educational attainment and unemployment, access to services and huge differences in lifestyle (Salford PCT, 2003).

Salford PCT serves a population of around 234,000 people who are cared for via 61 GP and 41 dentist practices. Children born and raised in families of lower socio-economic groups are more likely to experience declining health later in life, and Salford residents have a life expectancy almost three years below the national average for men and almost two years below for women.

The PCT is a key participant in Britain's biggest ever project to improve frontline health and social care facilities and services and has been driving forward radical plans for new health and social care centres, funded via the Manchester Salford and Trafford Local Improvement Finance Trust (LIFT).

1.8 Justification for this research

The need for this research stems from a host of deficiencies identified regarding understanding the quality of healthcare delivery (Hwang et al, 2003) as follows:

- Methodological dilemmas and lack of standardised approaches to service user satisfaction survey research;
- Lack of clarity and consistency in understanding the determinants of service user satisfaction;
- Lack of an accepted conceptual or theoretical model of service user processes;
- Lack of clinician consensus on the role that service user satisfaction should play in the assessment of quality of health care.

Consequently, the need for this research can be justified by a number of reasons namely:

- Lack of direct user involvement in NHS PCT information collection process led to misleading data in the measurement of service user experience.
- User satisfaction in PCTs is currently measured by the NHS based on their understanding and interpretation of findings from other NHS trusts, rather than on the exact needs of the users themselves.
- User experience is not currently measured.
- An examination of the current measurement system is required in order to move towards the measurement of user experience.

1.9 Research Outline

1.9.1 Aim

The aim of this research thesis was to explore the construct of service user experience as a key element of the concept of service excellence in a primary healthcare setting. The research thesis thereafter identified and evaluated the considerations for a positive service user experience as service users visualised them and from this developed a set of service user centred approach that should help NHS healthcare providers move from service quality stage to service excellence.

1.9.2 Objectives

The objectives of this research thesis were to:

- Demonstrate how service user experience can help NHS healthcare providers move from a 'service quality' phase to a 'service excellence' phase.
- Explore the need for the achievement of a positive service user experience within a primary healthcare setting and how it can help NHS healthcare providers move from service quality phase to service excellence phase
- Highlight the value to be gained by better designing healthcare around the true needs of the service users.
- Develop and propose a set of user - centred indicators in order to achieve a positive service user experience in a primary healthcare setting.

1.9.3 Research Question

The following research question was addressed:

What are the service user's impressions of the services and the environment in which positive service user experience is created within NHS PCTs?

This question was derived from literature review and enquires from practice regarding the need for the development of a set of elements to assess service user experience within a primary healthcare setting.

As illustrated in (figure 1-1), the result of enquiries has helped the researcher draw a concept diagram of the healthcare service and environment related elements that make up the service user experience within PCTs.

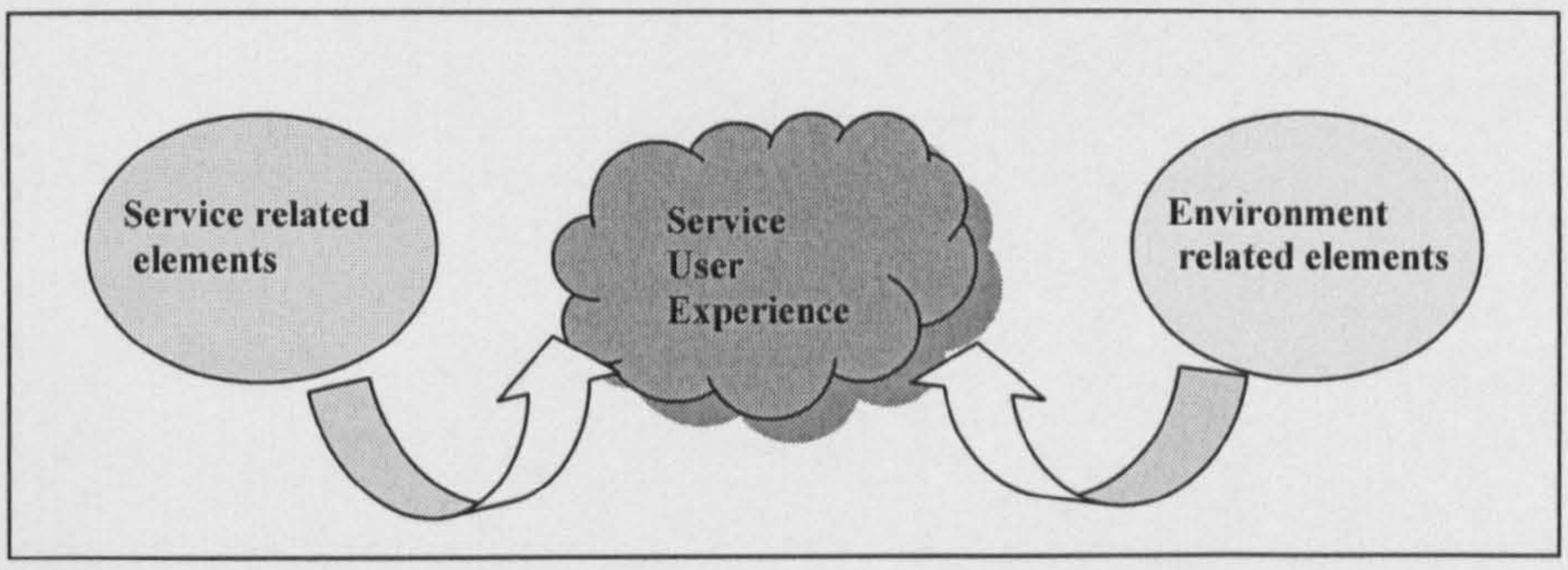


Figure (1-1), concept diagram

The above concept diagram shows that service user experience is made up of service related and environment related elements

1.10 Research Methodology

This study has adopted a number of research strategies and techniques for developing the theories contributing to the building of a solid

platform for understanding, measuring service user experience and further to test its validity. A triangulation approach was established to eliminate the biases inherent in the case study strategy if such strategy had to occur. Phenomenological paradigm has been adopted to meet the requirements of this research. Further, this study sought to gain a better insight, initially through, interviews, focus groups and subsequently through a questionnaire survey. Data analysis carried out to test a set of assumptions related to the development of the methodology and its implementation within PCTs.

1.11 Scope

This research has the profile to be of an exploratory nature rather than an explanatory one. An exploratory study is undertaken when not much is known about the situation at hand, or when no information is available on how similar problems or research issues have been solved in the past (Sekaran, 2000). Nevertheless, it attempts to understand how certain indicators could determine whether Salford PCT is likely to achieve a positive service user experience.

Furthermore, the investigations in this research emphasised the identification of the broad range of indicators that could help Salford PCT achieve a positive service experience rather than trying to focus on a specific and unique question. This approach is justified by the fact that service user experience does not appear to the author to have been measured in the PCTs. Therefore it is important to the author to raise issues that could be further investigated by future research. In this regard, the measurement of service user experience could offer benefits to PCTs as well as the research body of knowledge alike.

This research described a study of service user experience as a fundamental aspect of facilities management (FM), as a key element of service excellence in NHS primary care trusts (PCTs), and the concept of user-centred healthcare delivery. It examined user experience and current measurement techniques in the PCTs, which emphasise that the current system is not representative of user experience. It also describes the research approach employed in the study, and suggests how to move forward capturing and measuring service user experience in the pursuit of service excellence.

As mentioned earlier, PCTs were formed in 2002 as part of the national reform and modernisation drive. Their formation seeks to empower service users and the public to have an influence on the development and improvement of healthcare, bring the healthcare service closer to the communities and more responsive high quality services. Involvement of the service users was recognised as a key element to NHS policy.

1.12 Organisation of study

The order of this thesis is carried out in such a way that it introduces service concepts and service user experience in general before it addresses their applications in NHS healthcare sector. This order is meant to make the reader more familiar with the different concepts before they immerse in their applications. This study is organised into nine chapters. Each chapter leads into the development of an important part of this work.

Chapter one: "Introduction", is the introduction to the essence that necessitate this study and the needs for this research. Further, it lays the basis for the rest of the discussions that follow.

Chapter two: "Service Concepts", addresses definitions and characteristics of service, elements, evolution and types of service concepts, definitions, dimensions, theories, gaps and measuring service quality. It further examined different interpretations and implementation of service excellence with some examples from practice.

Chapter three: "Service User Experience", discusses the service user experience construct as a key element of achieving service excellence. This chapter further defines the construct and explores the essentials for service users to achieve a positive experience.

Chapter four: "Application of Service Concepts within NHS PCTs", investigates the application of service quality concept and measurement techniques within NHS PCTs. It moves on to the application of service excellence concept within NHS PCTs. It also critically examines the service user centred concept within NHS PCTs.

Chapter five: "Research Design", introduces the research methodologies adopted in this work. It further defines the philosophical key components on which the research process is based and describes the leading approaches used in the investigations.

Chapter six: "Literature review results", summarises the main elements and issues raised in relation to service user experience.

Chapter seven: "Interviews & focus groups results", reports on the techniques employed for data collection to fully capture the impressions of the service user as they experience healthcare delivery in Salford PCT. Theses techniques are: semi structured interviews and focus groups. Further, it discusses the results of the empirical investigations of the research semi structured interviews and focus groups conducted

in Salford PCT to contribute to the assessment of service user experience.

Chapter eight: "Questionnaire surveys results", reports on the data collection based on elements defined by service users through semi structured interviews and focus groups. Further, it discusses the results of the empirical investigations of the questionnaire surveys conducted in Salford PCT to contribute to the assessment of service user experience.

Chapter nine: "Conclusion" and recommendations', discusses the most significant limitations of this research and emphasises on the issues that have helped the use of a case study strategy to measure service user experience as a component of service excellence. It further explains how the presentations of the findings to a number of professionals in the healthcare in Salford PCT have to some extent filled-in the validation gap. The chapter also presents the different implications of this research on the healthcare providers and the academia alike. Further, this chapter provides a summarised description of the research. It focuses on showing how the results of the study relate to the original research questions and describes the limitation of this research and the objectives set out in this research thesis. It also proposes an instrument called ServExcel to measure service excellence that could help NHS Salford PCT move from service quality to service excellence.

1.13 Conclusion

This chapter has introduced the topics and research question that have brought about the undertaking of this research. It has shown how these reasons have led to a research question and onto the aims and objectives of the research.

Chapter 2: Service Concepts

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

2.1 Introduction

The past decades have witnessed the evolution of global integration in many service organisations. It has been regarded as a catalyst for change in service provision. Traditionally service organisations have set themselves strategic objectives, however they have frequently lacked the appropriate techniques to achieve them efficiently and effectively.

This chapter explores service, its definition, characteristics, elements, evolution, concepts, dimensions, theories, gaps and measuring tools, and different interpretations and implementation of service excellence with some examples from practice.

2.2 SERVICE

Despite more than 25 years of study, scholars in the field of services management do not agree on what a service is. Indeed, instead of coming closer to a definition, they seem to be less certain. The problem is that they are trying in few words to describe 75 percent of the economic activity of developed nations (Johnston and Clark, 2001).

Pine II and Gilmore (1999) defined services as intangible activities performed for a particular client. Antonacopoulou and Kandampully (2000) described services as a deed, act, performance or encounter in time rather than a physical object. Kotler (1988) defined services as any act or performance that one party can offer to another that is essentially

intangible and does not result in the ownership of any thing. Its production may or may not be tied to a physical product.

Gronroos (1990) defined service as an activity or sequence of activities of more or less intangible nature that usually, but not necessarily, take place in interactions between the service user and the service employee and / or physical resources or goods and / or systems of the service provider, which are provided in response to service users problems.

Ramaswamy (1996) described service as "the business transactions that take place between a donor (service provider) and receiver (service user) in order to produce an outcome that satisfies the service user".

Some researchers analyse service from the viewpoint of a system-thinking paradigm:

> A production system where various inputs are processed, transformed and value added to produce some outputs which have utility to the service seekers, not merely in an economic sense but from supporting the life of the human system in general, even may be for the sake of pleasure (Lakhe & Mohanty, 1995).

2.2.1 Characteristics of Service

Distinctions are often made between services and physical goods. Characteristics of services that distinguish them from physical goods include: inseparability of production and consumption, intangibility,

heterogeneity of output and perishability (Fitzgerald et al, 1994; Ghobadian, 1994).

Inseparability of production and consumption is the simultaneous result of services being produced and consumed at the point of contact (Thomas, 1978, Lovelock, 1981). In essence, services are believed to be created as the service provider interacts with the service recipient.

Compared to physical goods, services are primarily intangible and have been described as performances rather than objects (Zeithaml et al, 1988). A fundamental factor in defining what the service consists of and how to evaluate its outcomes is the information exchange process through interpersonal communication. There are varying types of cues that service users use when inferring outcomes such as quality. According to Zeithaml (1988), cues can be categorised into two broad categorise consisting of extrinsic and intrinsic. Extrinsic cues are the actual physical (tangible) elements related to the service but are not part of the service itself. These cues would consist of trademarks, physical facilities and the price. On the other hand, intrinsic cues are the essential elements that are set up by the communication behaviours enacted by the providers during the service encounters. They are the cues that are contained in the service delivery and are not available before service consumption, yet they are generally used as the essential element by the service users when evaluating service quality.

The inability of service providers to deliver a standardised output (i.e. no standardisation) is due primarily to the varying degrees of individual service user needs and experiences. Input from service user to service user

may vary, therefore satisfying specific service users requires a degree of flexibility on behalf of the service provider (Singh, 1993).

The inability of services to be stored (perishability) creates demand imbalances witch are typical of cyclical business (Sasser, 1976, Brown and Swartz, 1989). As a result, service users face the risk of not having a familiar and trusted provider when they need one.

2.2.2 Service Concepts

The service concept can be perceived at two levels: the organisational level and the service recipient's level. At the organisational level, the service concept is seen as the way in which the organisation wishes to have its services viewed by the range of the stakeholders including suppliers, lenders, service users and shareholders. At the service recipients` level, it is as the way in which the service user views the delivery of service by the organisation.

The variable and intangible nature of many services stems from the way in which they are packaged and delivered to the service user. The key issue is not simply providing an opportunity to satisfy their needs, but to exceed their expectations, thus ensuring that benefits overweigh potential disbenefits (Teare, 1998).

2.2.2.1 Elements of Service Concept

There are four key elements of the service concept according to Johnston and Clark (2001) as shown in figure (2-1).

- The service experience refers to the service users` direct experience of the service process that places much emphasis on the manner the service provider deals with the service recipient.
- The service outcome refers to the result for the service recipient.
- The service operation refers to the manner in which the provision of service is conducted.
- The value of service refers to the tangible benefit that a service recipient perceives to gain in return for their contribution either directly as in commercial relationships, or indirectly as in public service provision.

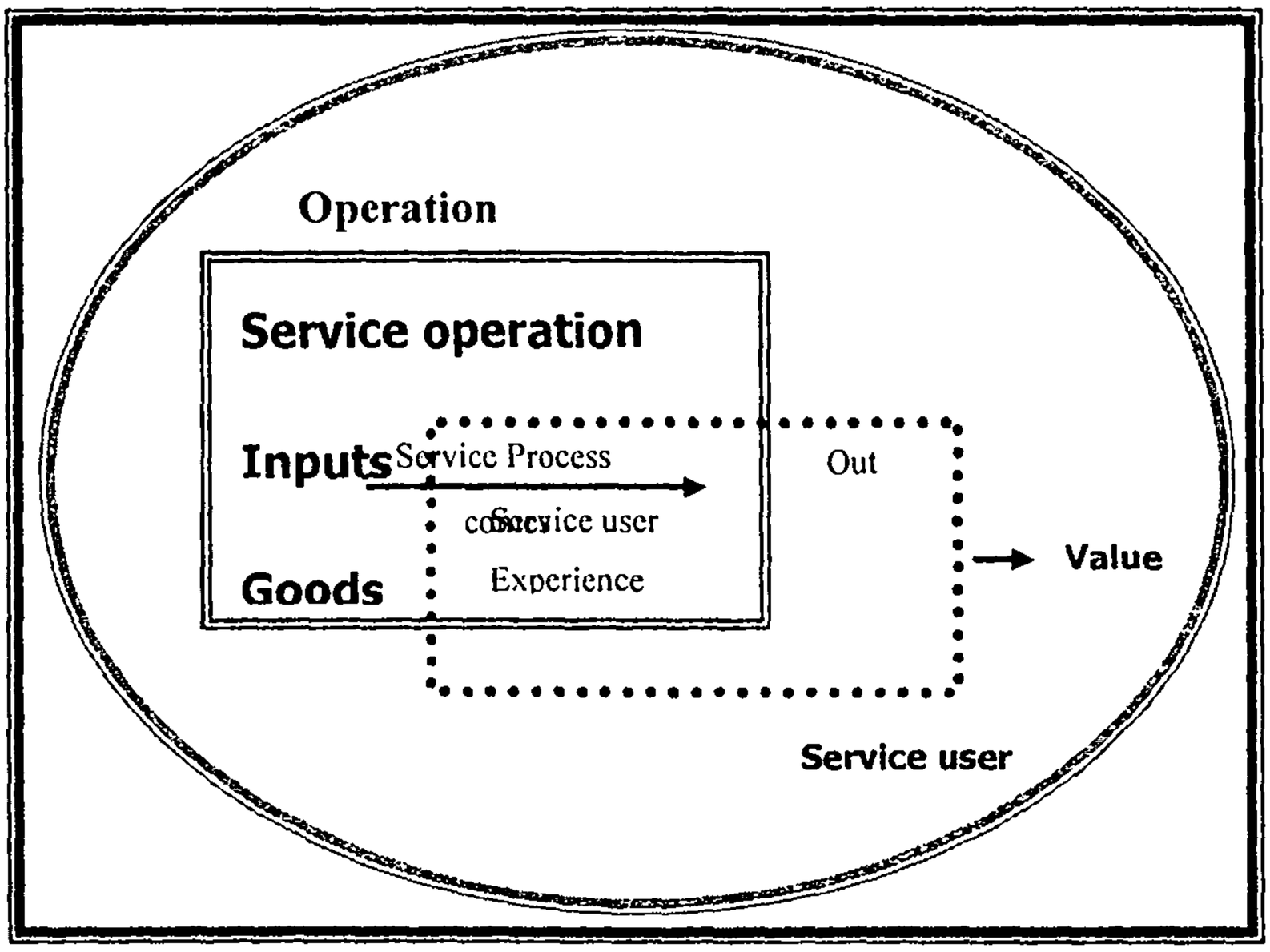


Figure (2-1) the key elements of service concept, (Johnston and Clark, 2001).

As illustrated above, the service concept is a communication instrument where experience, outcome, operations together with the feeling of recognition to the service recipient are put together to display the potential value of the service. Institutions where service organisations are aiming to gain a competitive advantage through service quality, the quality of interaction between employees and service users is deemed to be crucial determinant of service user perception of service quality. In order for an organisation to provide good perceived quality of service, it has to manage the service process as well as all necessary resources for the process (Lashley, 1997). Then the service users not only observe the experience in operation but also take part in it (Gronroos, 1998).

2.2.2.2 Evolution of Service Concepts

As illustrated in Figure (2-2) the evolution of service concepts consists of two essential dimensions: customisation and commoditisation.

- Customisation deals with the request of the individual (demand). According to Gilmore and Pine (2000) companies should tailor products and services to meet the unique needs of individual service users in such a way that nearly all can find exactly what they want at a reasonable price through a new mind-set, one of creating service user-unique value (mass customisation). They define customisation as manufacturing a product or delivering a service in response to a particular service user's needs in a very cost effective way. They conclude by saying that low-cost, high quality, customised goods and services can be achieved

through flexibility and quick responsiveness in ever changing environment, people, processes, units, and technology reshape to provide service users with their exact needs. Other essential aspects include: managerial coordination, self-determining, competent individuals and a well-organised linkage system.

- Commoditisation on the other hand, refers to the prescription process i.e. it prescribes whether the service delivery has been executed to the needs of every individual. It refers to the description process of a service i.e. it describes the steps to be followed so that a particular service gets delivered. It also deals with the way in which the request of the individual is packaged (supply). According to Ryder & King (2002), Commoditisation when taken to its rational wrapping up results in little if any discrimination between similar classes of products and consequently offers no technological or market advantage for organisations. Such a situation would mean that all value – add would then necessarily have to come from services or supplementary products related to commodity. Manufacturers and service providers will increasingly see their contribution commoditised as more and more organisations charge openly for the unforgettable encounters they provide (Pine and Gilmore, 1999).

A fit between what the individual precisely requires, and what is being offered must be maintained in order for the individuals' needs to be accurately prescribed and solutions are accordingly described.

2.2.2.3 Types of Service Concepts

As shown in figure (2-2) there are five levels of service concepts in the service evolution. These phases represent how the service concept has evolved from service task to service excellence.

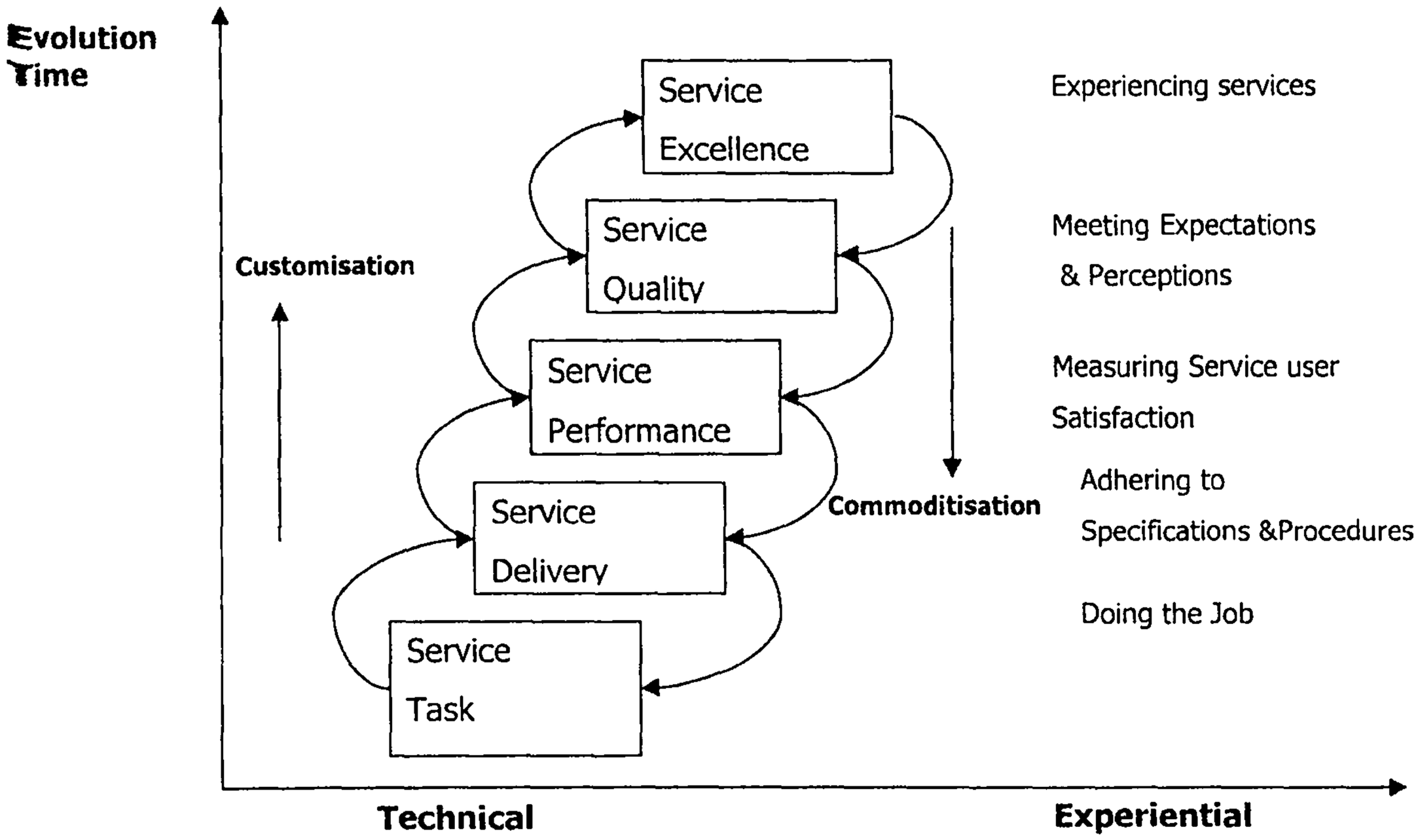


Figure (2-2) Service concept evolution diagram (Adapted from Pine &Gilmore, 1999).

As shown in the diagram, the higher the service concept moves up, the more customised the service becomes. Each service concept is defined as:

- Service Task Stage is the first phase of the evolutionary process. It is the most technical stage of all. This is where routine jobs/tasks get completed on direct orders from the supervisor. For example, sweeping the floor twice a day.

- Service Delivery Stage represents task completion. The service gets delivered according to set specifications and procedures. These include the input-based tasks to monitor the job sequence and its outcomes. For example writing a cleaning specification and the method of delivery are input tasks of this stage.

- Service Performance Stage has specific focus on the measurement of service performance. Besides service specification, service level agreements (SLA) and key performance indicators (KPI) are developed at this stage. Most UK corporate organisations are perceived to be at this level.

- Service Quality Stage represents robust tools for performance management and service quality measurement that demonstrate tangible results. Introducing tools like SERVQUAL, and measuring the quality of service by analysing the service user expectation and perception gap is a salient feature of this stage.

- Service Excellence Stage covers the final economic offering of this diagram with the least technical aspects. Service users enter this stage knowing that they will experience the service in a very pleasurable way. At the service excellence phase, the organisations' economic offering is not the materials, the products, the processes, nor the encounters; but the individual.

2.3 Service Quality

Even though the significance of service quality is undisputed, the theory and practice of service quality has not reached a consensus. This primarily because of service intangibility, the problems associated with simultaneous production and consumption of services and the difference between mechanical delivery of the service and the human component of quality. There is an instinctive connection between the concepts of service quality as distinct from product quality and service user satisfaction. However, the two constructs have followed distinctively different research streams.

2.3.1 Definitions of Service Quality

In order to understand service quality a distinction has to be made between services and goods in terms of how they are produced consumed and evaluated (Zithamel et al 1990). According to Gronroos (1984) the perceived quality of a given service will be the outcome of an evaluation process, where the service user compares his expectations with the service he perceives he has received, i.e. he puts the perceived service against the expected service. The result of this process will be the perceived quality of the service

Lewis and Booms (1983) stated that service quality is a measure of how well the service level delivered matches service user's expectations. Delivering quality service means conforming to service user expectations on consistent basis.

Parasuraman, Zithamel and Berry (1985) defined service quality as the overall evaluation of a specific service organisation that results from comparing the performance of an organisation with the general expectations of the service user of how an organisation in the industry should perform

Quality as defined by Zithamel et al (1988) is the judgement of service users about the overall excellence or superiority of an entity. Bowen (1997) distinguished between technical and functional quality. Technical quality refers to what the service user is left with after the service user-employee interactions have been completed. Functional quality refers to the process of delivering the service. Many times service quality is associated with satisfaction but the difference between the two is that satisfaction is the result of a specific encounter, while perceptions of service quality are based the service user's cumulative experience with the organisation's delivery systems (Boulding et al. 1993).

Gronroos (1984) suggested in his Service Quality Model that service users compared their expectations to their experience of service quality in making their decisions. He proposed that service users' overall evaluations of service quality were a result of their assessment of functional, technical and the impact of an organisation's image.

Using the Gronroos service quality model, the outcomes of technical quality and functional quality may not be adequate to identify what is perceived by the service user, because technical quality and functional quality, combined, comprise the construct of image. Gronroos suggested that

image might be a quality dimension that might not only influence expectations, but also might affect the perceived service quality, depending on the level of technical or functional quality present (Gronroos, 1984).

Gronroos (1984) believed both expectations and perceptions would be influenced by the image of the service firm, which was itself built up by the technical and functional quality. It should be noted that Gronroos used the terms technical quality and functional quality in the sense of internal quality: "...he will also be influenced by the way in which the technical quality is transferred to him functionally." (Gronroos, 1984). Gronroos implied that functional quality would be more important to the perceived service than technical quality, provided the latter was on a satisfactory level.

Even though the Technical/Functional Quality model has not been utilised or tested to the extent of the SERVQUAL model, it has received some research/empirical attention in recent years. Measuring service quality in the area of architectural design, for instance, Baker and Lamb (1993) suggested that, for evaluative purposes, service users tend to rely primarily on functional-based dimensions of service quality, as they may not have the knowledge and/or skill to evaluate more technical-based dimensions.

Similarly, Higgins and Ferguson (1991) reported that, although service users of an accountancy service evaluated both functional and technical dimensions of service quality, the functional dimensions seemed to carry the most weight. In the case of pizza delivery service, on the other hand, Richard and Allaway (1993) found that both technical and functional dimensions explained more of the variation in service user choice behavior than functional measures alone, as the technical dimension is easy to

evaluate for a pizza delivery service. Gummesson and Gronroos (1987) synthesised the Gronroos (1984) model with one from manufacturing, which incorporates design, production, delivery and relational dimensions of quality. Edvardsson (1989) presented four dimensions of quality: technical, integrative, functional and outcome.

Expanding on Gronroos's Model, Kelly, Donnelly and Skinner (1990) considered the role of the service user during service interaction. In addition to Technical Quality and Functional Quality, they proposed two further components - Service user Technical Quality and Service user Functional Quality. Service user Functional Quality refers to those dimensions brought to the interaction by the service user, and Service user Functional Quality relates to how the service user behaves during interaction. Specifically they included interpersonal aspects such as friendliness and respect. Contributions from the service user can range from labour performed to information supplied.

However, Gronroos did not conduct any research into the service user's view. Expanding on Gronroos's work, Parasuraman et al. (1985) did investigate the service user's view. Besides in-depth interviews with fourteen executives of four service firms, they conducted twelve focus group interviews with current or recent users of the four service categories: retail banking sample size equal 177 service users, credit card sample size equal 187 service users, long distance telephone company sample size equal 184 service users, and product repair and maintenance sample size equal 183 service users. Comparison of the executive and service user perspectives led the authors to develop the 'gap' model of service quality. Unlike Gronroos they proposed that perceived service

quality depends on the size and direction of the gap between expected and perceived service.

Parasuraman et al. (1985; 1988) offered the most widely reported set of service quality Parasuraman, et al., defined a perceived service quality model (based on the discrepancy between service users' expectation and perception). Factors affecting expected service include: word-of-mouth communications, past experience, and perceived needs (Parasuraman et al., 1985). These include ten general dimensions and evaluative criteria that service users use in assessing service quality. The ten dimensions are: tangibles, reliability, responsiveness, communication, credibility, security, competence, courtesy, understanding, /knowing the service user, and access (Berry et al., 1985).

The relative importance of the ten determinations depends upon the service feature, service user experiences and the amount of cognitive processing (Parasuraman et al., 1985). Subsequent factor analysis and testing by Parasuraman et al., (1988) condensed these into five categories (tangibles, reliability, responsiveness, assurance and empathy)

Further work by Cronin & Taylor, (1992) SERVPERF, Knutson et al., (1990) LODGSERV, Stauss & Weinlich, (1997) Sequential Incident Techniques, Cheung and Law (1998) ISQM, Aldlaigan & Buttle (2002) SYSTRA-Service Quality Scale have not been able to dominate the literature on the evaluation of service in the same way as the research applying the expectancy disconfirmation theory to evaluate service quality by researchers like (Parasuraman et al. 1985, 1988, Brown and Swartz, 1989, and Zeithaml et al. 1993). These researchers attributed dissatisfying

service encounters to discrepancies service user perceive when their pre-encounter expectancies are not met during the exchange.

2.3.2 Dimensions of Service Quality

Ten dimensions of service quality were identified:

reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding and tangibles (Parasuraman et al. 1985). These attributes were then narrowed down to five determinants namely:

- Reliability involves consistency of performance and dependability in which the organisation performs the service correctly and continues to do so.
- Tangibility includes the physical evidence of the service such as the actual facilities within the organisation.
- Responsiveness concerns the willingness or the readiness of the organisation to provide timely service.
- Assurance is based on communication, credibility, competence, courtesy and security.
- Empathy involves an understanding of the needs of the service user and providing them the access to fulfil those needs through ease of contact.

2.3.3 Service Quality Gaps

The service quality gap concept that has received the most attention is the connection between expectations and perceptions of service quality. It has been argued that:

> Service quality as perceived by service users stems from a comparison of what they feel service firms should offer (i.e., from their expectations) with their perception of the performance of the organisation providing the services. Perceived service quality is therefore viewed as the degree and direction of discrepancy between service users' perceptions and expectations.... In the service quality literature, expectations are viewed as desires and wants of service users, i.e., what they feel a service provider should offer rather than would offer. (Parasuraman, Zeithaml, and Berry 1985)

Parasuraman and his colleagues' model is based on insights obtained from numerous interviews and focus groups of service users in four service categories, reflecting a cross section of service industries (retail banking, credit card, securities brokerage, long-distance telephone company and product repair and maintenance. These producers were selected because they varied along key attributes of a multidimensional classification scheme (Lovelock, 1983). None of these services results in the outcome or association with anything tangible being produced, although product repair does involve service users' tangible possessions. While the credit card and securities brokerage have rather intangible processes, banking and product repair involve tangible processes.

Parasuraman et al. (1991 a) determined that research should be focused on the service user side by examining service user's expectations. Working with focus groups, their work examined different types of expectations and their nature. Reduced from the ten dimensions of their earlier work to five dimensions of service quality, the five dimensions were further classified in relation to service outcome or the service process.

Parasuraman et al. (1985) developed a model, which illustrates how various gaps in the service process may affect the service user's assessment of the quality of the service. The model is useful in assisting managers and staff to examine their own perceptions of quality and to recognise how much they really understand the perceptions of service users.

Gaps were evident from analysing the management responses and comparing them with the service user's response. As set of key discrepancies or gaps exists regarding management perception of service quality and the tasks associated with service delivery to service users. These gaps can be major hurdles in attempting to deliver service that service users should perceive as being of high quality (Parasuraman et al. 1985). Service quality gaps are prevalent in five areas namely:

- Service user expectation-perception gap – the difference between what service the service user expects and the management's perception of what the service user expects.
- Management perception-service quality specification gap – the difference between the service perception of managers and the specifications they direct for those who actually perform the service.

- Service quality –service delivery gap – the difference between the service specified and that delivered because of variability in the employee performance.
- Service delivery -external communications gap – media advertising and other communications may promise more than can be delivered.
- The expected service- perceived service gap- this equals perceived service quality and is the result of all the gaps.

Disend (1991) correlated the Gaps Model with the concept of service quality. He implied that poor service results if the difference is large between what is expected and what is delivered. When what is delivered matches what is expected, service users find the service acceptable. "If the service provided is better than what they expected, exceptional service materialises" (Disend (1991).

Consequently, when expectations and perceptions are ranked on a scale, the gap is a number reflecting the difference between the two, expressed as, 'expectation ranking minus perception ranking'. If there is a poor service gap, a minus number occurs. If the number, by chance, is zero, service is acceptable (expectations match perceptions). If a positive value emerges (perceptions exceed expectations), the service organisation has achieved exceptional service.

The definition of service quality presented in the Gaps Model recognises that expectations are subjective and are neither static nor predictable (Blanchard & Galloway, 1994).

Zeithaml and Bitner (1999) claimed that service quality is related to confirmation and disconfirmation of expectation, where satisfaction is related to the size and direction of the disconfirmation experience.

Churchill and surprenant (1982) believed that disconfirmation is related to the person's initial expectations. They investigated the determinants of service quality by answering the question "Is quality simply affected by the extent of the disconfirmation experience or do expectations and performance exert independent effects on satisfaction in addition to their impact via confirmation?

Prior conceptual research in service quality literature supported the disconfirmation of expectations (Gronroos, 1982, Carman, 1990, Bolton and Drew, 1991). Bolton and Drew (1991) concluded that consistent with prior exploratory research concerning service quality, a key determinant of overall service quality is the gap between performance and expectations.

2.3.4 Service Quality Models

Several researchers approached service quality from perspectives quite different from Parasuraman et al. (1988). On the one hand, some researchers provided multi-dimensional models of service quality. At first, Gronroos (1984) used a two-dimensional model to study service quality. The first dimension is Technical Quality that refers to the outcome of the service performance. The second dimension is Functional Quality that refers to the subjective perception of how the service is delivered. It is the

reflection of the service user's perception of the interactions between service users and service providers. According to his model, these two dimensions of service performance are compared to the service user's expectations and eventually the service user has their own service quality perception.

Further, McDougall and Levesque (1994) added a third dimension - physical environment to Gronroos (1984) model and proposed the Three Factor Model of Service Quality. It consists of service outcome, service process (Gronroos, 1984), and physical environment. They tested the model by a confirmatory factor analysis using the dimensions of the SERVQUAL scale, which provided empirical support for the model. These three components, together with Rust and Oliver's (1994) service product, represent one important aspect of services. All of them contribute to service users' perception of service quality.

Dabholkar, Thorpe, and Rentz (1996) proposed a hierarchical model of service quality. This model suggests that service quality is a multi-level and multi-dimensional construct, including:

(a) The service users' overall perception of service quality,

(b) A dimension level which consists of physical aspects, reliability, personal interaction, problem solving, and policy, and

(c) A sub-dimension level which recognizes the multifaceted nature of The service quality dimensions They found that quality of service is directly influenced by the perceptions of performance levels. In addition, service users' personal characteristics are important in assessing value, but not quality.

Brady (1997) combined these two lines. He developed a hierarchical and multidimensional model of perceived service quality by combining Dabholkar, Thorpe, and Rentz's (1996) hierarchical model and McDougall and Levesque's (1994) Three Factor Model (Brady, 1997). There are three dimensions in the model: interaction quality, outcome quality, and physical environment quality. Each of these dimensions consists of three corresponding sub dimensions:

(a) Interaction Quality - Attitude, Behaviour, and Expertise
(b) Outcome Quality - Waiting Time, Tangibles and Valence
(c) Physical Environment Quality - Ambient Conditions, Design, and Social factors.

This hierarchical and multidimensional approach is believed to better explain the complexity of human perceptions than the conceptualisations currently offered in the literature (Dabholkar, Thorpe, & Rentz, 1996; Brady, 1997). Lehtinen and Lehtinen (1982) provided a three-dimensional view of service quality. It is made of "interaction", "physical" and "corporate" quality. At a higher level, and essentially from a service user's perspective, they saw quality as being two-dimensional, consisting of "process" and "output" quality. This is not too different from the conceptualisation by Gronroos (1984).

2.3.4.1 Sasser's Model (1987)

The service user has a variety of needs which may cause conflicts in terms of the attributes they desire (Sasser et al model, 1987). These attributes are:

- Security - the safety of the service user or their property.
- Consistency - standardizations and reliability.
- Completeness - in interpersonal reactions, printed material, signs, etc.
- Condition - the service environment, cleanliness, comfort, atmosphere.
- Availability - ease of access in time and space.
- Timing-time required for, and pace of, service performance.

2.3.4.2 Parasuraman`s Model (1988)

According Parasuraman et al (1988) disconfirmation concept conceptualises the perception of service quality as a difference between the expected level of service and the actual service performance. They revealed the following 10 second-order dimensions that are used by service users in assessing service quality in a broad variety of service sectors:

- Tangibles - Appearance of physical facilities and personnel.
- Reliability - Performing service right the first time
- Responsiveness - Willingness and ability to provide prompt service.
- Communication- Explaining service to service users in language they can understand
- Credibility - Trustworthiness of service user-contact staff
- Security - Confidentiality of transactions
- Competence - Knowledge and skill of service user-contact staff
- Courtesy - Friendliness of service user-contact staff

- Understanding/knowing Service user - Making an effort to ascertain a service user's specific requirements.
- Access - Ease of contacting service company

2.3.4.3 Lovelock's Model (1988)

Having undertaken group interviews, Lovelock (1988) identified the following dimensions of service:

- Reliability- involves consistency of performance and dependability. It means that the firm performs the service right the first time. It also means that the company keeps its promises.
- Responsiveness- concerns the willingness or readiness of employees to provide service. It involves timeliness of service
- Competence- means possession of the required skills and knowledge to perform the service.
- Access- involves politeness, respect consideration, and friendliness of contact personnel
- Communication- means keeping service users informed in language they can understand
- Credibility- involves trustworthiness, believability and honesty. It involves having the service user's best interests at heart.
- Security- is the freedom from danger, risk, or doubt
- Understanding the service user- involves making the effort to understand the service user's needs.
- Tangibles- include the physical evidence of the service.

2.3.4.4 Johnston's Model (1995)

Johnston (1995) provided a complete list of dimensions. He identified eighteen service dimensions:

- Access- the physical approachability of service location, including finding one's way around the service environment
- Aesthetics- extent to which the components of the service package are agreeable or pleasing to the service user, including both the appearance and the ambience of the service environment, the appearance and presentation of the service facilities, goods and staff.
- Attentiveness/helpfulness - the extent to which the service, particularly the contact staff, either provides help to the service user or gives the impression of interest in the service user and shows a willingness to serve
- Availability - the availability of service facilities, staff and goods to the service user.
- Care - the concern, consideration, sympathy and patience shown the service user.
- Cleanliness/tidiness - the cleanliness, and the neat and tidy appearance of the tangible components of the service package, including the service environment, facilities, goods and contact staff
- Comfort - the physical comfort of the service environment and facilities.
- Commitment - Staffs apparent commitment to their work
- Communication- the ability of the service providers to communicate with the service user

- Competence - the skill, expertise and professionalism with which the service is executed
- Courtesy - the politeness, respect and propriety shown by the service providers to the service user
- Flexibility - willingness and ability of the service staff to meet the needs

  of the service user.
- Friendliness - the warmth and personal approachability
- Functionality - the serviceability and fitness for purpose or 'product quality' of service facilities and goods.
- Integrity - the honesty, justice, fairness and trust with which service users are treated by the service organisation.
- Reliability - the reliability and consistency of performance of service facilities, goods and staff.
- Responsiveness - speed and timeliness of service delivery
- Security - personal safety of the service user and his or her possessions while participating in or benefiting from the service process

2.3.4.5 Evans & Lindsay's Model (1996)

Evans and Lindsay (1996) identified the following dimensions of service quality:

- Time and timeliness - How long a service user must wait for service, and if it is completed on time.
- Completeness - Is everything the service user asked for provided?

- Courtesy - How service users are treated by employees?
- Consistency - Is the same level of service provided to each service user each time?
- Accessibility and convenience - How easy it is to obtain the service?
- Accuracy - Is the service performed right every time?
- Responsiveness - How well the company reacts to unusual situations, which can happen frequently in a service company

2.3.4.6 Mudie & Cottam`s Model (1999)

According to Mudie & Cottam`s model (1999), service users evaluate a number of dimensions to assess service quality. Dimensions listed below are used in different ways to portray an image that service users may have towards some services.

- Reliability - the ability to perform the promised service dependably and accurately
- Responsiveness - the willingness to help service users and to provide prompt service.
- Assurance - the employees' knowledge and courtesy, and the ability of the service to inspire trust and confidence
- Empathy - the caring, individualized attention the service provides its service users
- Tangibles - the appearance of physical facilities, equipment, personnel and communication materials.

Table (2.1) Service quality models

Model / Dimension	Sasser, (1987)	Parasuraman (1988)	Lovelock (1988)	Johnston (1995)	Evans & Lindsay (1996)	Mudie & Cottam (1999)
Security	✓	✓	✓	✓		
Consistency	✓				✓	
Completeness	✓				✓	
Condition	✓					
Availability	✓			✓		
Timing	✓				✓	
Tangibles		✓	✓			✓
Appearance		✓				
Reliability		✓	✓	✓		✓
Performing service right		✓				
Responsiveness		✓	✓	✓	✓	✓
Communication		✓	✓	✓		
Credibility		✓	✓			
Competence		✓	✓	✓		
Courtesy		✓		✓	✓	
Understanding		✓	✓			
Access		✓	✓	✓	✓	
Aesthetics				✓		
Attentiveness/helpfulness				✓		
Care				✓		
Cleanliness/tidiness				✓		
Comfort				✓		
Commitment				✓		
Flexibility				✓		
Friendliness				✓		
Functionality				✓		
Integrity				✓		
Accuracy					✓	
Assurance						✓
Empathy						✓

2.3.5 Measuring Service Quality

Parasuraman et al `s (1985, 1988) SERVQUAL instrument is one measure of perceived service quality derived from how the service user perceptions of actual service performed matched expectations. Parasuraman et al (1985) stated that service users use similar criteria in judging service quality regardless of service type. SERVQUAL could be used as a generic instrument for a range of services (Parasuraman et al, 1988).

According to Carman (1990), most SERVQUAL dimensions supported reliability and validity of the measure. Parasuraman et al (1993) further indicated that separate measure of expectations and perceptions allows managers to better understand the dynamics of service user's assessment of service quality over time and provides richer and more accurate diagnostics for improving organisation's service deficiencies.

2.3.6 Criticism

Although SERVQUAL has been utilised by both academics and practitioners since its initiation in the mid 1980s, it has received a range number of criticisms. Several researchers challenged the usefulness of the SERVQUAL scale as a measure of service quality by pointing out its shortcomings (e.g., Babakus & Boller, 1992; Brown, Churchill, & Peter, 1993; Carmen, 1990; Cronin & Taylor, 1992; Dabholkar, Thorpe, & Rentz, 1996). For example, Carman (1990) selected four service settings that were quite different from those used in the original test. He found that in some situations, SERVQUAL needs to be customised by adding items or changing the

wording of items, though it was originally designed to be a generic instrument for measuring service quality at any sector. In addition, he also suggested that the five dimensions in SERVQUAL are not sufficient to meet service quality measurement needs, and that the measurement of expectation in SERVQUAL is problematic.

According to Brown, Churchill, & Peter (1993) using the difference in scores causes a number of problems in such areas as reliability, discriminate validity, spurious correlations, and variance restriction.

Service user's expectations may fluctuate greatly over time (Reeves & Bednar, 1994). Therefore, it is not parsimonious to define quality in terms of service user's expectations. Empirically it is not valid to use the difference in scores between expectation and perceived service quality to measure service quality.

Confusion is associated with respondent's interpretation of the expectation measure and the lack of discriminate validity between the SERVQUAL expectation measure and the other expectation concepts used in marketing (Teas, 1993).

Based on the findings of Buttle (1996) the criticism can be summarised as theoretical and operational as follows:

Table (2.2) Criticism based on Buttle (1996)

Theoretical criticism	**Operational criticism**
Paradigmatic objectives means that SERVQUAL is based on disconfirmation rather than attitudinal paradigm	Expectations are swapped for standard by service user to evaluate service quality and so as moments of truth (MOT).
Gaps model indicates that there is little evidence that service users assess service quality in terms of P – E gaps.	Item composition implies that four or five items can capture the variability within each service quality dimension and so as the reversed polarity of items that causes respondent error
Process orientation implies that SERVQUAL focuses on process of service delivery not the outcomes of service encounter	Seven point Likert scale is flawed and the two administration system causes confusion and boredom
Dimensionality problems show that there is a high degree of intercorrelation between the five RATER dimensions	Variance extracted shows that the over SERVQUAL score accounts for a disappointing portion of item variance

In addition to the number of criticism explained earlier, Williams (1998) debated the factors that influence the formulation of the service user's expectation judgment (word of mouth, personal needs, external communications and past experience). She concluded that there is no way of knowing what the concept of excellence is to the individual service user.

Furthermore, Cronin and Taylor (1992) challenged that conceptualisation of service quality by defining service quality as the discrepancy between service user expectations and perceptions. In their empirical study, they stated that service quality does not posses a multi- dimensional nature, but rather it is uni-dimensional. The findings of their empirical study led to the introduction of a new tool called SERVPERF.

This instrument was introduced by Cronin and Taylor in 1992 in an attempt to theoretically and practically investigate the SERVQUAL measure. The authors of SERVPERF evaluated four models. These models were unweighted SERVQUAL, importance unweighted SERVQUAL, the unweighted performance subscale of SERVQUAL (SERVPERF) and importance weighted SERVPERF. They stressed that only unweighted performance measure (SERVPERF) was appropriate for measuring service quality.

Cronin & Taylor (1994) quoted Babakus & Mangold, 1992, Babakus& Boller, 1992 and Peter, Churchill and Brown, (1992) as supporting the use of performance-based measures of service quality over gap measures. SERVPERF was tested in four industries (banking, pest control, dry cleaning and fast food) its measure explained more of variance in an overall measure of service quality than did the SERVQUAL scale. A team of researchers, including Zeithaml herself has rejected the value of

expectations – based, or gap- based model in finding that service was only influenced by perceptions (Buttle, 1996). SERVPERF does not include expectations and evaluates quality perception solely on the basis of service user's perception of performance (LIusar & Zornoza, 2000).

2.4 Service excellence

Service excellence has captured the interest and the imagination of practitioners more than academics. This movement is being driven in part by the fact that service delivery, whether satisfactory or otherwise, has a powerful influence upon service users making impressions about the organisation, its employees and its services and other stakeholders including the local community. Although many organisations tend to perceive service excellence as elusive, slippery and difficult to achieve, service excellence can be achieved if all stakeholders are taken on board.

2.4.1 Definition of Service Excellence

Service excellence has been variously defined (Street, 1994; Cina 1989; Caruana *et al,* 1995; Sharma *et al,* 1990; Peters and Waterman, 1982). However, the earliest explicit findings for the elements of service excellence were found by Kim and Kleiner (1996). The findings of their work on three American banks shared these common elements of service excellence: a clear banking culture, management commitment, employee empowerment and improved operating processes with technological applications. In addition, the three organisations believed that service

excellence is a continuous process with strong commitments from every level of the organisation.

Similar investigations in search of excellence by Emerson and Harvey (1996) compared the Canadian and Australian visions of excellence in the management of not for-profit human service organisations. They revealed the following common elements of service excellence: clear purpose, serving client needs, commitments to staff, flexibility and internal processes. They concluded by emphasising that excellence is not a static state but a moving target; a paradigm that changes in its emphasis according to our changing values and circumstances.

A study by Duffin (1997) on a fashion retailer (Jaeger) found that creating an environment of trust and empowering employees helped deliver memorable shopping experiences. He concluded by stressing that in order to achieve and maintain service excellence, staff need truly to feel they own their business, appreciate the value of service users, and feel that they are empowered and supported.

Jackson's (1999) examination and visits to over a hundred organisations identified five important points that separated the best from the rest. These were: singular excellence is important but not enough, fit is as important as excellence, values are the basis of fit, and leadership and people make the difference.

Antonacopoulou and Kandampully (2000) promoted the concept of Alchemy (the transformation of services to higher value as perceived by the service user through the influence of the people within it). This was in line with the concept of 'Learning Organisations' and address the crucial

role of people. They argued that Service Alchemy provides an opportunity for organisations to improve, attain and maintain excellence. They defined service excellence as the process of transformation that provides greater value to the service by discovering new uses and possible alternatives of generating satisfaction/ enjoyment in the consumption process.

Table (2.3) Approaches to service excellence

Authors	Constructs
Emerson and Harvey (1996)	Clear purpose, serving client needs, commitments to staff, flexibility and internal processes, continuous change and improvement
Kim and Kleiner (1996)	Clear banking culture, management commitment, employee empowerment and improved operating processes with technological applications, continuous process with strong commitments from every level
Duffin (1997)	Staff feel the ownership of business, and feel empowered
Jackson's (1999)	Multi dimensional excellence, fit is as important as excellence, values are the basis of fit, leadership and people make the difference
CFM (2001)	Commitment to service users through people top priority
Erstad (2001)	Research, service standards, training, leadership, communication, people development process, recognition and measurement.
Johnston (2001)	Easy to do business with through service culture, service personality, committed staff and customer focused systems,
Mosely (2001)	Service users` needs, service delivery, people, values and leadership and response to change

CFM (2001) conducted a study on the Tullos Project at Shell UK Exploration and Production (Shell Expro - part of the Shell group of companies operating on behalf of Shell, Esso and other co-ventures). It identified service excellence as a business strategy where measurable success is achieved through an intensive focus on people management to deliver exceptional service to service users; i.e. service excellence is the focus with commitment to service users through people the top priority.

Erstad (2001) reported on the commitment to excellence program introduced at the Forte Hotel Group in London. This strategy adopted by

the hotel identified eight key elements, namely: research, service standards, training, leadership, communication, people development process, recognition and measurement. Erstad concluded that recent figures after the adoption of this strategy showed a drop in complaints by 15% and a rise in compliments by 24%.

Johnston (2001) defined service excellence operationally and how to achieve it, by looking at the meaning of reputation for excellence, organisations that have such a reputation, and development and sustainability of reputation for excellence through five service organisations; including one in Singapore and another in Hong Kong. He also stressed the fact that organisations that provide better services gain financial benefits. Further, Johnston (2001) stressed that a reputation for service excellence is about being easy to do business with through the development and sustainability of service culture, a service personality, committed staff and service user focused systems.

The findings of his study showed that a reputation for service excellence is about being easy to do business with. The key findings of his work included:

- A reputation can be a great financial benefit.
- A reputation attracts service users, employees and investors.
- Reputations depend on experience not image.
- Organisation values are important for developing and maintaining reputations.
- Service excellence is a bout delivering the promise, providing a personal touch, going the extra mile and resolving problems well.
- Service is tested by the way an organisation deals with complaint and problems.

- If better service is provided, better financial gains are achieved.
- A reputation for excellence can be developed and sustained through service culture, a distinct service personality, committed staff and customer focused systems.
- Service excellence needs a total approach and does not have to be costly.

Merkens and Spencer (1998) confirmed that leaders should: learn patience, listen to people, give support, build on success and always give credit. Committed leadership is essential to ensure clarity of directions and to monitor improvement towards jointly agreed objectives. Further, many researchers including Jackson (1999) and Erstad (2001) pointed out that leadership commitment is a prerequisite for sustainable service excellence. As emphasised by Lipovatz (1998), the first requirement of leadership is noticeable involvement in total quality that can be expressed by the openness of management to the staff and communication.

2.4.2 Examples from Practice

Examples of service excellence practices are prevalent in day to day transactions within various organisations both in the UK and internationally. For example, service excellence is a business strategy at Shell UK Exploration and Production (Shell Expro, a joint venture between Shell, Esso and other co-ventures), where measurable success is achieved through an intensive focus on people management to deliver exceptional service to service users. The focus here is on commitment to service users with people as top priority. Service excellence within (Shell Expro) has

become a habit, and part of the organisational culture and individual behaviour CFM (2001).

Walt Disney in the USA is perceived to have taken on a leading role in service excellence. Many companies have started to benchmark against Disney, including Swedish car manufacturer Volvo.

Other practitioners, like Mosely (2001), in association with Manchester Business School, organises service excellence tours in the USA by studying outstanding organisations and sharing the secrets of their excellence. In addition, the UNISYS (2002) award assesses five key business constructs: service users' needs, service delivery, people, values and leadership, and response to change.

Furthermore, Trafford Shopping Centre in Greater Manchester dresses up its people in red coats. These people are meant to make the shopping journey as pleasant as possible by getting to the" nitty gritty" of every detail of the shopping experience. What this means, is that understanding and enacting the single need of every service user requires the commitment and dedication of every single person in the team. This is towards making the shopping experience a very positive one, as well as making sure that the shopping journey is going to linger in the mind and become the talk of every visitor for sometime. One of course may argue the logic behind this. Simply, if a service user is to go on a shopping journey or on any other type of journeys, they expect their journey to be a value- adding one, because they know quite openly that they will park with their money, so why not in a valuable enjoyable and memorable fashion.

2.5 Discussion

Although, SERVQUAL and SERVPERF are claiming that they measure service quality. In fact, they measure service quality according to their understanding and interpretation based on statements/questionnaires designed according to their judgement and evaluation rather than to the exact needs of the service users themselves. Theses tools that are in place tend to be supply pull not demand push, i.e. providers frame the questions to the service users in such a way to get answers of them according to their interpretations. It is a bout time that this perspective is flipped to really dig deep for the exact requirement of the service user.

If the intent is to deliver and sustain service excellence within organisations around the needs of service users, obtaining feedback from them and taking account of their views and priorities is vital for bringing about improvements in the quality of service delivery which should help organisations move from service quality stage to service excellence.

It can be emphasised here that, unlike existing service quality measurement tools, the new service excellence tool has to be demand based. It should do the following:

- Measure service user experience rather than service user satisfaction
- evaluate the effect of service characteristics rather than the service characteristics
- focus on service excellence rather than service quality
- deal with out come of impressions of excellence rather than the process of service delivery.

- be demand push rather than supply pull
- identify major service user issues rather than assess P-E gap or service performance.
- multi dimensional rather than singular

2.6 Conclusion

Although, SERVQUAL and SERVPERF claim that they measure service user experience whether on the basis of P-E gap or service performance, they measure service user experience according to their understanding and interpretation rather than to the exact needs of the service users themselves. Furthermore, if this work is to be accepted as a means of measuring service user experience, new approach on the other hand has to come from a different perspective. It seeks to flip the perspective by attempting to measure service user experience rather than service user satisfaction. This is achieved by providing service users with the opportunity to define issues directly matter most to them as they experience their service delivery.

The service excellence concept has evolved without corresponding evolution in the measurement tools. This in essence means that the service concept has reacted to the call for change, however the measuring tools have not done so. Most of the tools used to evaluate and improve service quality seem to neglect the role of the service user construct as well as other constructs that can contribute to the creation of service user experience. These constructs include: staff delight, operational effectiveness, organisational culture, and continuous improvement.

The 'service excellence' concept is still in its infancy. It has got as far as service quality, and the promise of superior service delivery is far from being recognised. Therefore, there is a need for being more aware of the value - creating elements within the concept of service excellence and the supporting processes that would help develop those elements. Further, service excellence needs a total approach and does not have to be costly.

It has also been identified that just as important as making a step change required, is defining the true service user needs and desires to create the right experience. In order to take on such a change, organisations are increasingly required to flip the perspective to justify their added value to the service users instead of service providers. The main challenges in the future however lie with organisations in managing all stakeholders in an ever evolving task that should help them move away from service quality stage to service excellence stage where service user experience is created.

Moreover, although, SERVQUAL and SERVPERF are claiming that they measure service quality. In fact, they measure service quality according to their understanding and interpretation based on statements/questionnaires designed according to their judgement and evaluation rather than to the exact needs of the service users themselves.

Determining the key constructs associated with service excellence is a significant concern for healthcare providers. It is also of great importance to be aware of what is valued and essential by service users to know where and how service excellence can be achieved and sustained. The acknowledged gap between healthcare provider and user assessment of the healthcare delivery further emphasises the need for a mechanism to better respond to their needs.

In conclusion, if the intent is to deliver and sustain service excellence within organisations around the needs of service users, obtaining feedback from them and taking account of their views and priorities is vital for bringing about improvements in the quality of service delivery which should help organisations move from service quality stage to service excellence.

Chapter 3: Service User Experience

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

3.1 Introduction

The role of the service user as a component of service excellence is the basis of this study, with a focus on the applicability of service user centred concept. This is however a new subject of research in FM. The researcher has had to look to other sectors to gain a better insight of service user experience.

This chapter defines service user concept in its various settings. It looks at the background, definitions, types and elements of service user experience.

3.2 Background to service user experience

There is increasing recognition by organisations that service user experience changes social behaviour, and affects not just the composition of demand but also patterns of interaction between service users and service providers. This is at a time when a broad comparability is more important than ever, given the rate of change, the need to understand the effects of service user experience across different contexts. Additional work is essential to underpin such thing, and existing frameworks may not be able to deliver it.

However, the reality is that, it is necessary to have a unified consensus for required changes on this understanding. The relevance of new service user experience approaches must therefore be demonstrated, and it is not currently clear that changes considered useful by some organisations are beneficial to all. Long-term commitment to supporting change is required to pool resources, and focus on areas of expertise in a shared research

agenda. This is the only way to make progress affordable. There must also be more effective use of academic input within such a framework. This may require more, and perhaps different, resources and skills in national and international organisations to implement the changes needed.

Facilities management (FM) is responsible for the physical environment in which service delivery takes place. FM has been defined as:

> ...the process by which an organisation ensures that its buildings, systems and service support core operations and processes as well as contribute to achieving its strategic objectives in changing condition'" Alexander (1996).

More recent definitions (BIFM, 2001; IFMA, 2003) view FM as a business support function. Its goal is to improve the efficient management of and suitability of space and other related assets including people and processes. These actions enable staff to achieve their missions and goals efficiently and effectively, (Amaratunga *et al*, 2000). Additionally, FM staff has responsibility for creating the right environment to exceed user expectations and achieving service excellence.

Service users and staff see the environment in a number of dimensions such as signs, symbols, ambient conditions, spatial layout, functionality, and artefact. Any of these dimensions may affect service users' overall impressions either separately, or in combination with other dimensions. Due to the inseparability of service production and consumption (Zeithaml et al., 1985) other service users are often present in the service environment and as such can influence the behaviour of the individual service user. This suggests that servicescape should be considered not only

from the physical perspective but should also include the contents (the people) as factors that will help create the overall atmosphere.

3.3 Definition of Service User Experience

Service users always have good, bad or indifferent experiences whenever they approach service providers. The quality of the experience lies in how effectively the service provider manages it, in all its facets and from beginning to end. User experience begins from the first moment a user or potential attention is engaged. That might be person-to-person contact, but it could also be over a web site or through advertising literature. The user experience then continues through the pre-sales and sales process, product or service delivery, billing, on-going support and after-sales service. In brief, it's every point of interface between the provider and service user.

A first step toward managing the user experience should recognise what the clues can include the service itself (does it work as advertised?), the layout of a surgery (are the signs easy to follow?), the tone of voice of the staff (did he really mean it when he said, "Have a nice day"?), and so on. Organisations that orchestrate the sum total of all the clues can create an optimal experience for their service users.

Any organisation seeking to achieve service excellence will benefit from higher levels of service user satisfaction – repeat visits, enhanced revenues and profits (Pugh, et al, 2002; Schneider, Bowen, Ehrhart, & Holcombe, 2000; Wiley & Brooks, 2000).

According to the Oxford Advanced Learners` Dictionary (200) a user is:

> ...a person or thing that uses something", whilst experience is "an event or activity that affects some one in some way: enjoyable, exciting, unusual or unforgettable".

According to Haselgrove (1995) the service user (student) experience in higher education is what the whole process is supposed to be about. She further argued that providers of higher education are interested in the learner's perspective of the students rather than taking account of the rest of service user's (student's) lives. As Blakey (1995) pointed out Higher Education Institutes (HEI) have embarked on million-pound building schemes without testing what service users (students) themselves may want actually of their accommodation services.

Shaw and Ivens (2002) defined service experience as:

> A blend of a company's physical performance and the emotions evoked, intuitively measured against service user expectations across all touch-points.

This definition is a mix, not one thing or another but mixed together. It is about the physical and very importantly the emotional. It is measured instinctively by the service user against their expectations. Lastly it is not just when the service user is in a shop, it's whenever they come into contact with that organisation or its brand across all of their service user touch-points. It goes into fundamental details that tell you the truth about an organisation.

3.4 Factors Affecting Service User Experience

Rowley (1994, 1999) applied factors that contribute to the user experience to liberalities and museums. These factors are: speed of service delivery, convenience, age, choice, life style, discounting, value adding, service user service, technology and quality. Some of these factors may not necessarily apply to all organisations, although there are some common factors that can be shared. For example, discounting can be more influential in profit driven organisations and less so in non-profit making organisations such as the NHS. Furthermore, organisations that rely on handcraft work would be less affected by technology than those that are heavily dependent on technology such as the NHS.

3.5 Classification of Experience

Experiences can be classified into four categories, Pine II and Gilmore (1999):

- Entertaining experience - a passive way to engage a service user and attract an audience of shoppers.
- Educational experience - where the service user immerses in the event developing before him. This type of experience requires an active participation of the service user in the event to increase his knowledge and skill.
- Escapist experience - where the service user is completely immersed and actively involved in shaping the experience.
- Aesthetic experience - where the service user is immersed in an environment but has little or no effect on it, leaving it untouched.

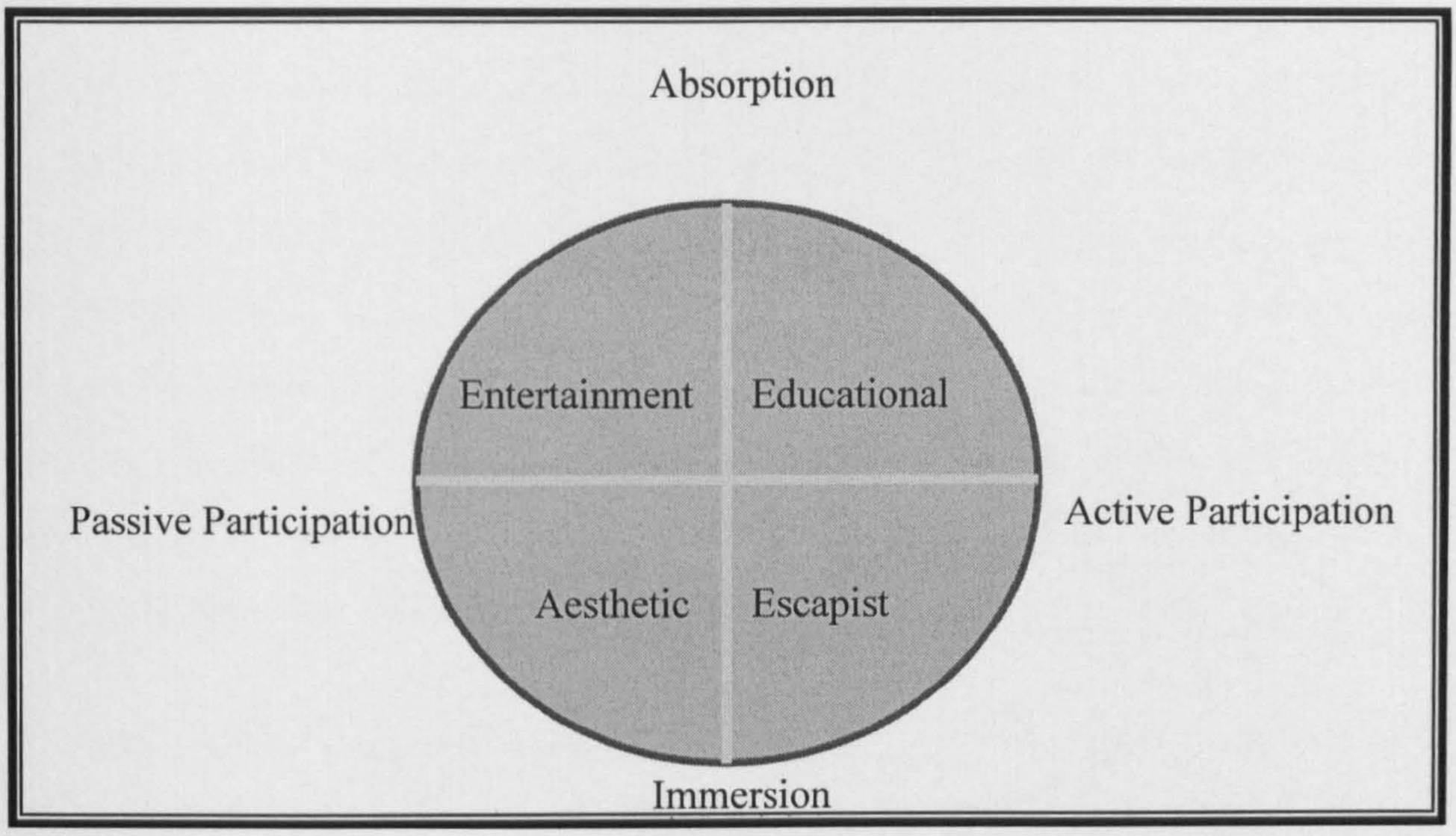


Figure (3-1): the Experience Realms, Pine II and Gilmore (1999)

The above figure does not explicitly demonstrate that it is capable of providing an experience for service users that is similar to what a pool of excellence assessors would have provided if a formal application was submitted at about the same time within the NHS. Moreover, in the Bitner (1992) framework, social interactions are viewed as outcomes of the service user/employee/environment interaction rather than as a form of environmental incentive.

Last but not least, in an economy driven by service users, service user experience has social dimensions, which must be recognised - in education, health, labour markets and elsewhere. It is the combination of services and environment that determines the ability of services to operate effectively in society, and for individuals to derive benefits from public services. The above diagram fails to address these benefits that need to be understood in terms of outcomes.

3.6 Service user experience & Service user satisfaction

In order to understand service the difference between service user experience and service user satisfaction a definition of service user satisfaction has to be determined. Drucker (1972) states that the aim of the organisation is to create and keep service users. Service users are richer and better educated than before. They are more demanding about the service they receive. Therefore satisfaction or lack of it can be defined as the difference between how service users expect to be treated and how they perceive they are being treated.

Several studies have found that it costs about five times money and resources to gain a new service user as it does to retain an existing service user (Pizzam and Taylor, 1999). They also indicate that more than 15000 academic and trade articles have been published on the topic of service user satisfaction in the past two decades leading to the development of nine distinct theories of service user satisfaction. The nine theories include (1) expectancy (2) assimilation or cognitive dissonance (3) contrast (4) assimilation contrast (5) equity (6) attribution (7) comparison level (8) generalised negativity (9) value-precept.

Pizzam and Taylor (1999) go on to apply satisfaction theories in the hospitality sector establishing that a persons` satisfaction with outcomes received from a hospitality experience is the result of comparison between outcomes and expectations. Expectations can be described as a changeable internal standard based on a great number of factors such as personal desires, experiences with similar organisations and the availability of alternative organisations.

While a small number of researchers state that a satisfaction process is subjective in terms of the expectation and objective in terms of the outcome, other researchers point out that what is perceived and what is expected are subjective, thus a psychological phenomena. Pizzam and Taylor (1999) further state that expectations and perceptions are psychological phenomena not reality, thus they are both vulnerable to external influences and manipulations. According to Kandumupully and Suhartanto (2000) service user satisfaction is considered to be one of the most important outcomes of all marketing activities in market-oriented organisations.

The obvious need to satisfy a service user is to extend the businesses to earn a greater market share and to develop repeat and referral business all of which lead to improved profitability. Johnston and Clarks (2001) define service user satisfaction as a result of service users` assessment of service based on comparison of the perception of service delivery with their prior expectations. They go on to say that if the service users` perception of the service, the experience and the outcome matches their expectations then they should be satisfied. If their perception of the service exceeds their expectations then they will be more than satisfied. If their perception of the service does not meet their expectations then they are dissatisfied.

Whilst, service user experience is defined by the author as a journey on which the service user senses the core benefit, the hedonic and aesthetic performance of the service transaction in finding and approaching the service, departing from it and interacting with other service users in the right environment.

This definition implies that service user experience is broader than service user satisfaction in the sense that all touch points are involved in such a journey. The difference can be best explained in that service user satisfaction is only one of the many service dimensions featured into service user experience. In other words, service user experience is an antecedent of service user experience.

It has been determined in some of the work done in the service sector that the service user experience is complex, and adding to its complexity is the understanding of the extent of engagement between service providers and users in achieving successful outcomes. Yet, in all, service user behaviour and marketing research have neglected service user views and responses to service provider engagement behaviours and the subsequent Assessment of service user experience outcomes.

Assessment of service user experience with encounters requiring interpersonal engagement is affected by the nature of engagement between the service provider and the user. In many respects, the service user – provider exchange may be characterised as a social engagement within which participants jointly negotiate outcomes.

3.7 Servicescape – service user relationship

Interaction process is the core of relationship. According to Lashley (1997) institutions where service providers are aiming to gain a competitive advantage through service quality, the quality of interaction between employees and service users is deemed to be crucial determinant of service user perception of service quality.

In order for an organisation to provide good perceived quality of service, it has to manage the service process as well as all necessary resources for the process. Then the service users not only observe the experience in operation but also take part in it (Gronroos, 1998).

Lassar et al (2000) stressed that communication plays an important role in the service delivery process. They further stressed that ignorance regarding service users` expectations is one of the root causes of failure to satisfy these expectations and ignorance of service user expectations is likely to result from lack of direct interaction and communication with service users. Barnes (2001) stressed that the achievement of service user satisfaction is very dependent on interaction with service users at the interpersonal level.

A further range of views from architectural and landscape design literature relevant to this study focus on impressions, attitudes and response discussed in the work of Preiser and Vischer (1991) and Beer and Higgins (2000). In their work, Preiser and Vischer (1991) stated that the mental habits and attitudes of people are greatly influenced by their physical environment and designers often miscoded the environment, which led to misinterpretation by users. This compares with the work undertaken by Lam in (1977), Lassar et al (2000) and Barnes (2001), which stressed that perception was based on flow of information, interaction and communications with the users.

Steinfild and Dunford (1999) added a further dimension to consider in discussions of perception and raise the question of whose and the existing

state of wellness or embodiment of the user of the environment. These writers, in considering enabling environments from the viewpoint of the disability and rehabilitation, pointed to the importance of the physical environment as a factor in determining the degree of independent living and in defining the status of people with disability in society. Commenting with respect to the environment, the authors have argued that most people with impairments and professional who serve them recognise the important role that the environment plays in the life of those with impairments.

Beer (1991) and Beer and Higgins (2000) are among a number studies of environmental panning and architecture for human design that have considered the importance of the human perception with respect to locational and positional information flows and functions. Various notions of perception discussed in Beer (1991) and Beer and Higgins (2000) are discernibly linked to the present study. These are: sense of place, sense of space and making environments liveable.

Although the work of beer and Higgins (2000) relates to environmental settings within site planning and designs contexts, some of the conceptual foundations of their discussions are relevant to the present discussion on perception, in particular, the concepts of place and apace, as represented by examples of the visual characteristics of space, factors influencing perception of space are particularly useful and applicable within the present case of the built environment, even though within the healthcare sector. For Beer and Higgins (2000), people experience and react to the place in which they live their lives and in which they carry out occasional activities.

Furthermore, in discussing the factors that influence peoples' perception of space, Beer and Higgins (2000) emphasised that it is not just image alone

of a particular space which decides how it is perceived and understood. Perception of the special characteristics of an individual space also relates, amongst other factors to:

- The sequence and type of space passed through on the way to the space,
- The other space seen from the particular space,
- Past knowledge of the space and of similar spaces,
- The condition of mind, to past experience of the natural environment,
- The service user's cultural, educational, social and economic background,
- The aesthetic sensibilities and to such factors are state of physical well being,
- The evidence of human activities such as noise, dirt and smell, who is in the space when its visited or observed and what the service user feels able to do or prevented from doing when there.

Bitner (1992) suggested that the physical environment's impact on users cannot be underestimated. She proposed a framework for understanding the physical environment and user relationships in service organisations. This conceptual framework describes the complex mix of environmental factors that can influence the internal responses and external behaviours of both service users and employees.

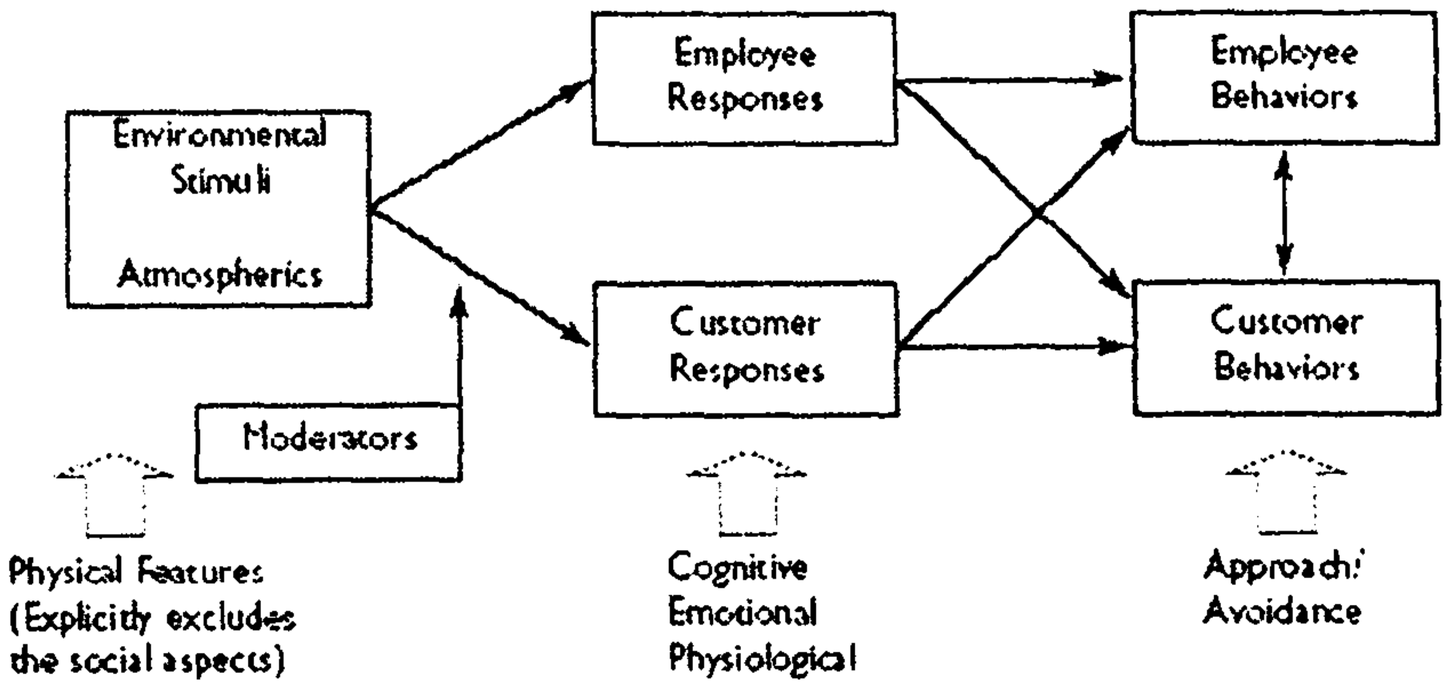


Figure (3-2) the servicescape conceptual framework (Bitner, 1992)

For example, users and employees see the environment in a number of dimensions such as signs, symbols, ambient conditions, spatial layout, functionality, and artefact. Any of these dimensions may affect users' overall impressions either separately, or in combination with other dimensions. The behaviours resulting from the influence or interaction with the service user's physical environment are described both as individual behaviours, which follow Mehrabian and Russell's (1974) approach-avoidance behaviours, and as social interactions that occur between the service users and the employees.

Tombs and McColl-Kennedy (2003) have presented 'Social-servicescape' conceptual model which builds on Social Facilitation Theory (Zajonc, 1965), Behaviour Setting Theory (Barker, 1968) and Affective Events Theory (Weiss and Cropanzano, 1996). They argue that the concept of atmospherics be broadened to include service users, and thus also extending Bitner's (1992) servicescapes.

They suggested that the Social servicescape is comprised of five key elements:

(1) Purchase occasion (context);

(2) Social density (physical elements);

(3) Displayed emotion of others (social elements);

(4) Service user's affective responses (internal responses); and

(5) Service user's cognitive responses (either as intention of behaviour or actual behaviours).

Within this conceptual framework they proposed that the purchase occasion will influence the reaction to and acceptance of the social density and the expressed emotions of the other service users, this will in turn influence the service user's affective responses (e.g. the service user's moods and emotions), and the service user's affective and cognitive responses (e.g. interacting with others and repurchase intentions respectively). See figure (3-3).

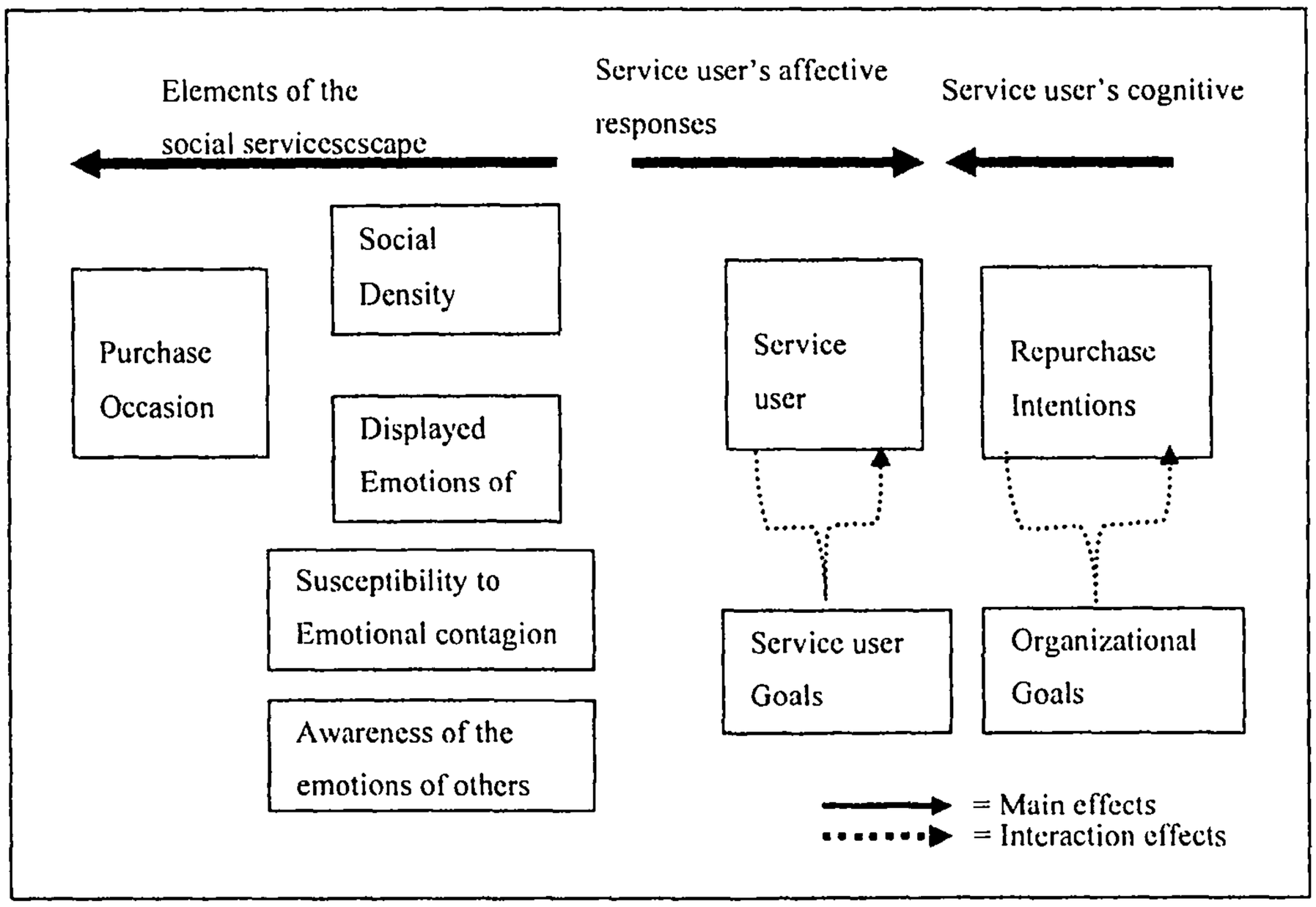


Figure (3-3) Tombs and McColl-Kennedy 'Social-servicescape' model

Although, this work is a significant departure from the majority of atmospherics literature, which suggests that the service environment be considered only in terms of its physical attributes. It does not specifically allude to healthcare environment,

Furthermore, Tombs and McColl-Kennedy (2003) have argued that emotional contagion is an important component so that service users' affective states and their subsequent cognitive and behavioural responses primarily repurchase intentions, are likely to be affected by the purchase occasion, social density and the displayed emotions of others in the service setting. In doing so, they extend Mehrabian and Russell's (1974) classic approach–avoidance model.

3.7 Discussion

The usefulness of the information picked up from the literature review within the subject area of service user experience has varied enormously. The majority of the literature that is available within the subject area of service user experience is all limited to a certain degree, when viewed within the context of this thesis, in that, more often that not, the generic concept is documented only, and is rare to find literature which details service user experience within the context of Primary Care Trusts.

Supporting information realised from the review of journal articles, in respect of the afore-mentioned thesis area, have been of almost equal use to the information obtained from within established texts.

Therefore, the amount of time expended by the author in reviewing the literature to assess the composition of this thesis has proved necessary to

realise a comprehensive and cogent data set, that seeks to best to best support the concepts contained within the thesis, and inform the reader accordingly.

3.8 Conclusion

As service user experience varies with individual service user's impressions, these impressions need to be managed to improve service delivery. The excellent way to go about this is to solve ambiguity of service user experience that extends to its role within the evaluation process of service excellence itself being conceptualised as driven by the user experience.

The key is interaction and communication that could help impressions of service users be better understood. In order to survive in the next decade, organisations will need to better define the impressions of the service users and encourage the process of interaction and communication as it is deemed crucial.

It has been identified that becoming an excellent manager implies that a wide spectrum of knowledge and skills is required not only to manage a physical building but also a host of stakeholders including users, auditors and inspectors

Chapter 4: Application of Service Concepts within the NHS

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

4.1 Introduction

The national health care sector in the UK (NHS) as a comprehensive and government sponsored public system, has witnessed the introduction of numerous quality initiatives over the past decade. These initiatives have been driven by the realisation that service users were not satisfied with the health care delivery and also the willingness of the NHS to restructure in order to better respond to their demands. The general consensus is that, once people start using a certain quality initiative, another initiative is introduced. Furthermore, most of these initiatives seemed to lack two important features: relationship with each other and the integration of all aspects of the organisations` activities into focused action on continuous improvement and service user desires (Stahr, 2001).

This chapter examines the application of service concepts in NHS PCTs. The findings have come out of extensive research survey include: birth, application and measurement of service quality in healthcare, different interpretations and implementation of service excellence, and service user experience in NHS.

4.2 Background to healthcare

NHS Trusts were first established under the NHS reforms of the 1991 which were brought about as a direct consequence of the 1989 Government White Paper "Working for Service Users". The defined function of the NHS Trust under these reforms is to provide hospital and / or community based healthcare services on behalf of the Secretary of the State for Health. To meet this commitment NHS Trusts are structured to be self-governing units with their own boards of directors, both executive and

non executive, and have the freedom to conduct their primary goal of providing healthcare services.

Flynn (1993) outlined some basic healthcare related facts:

- The UK NHS employs just over one million people. The vast majority are employed within the acute medical or hospital healthcare sector.
- The social Security Service is by far the biggest central government application of resources, followed by Defence, then Health
- The total potential healthcare needs of the UK are defined through a population of about fifty eight million people.

Appleby (1994) approximated the total weekly expenditure on healthcare in the UK as being in the order of £ 12.30p per person, or £37 billion per annum in total.

It is evident, therefore, that the costs of providing healthcare within the UK are massive. Healthcare total public spending alone in the UK accounts for approximately five and a half percent of the national GDP.

With reference to the White Paper "Working for Service Users" (DOH, 1989), the proposal was to secure two healthcare objectives, these being:

- To give service users, wherever they live in the UK, better healthcare and greater choice of the services available
- To provide greater satisfaction and reward for those working in the NHS who successfully respond to local needs and preferences

Further, the introduction of the Government White Paper "The New NHS Modern and Dependable" (DOH, 1997) sought to increase the role of primary care within the NHS. Through the application of the key principles contained within the White Paper, the aim was to offer service users a modern and dependable NHS, capturing developments in medicine and Information Technology and offering services that are quickly and of consistently high quality:

- at home: easier and faster advice and information for people about health, illness and the NHS so that they are better able to care themselves and their families
- in the community: swift advice and treatment in local surgeries and health centres with family doctors and community nurses working alongside other health and social care staff to provide a wide range of services on the spot
- in hospital: prompt access to specialist services linked to local surgeries and health centres so that entry, treatment and care are faultless and fast

It can be seen, therefore, that the government is placing great emphasis on the development of community based healthcare services both on a stand-alone basis and also with necessary inks into the hospital or secondary care health sector.

With reference to above-mentioned White Paper, Primary Care was defined as being family health services provided by family doctors, dentists,

pharmacists, optometrists and ophthalmic medical practitioners. The white paper made further reference to the Community Nurse group comprising practice nurses, health visitors and school nurses.

Chapter five of the same White paper referred to the development of Primary Care Groups in terms of bringing together GPs and community nurses to work together to improve the health of local people through commissioning services and through better co-ordination of primary and community services. The main function of the Primary Care outlined within the White Paper as helping to:

- Contribute to the Health Improvement Programme on health and healthcare, helping to ensure that this reflects the perspective of the local community and the experience of service users.
- Promote the health of the local population, working in partnership with other agencies.
- Commission health services for their population from the relevant NHS trusts within the framework of the health Improvement Programme, ensuring quality and efficiency.
- Monitor performance against the service agreements they have with NHS Trusts.
- Develop primary care by joint working across practices, sharing skills, providing a form for professional development, audit and peer review, assuring quality and developing the new approach to clinical governance; and influencing the deployment of resources for general practice locally.

- Better integrate primary and community health services and work more closely with social services on planning and delivery.

Furthermore, the introduction of the latest White paper in January (2006) termed as (our health, our care, our say) is indicative that the government is willing to build a new world class system of health and social care in England. The new initiative adopted by the government will allow the move towards the approach where service is designed around the service user rather than the needs of the service users being forced to fit around the service already provided.

The challenge for the NHS should maintain this development and make sure that GPs are capable of expanding their services and responding to changing service user's demands. The new initiatives will guarantee that GPs are allowed to acquire for their service users services within the NHS and private sector. This white paper looks to provide greater choice for service users so they can take full advantages of the new range of services provided. It also seeks to improve care, cut delays, make services more convenient, expand the role of practice nurses and local pharmacists and encourage GPs to offer longer surgery hours.

4.3 Quality Management in Healthcare

Across the Western world the demand for the costs of healthcare are on the increase with the demand for resources being greater than supply. Demand is shaped not only by service users but also by the clinical decisions of doctors and other healthcare professionals.

Healthcare is values- driven profession particularly in the service user care areas. These values of concern for service user, working together as a team to serve the service user and concern the support for employees influence the action of nurses, physicians and hospital staff (Mallak et al, 2003). In order for healthcare providers to sustain survival in the ever-turbulent condition, they need to act more like an integrated business by paying a close attention to goals, competition, markets and the legal regulatory- environment.

There are now more than 300 primary care trusts (PCTs) in England. PCTs plan and manage NHS services locally, either by commissioning services from other organisations or by providing services directly. They have been given a key role in running the NHS and improving the health of people in their local areas. Along with acute trusts, mental health trusts, foundation trusts and other providers of NHS services, they are changing the way the NHS works to ensure that the needs of service users are put first.

NHS hospitals provide acute and specialist services, treating conditions which normally cannot be dealt with by primary care specialists or which are brought in as an emergency. It covers medical treatment or surgery that service users receive in hospital following a referral from a general practitioner (GP). Secondary care is made up of NHS, foundation, ambulance, children's and mental health trusts.

Social care covers a wide range of services that can help people to carry on in their daily lives and is one of the major public services.They provide services that meet an individual's or an area's circumstances and needs. They also work closely with others including the NHS, voluntary and private

organisations as well as with the education service, the probation service, the police and other agencies who share the responsibility to provide this care and support.

According to Curry and Sinclair (2002), the need to respond to increasing service user expectations and governmental pressure to contain costs have reflected in the internal forces of change, from the structural change within the NHS to the growing emphasis on clinical effectiveness and the need to consult with different stakeholders in healthcare services. Wong (2002) noted that in health care setting, service user satisfaction is an important component of service quality due to its strength in being very indicative of the success of the health care provider in meeting the service user's values and expectations.

Curry and Sinclair (2002) further noted that healthcare providers will have to better manage their resources with a consequent focus on quality management and more effective service delivery. The NHS will not need to focus on spending money but on really identifying and meeting service user's needs as well as forces of change such as growing public expectations, greater service user culture, medical advances and demographic changes.

According to Bull (1994) quality should be a central issue in the commissioning and provision of healthcare. This requires a systematic approach to defining and monitoring quality. Such an approach should address: quality characteristics such as efficiency, accessibility, effectiveness (which may conflict with each other); the several levels at which quality may be specified, from general (across all healthcare) to specific (particular conditions or service user groups); and the methods of

quality monitoring which include documented policies, clinical audit, inspection visits/service user surveys, and routine information returns. He demonstrated how a matrix for quality surveillance can be devised which provides a framework for purchasers and providers to work together in developing quality in healthcare.

As stated by Aukett (1994), if clinical audit revolves around concepts of quality, then there is a need to examine the basis of quality and thereby clinical audit as traditionally defined by healthcare organisations. Basing quality on service users' stated needs is often insufficient. Healthcare service users should not be confused with the term service users, and professional staff should be ready to consider service users' needs before those of any organisation. He further argued that in order to handle the wider view of quality in health care, a construction of quality web could help clinical managers adopt a broader perspective to quality and audit in the service they provide.

Newman and Pyne (1996) presented the results of an empirical study of junior doctors' views on quality and clinical audit in healthcare. They went on to claim that the requirement for annual efficiency gains and rising service user expectations, together with the realisation that the "costs of quality" can consume between 30 and 50 per cent of costs, has brought quality in health care to the forefront. They studied the perceptions of junior doctors on dimensions of quality in healthcare, their knowledge of, and participation in, clinical audit and the obstacles to providing quality care. They concluded that the role, significance and outcome of clinical audit as a quality improvement tool is shed into doubt by these consultants of tomorrow.

John (1996) examined the "dramaturgical" view of the service encounter to understand the service consumption experience. He demonstrated how the drama metaphor is applicable and useful in understanding perceived quality in healthcare services. A strategic model of the medical encounter was presented and an impression management guideline is suggested. He went on to stimulate the imaginations of physicians and healthcare administrators on managing evaluations from a practical standpoint by paying attention to certain characteristics of the medical encounter.

Hogarth-Scott and Wright (1997) examined the debate on quality in health care in light of GP fund-holding and the Service users' charter focus on the development of quality issues in general practice by carrying out research based on two stages: first, an exploratory stage aimed at the understanding of key issues; and second, a questionnaire made up primarily of attitude elements drawn from stage one. They concluded that, in the changing political and public environment, GPs are facing the challenges of managing service quality.

Hansson (2000), explored the notion that the introduction of total quality management in the public healthcare sector indicates a conceptual break with a tradition in which the authority to define and interpret the meaning of medical practice has been located solely within the medical profession. It also serves to shift the focus of medical practice away from its contextual and interactional character towards numerical representations and codification in monetary terms. He emphasised that the realisation of management ideals in everyday practice is dependent more on the availability of pre-existing technologies and standard procedures than on

the ingenuity of particular organiational and institutional actors within Swedish hospital organisation.

Lindberg (2002) stated that quality in healthcare is largely dependent on the behaviour and action of the health care staff. What's more, behaviour and action stem from the individual and group sense making. When the organisation is viewed as a complex adaptive system, the necessity of becoming aware of and co-evolving with the process of sense making becomes very clear. It has potential to view the individual's attraction patterns as the channel for creativity. The quality system can serve as the framework on which to enlighten this vital dimension. He further states that the concept of meaning status in the group is useful when it comes to managing a complex system through a quality system. He stressed that the core objective of the quality system is to support and enhance the awareness of all the disparate meanings (future-perspective), stimulate reflection upon them and transform them into a collective meaning status (presence) in order to make effective decisions and a successful adaptation to change.

Humphrey, et, el (2003) explored the implications for continuity of care of the wide range of policy initiatives currently affecting the management and use of human resources in the UK National Health Service. They described the findings of a short study undertaken in 2001 comprising a policy document analysis and a series of expert seminars discussing the impact of the policies in practice. They went on to say that the impact to date has been rather more equivocal as a result of the damaging effects of the process of policy implementation on continuity within the system and on staff attitudes and values. They emphasised that if continuity of care is

accepted as an important element of quality in health care, more attention must be paid to developing strategies which support system continuity. (See table 4.1)

Table (4.1) Approaches to quality of healthcare

Authors	**Focus**	**Sub-theme**
Bull (1994)	An approach of quality monitoring in the healthcare	A matrix for quality surveillance can be devised which provides a framework for purchasers and providers to work together.
Aukket (1994)	A development of clinical audit for a community dental Service.	Managers should adopt a broader perspective to quality and audit in the service they provide
Newman and Pyne (1996)	Presentation of the results of an empirical study of junior doctors' views on quality and clinical audit in health care	The role, significance and outcome of clinical audit as a quality improvement tool is cast into doubt by these consultants of tomorrow.
John (1996)	Dramaturgical view of the service encounter to understand the service consumption experience.	A demonstration of how the drama metaphor is applicable and useful in understanding perceived quality in health care services.
Hogarth-Scott and Wright (1997)	A development of quality issues in General Practice by carrying out research based on two stages	Due to the changing political and public environment, GPs are facing the challenges of managing service quality.
Hansson (2000)	An introduction of total quality management (TQM) in the public health-care sector	The realisation of management ideals in everyday practice is dependent more on the availability of pre-existing technologies and procedures
Lindberg (2002)	A Description frame and function of a quality system in health care which is largely dependent on the behaviour and action of the health care staff.	In order to make effective decisions and a successful adaptation to change. The quality system should support and enhance the awareness of sense making processes.
Humphrey, et el (2003)	Exploration of the implications for continuity of care of the wide range of policy initiatives currently affecting the management and use of human resources in the UK National Health Service	If continuity of care is accepted as an important element of quality in health care, more attention must be given to developing strategies which support system continuity.

4.3.1 Measurement of Quality of Healthcare

Deficiencies as with regard understanding the quality of healthcare have been summarised by Hwang et al, (2003) as follows:

- Methodological dilemmas and lack of standardised approaches to service user satisfaction surveys research.
- Lack of clarity and consistency in understanding the determinants of service user satisfaction.
- Lack of an accepted conceptual or theoretical model of service user processes.
- Lack of consensus within the medical professions on the role that service user satisfaction should play in the assessment of quality of health care.

Brown & Bell (1998) developed a new audit instrument to elicit user's perceptions of quality in medical, clinical managerial and professional areas based on SERVQUAL. They stressed that audits in clinical and managerial areas can be measured. They concluded that gaps between what service offers in terms of quality and user's perceptions of what the service is actually being delivered can now be highlighted.

Carman (2000) investigated the way the attributes contained in a service user's perception of quality are shared in that attitude structure as well as how similar are the importance weights used in this attitude structure for different classes of a cute hospital service users. He found that nursing care was rated as most important, the outcome of the hospitalisation was rated second and physician care was rated as third. He concluded that the conjoint methodology is a robust way to study attitude structure and service users seem to separate affective dimensions of service quality from technical dimensions.

Curry & Sinclair (2002) tested the applicability of SERVQUAL model to assess the quality of three different types of physiotherapy service provision in Scotland. The findings showed that service users appreciated services despite the perceptions-minus- expectations scores being slightly negative. The dimensions of assurances and empathy were indicated as important. They concluded by confirming the potential usefulness and relevance of SERVQUAL in the public sector context in order to determine service user priorities and measure service performance.

Amaratunga et al (2002) tested a framework that organisations can use to monitor continuously and subsequently improve their performance. The structured process improvement for construction environments- facilities management approach (SPICE FM) is examined in a number of case studies within a NHS facilities directorate. They emphasised that the concept of assessing FM process improvement within NHS facilities develops participation, awareness, a decentralized decision-making process and responsibility for achieving formulated goals. They concluded that goal achievement analysis is important for organisations to draw conclusions about their performance and ways of improving it.

Amaratunga et al (2002) discussed the application of the Balanced Score Card (BSC) concept as a framework for measuring organisational performance within NHS facilities directorates. They chose NHS estates and facilities in the North West of England for the establishment of the conceptual framework for performance management for facilities directorate. They concluded that a directorate should always review the validity of the measures on regular basis and ensure that they reflect the directorate strategy.

Sohail (2003) examined and measured quality of services provided by private hospitals in Malaysia using empirical research to determine service user's expectations and perceptions of the quality of service. He adopted a comprehensive SERVQUAL scale to evaluate its usefulness in the Malaysian hospital environment. He concluded that Malaysian health care providers seem to be doing better in achieving service user satisfaction with regard to service quality.

Radnor & Lovell (2003) critically evaluated the case of need for full application of the Balanced Score Card (BSC) within the Bradford health sector paying a close attention to the factors that may facilitate successful adoption of BSC within the UK health care sector. They identified factors related to existing and alternative performance measurement systems (PMS) potentially inhibiting BSC use, resources based concerns potentially inhibiting BSC system and other practical factors potentially seen as inhibiting BSC. They concluded that blind implementation of BSC in NHS without consideration of these factors may result in potential failure.

(See table 4.2 overleaf)

Table (4.2) measurement instruments of healthcare quality

Author	Focus	Sub-theme	Measurement Instruments
Brown & Bell (1998)	A development of a new approach to audit medical, clinician, managerial and professional areas in the UK health care field	Measuring health out come from the user's perspective	SERVQUAL
Carman (2000)	Investigation of the way the attributes contained in a service user's perception of quality are shared in that attitude structure	service users seem to separate affective dimensions of service quality from technical dimensions.	Conjoint Methodology
Curry & Sinclair (2002)	Applicability of the SERVQUAL model to assess the quality of three different types of UK physiotherapy service provision	A confirmation of the Potential usefulness and relevance of SERVQUAL in the service sector	SERVQUAL
Amaratunga et al (2002)	A test of the structured process improvement for construction environments- facilities management approach (SPICE FM)	The SPICE FM framework is a method that organisations can use to monitor continuously and subsequently improve their performance	SPICE FM
Amaratunga et al (2002)	A discussion of the application of the Balanced Score Card (BSC) to measure organisational performance Within UK NHS facilities.	Identification of a framework as a strategic measurement and management system within UK NSH	BSC
Sohail (2003)	Examination and measurement of quality of services provided by private hospitals in Malaysia	Service user's perceived value of services exceeded expectations for all the variables measured	SERVQUAL
Radnor & Lovell (2003)	An assessment of the BSC system's potential to enhance performance management within a UK NHS multi agency setting.	A full BSC system can be developed as a diagnostic control system to improve achievements of government based targets	BSC

4.4 Service Excellence in Healthcare

Möller and Sonntag (1998) argued that the EFQM model for organisational excellence is used in the healthcare sector as a tool to diagnose and assess the starting position for an effective QM programme. Building on the EFQM feedback reports, the Modular Concept for Quality in Health Care ("Heidelberg Model") improves QM both holistically and specifically by implementing so-called "Modules for Excellence". The implementation process follows principles of project management covering medical, nursing

and managing issues and the performance is periodically evaluated against targets. Different assessment approaches lead to a diagnosing feedback report for QM in health care. The Modular Concept for Quality in Health Care ("Heidelberg Model") clusters, prioritises, implements and evaluates the organisation's key areas for improvement.

Jackson (1999) described the initiation of self-assessment and the European Foundation for Quality business excellence (EFQM) model in Huddersfield NHS Trust, which is situated within the Northern and Yorkshire region of the UK. He goes on to state utillising the EFQM model is vital for achieving the culture of continuous improvement. He concluded that one of the major benefits of the business excellence model is its ability to enable the team to see the directorate and the trust as a whole in an attempt to attain a culture of continuous improvement and delivery of quality health care.

The NHS published its programme for excellence (2002), which contains the following domains:

- Introducing managing for excellence in the NHS implies that care and safety of service users are prime concern by protecting them from risk.
- A step change for excellence implies that the new management task is made of: partnership in maintaining clinical processes and service delivery, full engagement with service users, staff and local communities, and new skills to deliver lasting change.
- Culture, style and organisation implies that judging the effectiveness of local NHS services and their management by what staff and local

people tell just as much as the monthly performance statistics and inspectorate report

- National action to support change and development implies that the scale of the challenge means systematic development across the whole of the NHS is needed of managerial skills and organisational development to move fast and confidently.
- Moving forward together implies making a lasting contribution to improving health and health services requires raising the sights and ambitions of management and staff within the NHS.

Judging by the excellence criteria in the quoted literature, service excellence can be defined as:

> An ongoing transformational process in operationally effective and continuously improving organisations with matching culture; that guarantees service is experienced by the service user in a valuable, enjoyable and memorable manner, delivered by delighted staff.

It is important to note that this definition of service excellence emphasises three aspects:

- Service excellence is driven by the service user to best create a positive experience for the service user.
- Constructs such as staff delight, culture, operational effectiveness and continuous improvement are integral parts of the overall loop for a complete picture of excellence.
- Service excellence is a shared practice.

In the most basic sense, it is clear that everyone understands the need for service excellence regardless of the different interpretations and

evaluations criteria. If the work by practitioners as well academics is to be accepted, these examples point to the fact that in general, the concept of service excellence has remained ambiguous. The general consensus however seems to identify the best predictors of service excellence as:

- service user
- employees
- operational effectiveness
- continuous improvement
- culture

Armed with the definitions of service excellence and the clear understanding about the importance of making service users prime concern, one can allude to the applicability of such an initiative that strives for positive service user experience at what ever costs. This is stemmed from the notion that the service user is the driving force that keeps the economy rolling and any business that turns a blind eye to its service users is bound to run into trouble.

4.5 Service User Experience within NHS

As mentioned earlier, service user experience is defined as a journey, which implies that the service user will go through a sequential process. This process varies depending on the type of healthcare provider, and on the circumstances that a service user may experience in a given healthscape.

4.5.1 Healthscape

The majority of studies seeking service user views on health care provision have been concerned with delivery and outcomes of health (Bruster et al, 1994; NHS survey of NHS service users: General practice, 1998; Hiscock et al.2001). Little work focused on service users' preference and views on how the built environment can meet their needs and affect their quality of care. Historically, the focus has been on topics related to managers' and professionals' priorities and agendas. These are not necessarily the priorities of the service users. Examples of processes addressed in service user satisfaction surveys include, for example, how long they had to wait for a bed, whether or not they were given enough information about their condition by staff, pain management and staff communication with service users.

Following the introduction of the service user's Charter in 1992 in the UK, hospital teams and academic researchers have carried out surveys of service users' satisfaction. Some surveys have detailed views of the service users experience in contrast to earlier approaches which focused on how 'satisfied' the service users were with the quality of care (Bruster et al, 1994; Stevens et al, 1995; MacRae and Michel, 1998; and Fowler, et al, 1999; Airey, et al, 2001).

Steven et al. (1995) carried out a survey, which focused on various issues, including involving service users and their relatives in the process of care, using a qualitative survey methodology, focus groups and personal interviews. Findings were grouped into three categories, comprising the environment, communication and accommodation. For environment, service users listed factors such as free or concessionary parking,

automatic doors, security and aesthetic factors including bright and friendly décor. The communication category represented a range of requirements for information about the layout of the hospital and the facilities that were available to both service users and carers. With regard to accommodation, the study found that service users preferred small cluster designed rooms rather than single rooms. The study also reported that service users' preferences included having additional facilities on each ward with kitchen provision, a children's area, an information point and the facility for relatives to stay overnight.

Good environments make service users feel better, and feeling better is the key to getting better. Most users of the NHS understand the impact of the environment on the service user experience. There is evidence that good environments can have a therapeutic effect on service users (Ulrich et al, 1991; Fowler et al, 1999). Furthermore, in discussion of personal space, Fu (2005) argued that space always plays a central role in the building design to define the users' requirements and functions of a building. From the space usage point of view, any activities of an individual or an organization in a building must be carried out in a certain space of the building. Many of the buildings' spatial properties are determined on the basis of user organization requirements

In the UK, there is great concern about improving healthcare outcomes for service users. This is reflected in the healthcare modernisation programme (DOH, 1998), which aims at tackling the root causes of ill health, breaking down barriers between services and making services faster and more convenient. Research has shown that good healthcare environment increases service user satisfaction, speed up recovery and improve staff moral and performance (www.nhsestates.gov.uk). According to (Plunkett Raysich Architects) the design of healing environment should be clutter

free to encourage mobility and a sense of safe shelter. They further suggested:

> ...that environment stressors such as unwanted noise and odours can be minimised by access to fresh air and better circulation systems, carpet background music and adjustable varied lighting and or indirect lighting sources.

A renewed focus on service user -centred care is a fundamental part of the modernisation programme in the NHS (the National Health Service in the UK). This focus is putting greater emphasis on the need to improve the quality of healthcare environments. Healthcare environments, by their own nature, are supposed to be spaces for healing. The idea of the therapeutic environment has been discussed for some time and has supporters not just among architects and designers, but also among health providers (Francis, 2002). There is growing interest to support the link between the environment and health, through the proposition that the environment has an influence over the healing process and over health outcomes. Therefore, the design of healthcare facilities has recently re-emerged to become a major focus in debates over therapy (Gesler et al., 2004). The challenge is delivering high-quality buildings that successfully accommodate clinical interventions and complex medical technology while providing a humane, therapeutic environment (Devlin and Arneill, 2003; Gesler et al., 2004).

Studies of the perceptions of service users and other stakeholders concerning the built environment and facilities in UK hospitals have been undertaken by some researchers. At the beginning of their 'investigation and assessment of attitude to and perceptions of the built environment' in

Salford hospitals, Todd et al (2002) found that 'A review of the literature provides little evidence of research to provide understanding of how service users, families and staff perceive and socially interact in the built environment and with facilities in NHS hospitals, and the value that they place upon a range of provisions'.

In the UK, some studies have shown that careful design of hospital and other healthcare units help to speed service user recovery. Douglas et al, (2002) investigated the perceptions and attitudes of stakeholders including service users and visitors to the built environments and supporting facilities provided by an NHS Trust hospital. The investigation suggested that the notion of service user-friendly environments were based on three conceptual visions of the role and the function of the built environments of healthcare facilities. They are notions of homeliness, notions of accessibility through transitional spaces and notions of supportive environments. The study provided a framework for evaluating potential designs for the built healthcare environment internally as well as externally.

In empirical studies (such as CABE, 2002) mostly, modern units fare far better than older units, and design issues, such as the presence of accessible windows, improved service user health. Indeed, service user treatment times in new hospitals compared to old hospitals have reduced significantly, resulting in financial savings of £2000 to £7000 per head in two sample cases (Lawson and Phiri, 2003).

Douglas and Douglas (2004), in their Salford NHS Trust hospitals study, argued that the provision of welcoming, homely spaces promote health and well-being. NHS Estates has an initiative *'Improving the Service user Experience'* (2004) through which they are committed to providing

excellence in healthcare by supporting medical staff with a high quality built environment. The NHS programme for '*Improving the Service user Experience'* is based on the concept of: *'Delivering a service user environment fit for the twenty-first century.'*

The evaluation of this programme will be based on discovery of the perceived benefits from improving hospital settings. These are expected to be in the form of:

- Reducing vandalism
- Helping service users recuperate faster
- Creating a positive ambience and feelings of well-being
- Improving staff morale and motivation
- Helping staff recruitment and retention

According to Vischer (2005) the introduction of "payment by results" approach in the UK implies that service users will choose where they want to go for treatment. Some factors affecting service user choice include: accessibility and environmental quality. Accessibility means location of entrances, parking facilities, spatial orientation and way finding, and comfort for users with mobility restrictions. Whereas, environmental quality means cleanliness and infection control, food quality, parking, and overall maintenance and building functioning.

Vicher (2005) further argued that the needs of healthcare FM are changing as healthcare environments increase in complexity and have to meet more demands. As the cost of healthcare services rise, so less funding is available to operate and upgrade buildings. However, as equipment and

technology costs increase, more demands are being placed on buildings to accommodate new technology effectively. In addition, healthcare funding agencies favour reducing dependency on expensive, acute-care hospitals and providing sub-acute and secondary services in alternative facilities that are less costly to run. Such services imply a different philosophy of care: more service user choice and control, greater responsibility invested in healthcare professionals who are not medical doctors, service user autonomy and access to alternative and complementary care, and service user access to information.

The new generation of healthcare buildings in the UK has been informed by a number of design goals which include a new understanding of healthcare settings as therapeutic environments as well as efficient clinical spaces, and the buildings need to be integrated with their urban surroundings and be accessible to service users (Gesler et al., 2004). Within primary healthcare, such goals are even more ambitious, as primary healthcare centres are supposed to be spaces that attract people and therefore promote the health of the population, as well as work as focal points for the regeneration of deprived urban areas.

The work of Lawson and Phiri (2003), studying the effects of the hospital environment on the service user and staff, showed that the healthcare environment plays a significant role in assisting service user recovery.

Arguing that there was little systematic assessment of how the built environment of health are facilities affected the quality of care, MacRae and Michel (1998) and Fowler, et el. (1999) carried out a study of consumer perceptions of the healthcare environment in order to determine what mattered to service users. As part of the project supported by the

Picker Institute, the primary focus was quality assessment of healthcare and improvement strategies. The purpose was that of taking step to understand and adopt the service user perspective and in so doing driving for improvements and change in healthcare and provision. The study found that service users cared and were concerned about the nature of the physical environment of hospitals. Analysis of the information collected from the focus held in three settings of ambulatory care, acute care and long-term care suggested eight consistent themes representing what service users and their relatives looked for in the built environment of hospitals. The researchers reported that service users and their families wanted health care environments that facilitated connections to staff and carers, was conducive to the sense of wellbeing and provided connections to the outside world.

Some government initiatives in the UK to modernise healthcare and promote service user-centred care have led to an increase in the measurement of service users' response to care delivery (DOH, 1998; NHS Plan, 2000). Each acute Trust needs to have systems in place by 2004 to demonstrate their commitments to the conduct of service user satisfaction surveys and to have implemented action plans to address issues raised. However, to date, quality assurance of the structure and environment in which care is delivered does not rely on service user feedback.

A typical service user journey (figure, 4-1) may consist of eight sequential phases:

- Phase one is initial contact where the user will contact the doctor's surgery either by telephone or the Internet to make an appointment.

- The second phase involves the way in which the service user will get there for the appointment. This involves physical appearance at the surgery either by walking or by any other means of transport.

- The third phase is entering the surgery. This phase is important because the service user starts to engage with both the service and the 'servicescape' at this point.

- Having walked into the surgery, the service user will interface with the receptionist. This can take the service user a while until they are attended to because of the queue.

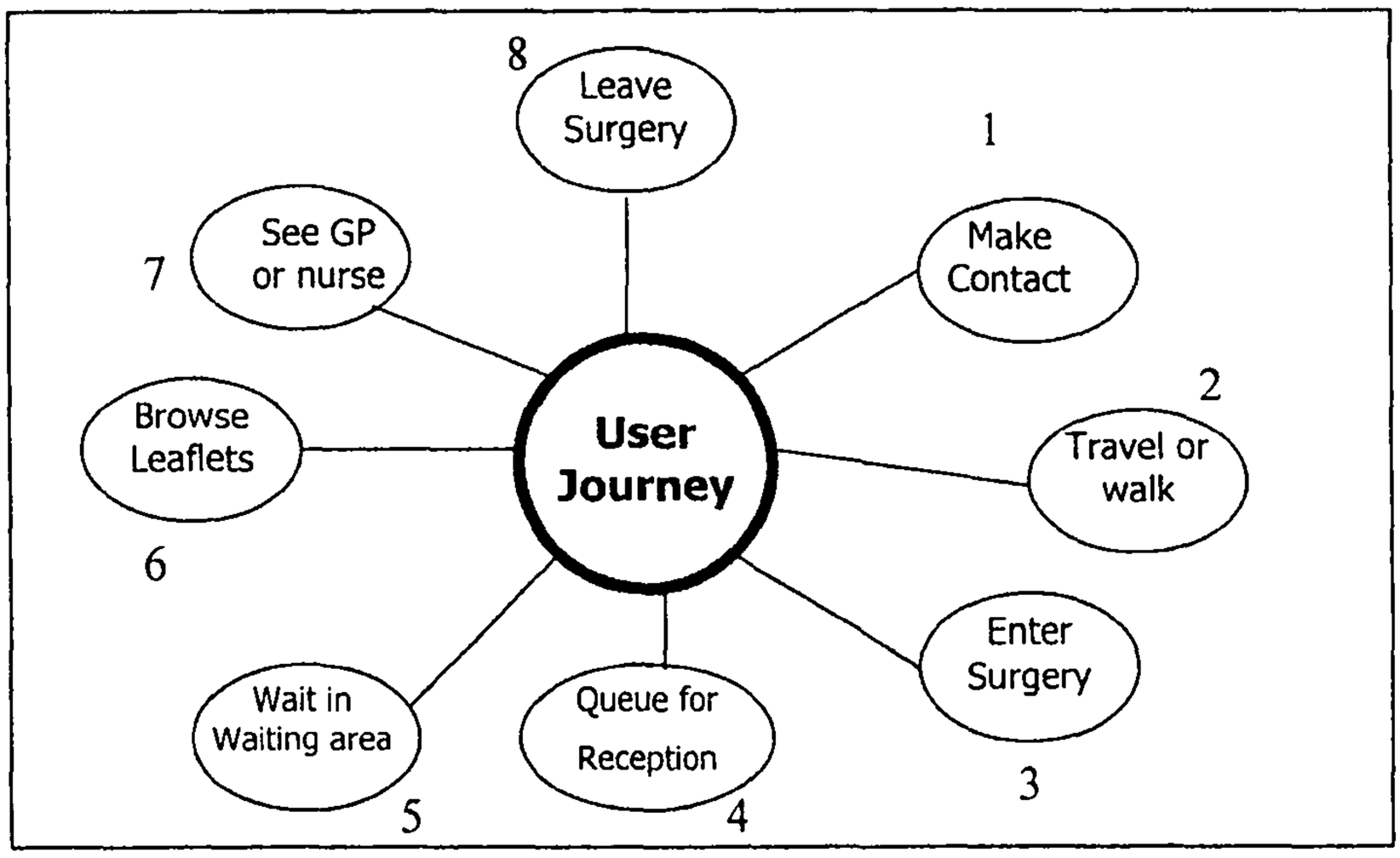


Figure (4-1) a typical service user journey to a doctor's surgery.

At stage five, the service user is asked to take a seat in the waiting room to be seen by either the GP or the practice nurse. Once the user secures a seat, they then tend to wander around, usually looking for something to keep them occupied such as browsing through the surgery leaflets or a magazine. The user will then be seen either by the GP or practice nurse

and departs the surgery either with a positive experience or otherwise depending not only on the quality of care received but also on the quality of process of accessing and exiting the 'servicescape'

4.5.2 Measuring Service User Experience within NHS

The key role of a PCT within the NHS is the development, administration, provision and delivery of healthcare to the local community, in conjunction with its partners. Improving the health of the community is not simply about providing the best health care services, but also about delivering the right mix of health promotion activities and social care services. This differs from the key role denoted to other trusts such as acute and mental, which is the treatment and curing of illnesses, rather than the initial prevention, Salford PCT (2003).

A review of PCT services to make them fit for purpose for staff and service users, rather than systems, has led inevitably to a radical rethink in the way that the PCTs' healthcare services are provided. According to Salford PCT (2003), the new way of thinking about primary healthcare has affected almost every area of the PCT's activities, as health and wellbeing cannot be separated from housing, employment, the environment and a thriving local economy.

Reasons for selecting Primary care Trusts (PCTs) follows the greater freedoms for PCTs announced by the Health Secretary Alan Milburn at a conference (Primary Care Trusts: The Way Forward) attended by Tony Blair, Alan Milburn and NHS chief executive Nigel Crisp. The health secretary Alan Milburn made it clear that: Commissioning should be less

about cost and more about quality. PTCs will be permitted to commission care from NHS, voluntary and overseas providers to ensure the best treatment for service users.

An examination of previous work carried out on behalf of the Health Commission Reviews (formerly CHI) has shown that the basis on which service user experience was interpreted cannot be traced back to their roots. From a research perspective, an understanding of the basis is important to ensure the reliability and validity of the outcomes. Many questions currently remain unanswered which impact on the reliability of current measures.

The Picker institute service user surveys (2005) distinguished eight dimensions of user-centred care:

- Access (including time spent waiting for admission or time between admission and allocation to a bed in a ward);
- Respect for service user' values, preferences, and expressed needs (including impact of illness and treatment on quality of life, involvement in decision making, dignity, needs and autonomy);
- Coordination and integration of care (including clinical care, ancillary and support services, and 'front-line' care);
- Information, communication, and education (including clinical status, progress and prognosis, processes of care, facilitation of autonomy, self-care and health promotion);
- Physical comfort (including pain management, help with activities of daily living, surroundings and hospital environment);

- Emotional support and alleviation of fear and anxiety (including clinical status, treatment and prognosis, impact of illness on self and family, financial impact of illness);
- Involvement of family and friends (including social and emotional support, involvement in decision making, support for care giving, impact on family dynamics and functioning);
- Transition and continuity (including information about medication and danger signals to look out for after leaving hospital, coordination and discharge planning, clinical, social, physical and financial support).

Their definition of service user experience is based on the following:

- Preliminary discussion with stakeholders in the NHS and Department of Health (DoH) about issues to address in the surveys;
- Review of the existing literature and surveys;
- Focus groups with Acute Trusts' users to identify what matters to them; and
- Drafting, testing and piloting the questionnaire for 2003/2004 carried out with service users who recently experienced Acute Trust services.

Further investigations indicated that the development of the questionnaire used by CHI to assess user experience within PCTs has followed the same developmental process as for other NHS Trusts. This process is regarded by the researcher as highly alarming, because it does not address issues that directly matter to the service users in PCTs.

4.6 Discussion

The National Health Service sector in the UK will be going through dramatic changes in the next few years. This is due in part to changing service user requirements. Many healthcare providers within the NHS have lost track of the true needs of their service users and are trapped in outdated views of what healthcare delivery is all about. This is evidenced in the report by Nigel Crisp (NHS chief executive) in October 2002, published by the Department of Health (DoH). This report clearly stated that the NHS needs to refocus its management efforts, engage with service users, staff and the public and build momentum to manage for excellence.

Service user experience research in the public primary healthcare sector to date has been questioned by this research, because it has failed to identify and address issues that matter the most to service users. Furthermore, the research identified that most established methods of measuring user experience are secondary healthcare- based, a sector, which has a different role to PCTs. Additionally, current measurement methods impose issues that are professionally rather than user oriented. This is an issue of concern for the rigour and reliability of the measurement instrument, especially if the intent is to design an excellent primary healthcare delivery system around the needs of service users. Obtaining feedback and taking account of users' views and priorities are therefore vital to bringing about quality improvements.

It is, perhaps, surprising that the current state of knowledge regarding the user experience seems somewhat very limited. There is no consensus of definition regarding what experience is or what it does. This ambiguity also extends to its role within the evaluation process of service excellence itself

being conceptualised as driven by the user experience. Users do form impressions about a range of service excellence constructs and these impressions vary across service providers and individual users, what is not clear is the extent to which these impressions are used, if at all, once the service has been experienced in a user's evaluation of service excellence.

In part, difficulties of definition occur because service user experience is multidimensional. However, the multi-dimensional nature of service user experience raises issues not so easily solved.

User satisfaction within the UK NHS is based on assumptions about the essentials to the users from NHS perspective. And, whereas the NHS thought they got right, it turned out to be completely off the track. Many approaches deployed to measure the user satisfaction neglected the impact that healthcare delivery may have on the user satisfaction. Whereas, user experience differs from satisfaction in the sense that it allows the user's own interpretations to be discovered.

Despite the shared concerns that service user satisfaction in health care setting is an important component of service quality due to its strength in being very indicative of the success of the health care provider in meeting the service user's values and expectations. Deficiencies outlined earlier have not been solved. These deficiencies include:

- Lack of standardised approaches to service user experience surveys research,
- The need of clarity and consistency in understanding the determinants of service user experience, and
- Lack of an accepted conceptual or theoretical model of service user processes, and

- Lack of consensus within the medical professions on the role that service user satisfaction should play in the assessment of quality of health care.

Although changes in healthcare performance measurement in the NHS are currently in the process of being implemented, the earlier findings of this study still apply in terms of the relevance and reliability of previous measurement tools in use for measuring PCT performance. Previous measurement criteria did not truly reflect user needs and requirements to ensure the measurement of user experience or service excellence.

4.7 Literature Review Critique

Although, SERVQUAL and SERVPERF are claiming that they measure service quality. In fact, they measure service quality according to their understanding and interpretation based on statements/questionnaires designed according to their judgement and evaluation rather than to the exact needs of the service users themselves.

There is a growing consensus that the experience of service users is an important indicator of healthcare quality, many healthcare providers are searching for ways to change the delivery of healthcare. This is due to the fact that service users are expecting more of healthcare providers and are demanding higher standards of care and service. Achieving this however, is far from straightforward.

The roots of thinking about experience— what philosopher John Dewey referred to in his book—Art as Experience has a beginning and an end, and

changes the user, and sometimes, the context of the experience as a result. An example of an experience is witnessing a story that allows the user to feel powerful emotions (memory), assess the system of values (value), and possibly make changes in the behaviour (enjoy and learn).

An extensive review of literature shows that no study within Primary Care Trusts (PCTs) to date has investigated the non-physical impact of healthscape and suggested that there are non-physical (social interactions) that give rise to emotion and emotional displays, which in turn influence the service user's impressions of a given healthscape. There is no doubt that service user's environment in healthcare settings has undergone some changes recently, however, FM managers continually plan, build and change physical surroundings in an attempt to control their influence on service users, without really knowing the impact of a specific design on service users. This lack of research is surprising given the large number of services that focus on experiential factors, which include interactions between individuals (healthcare providers as well as service users).

While it is acknowledged that healthscape environmental psychology has explained the effect of environmental factors on a service user and his or her subsequent attitude. However, little attention has been given to what environmental psychologists mean by the term environment. A review of the environmental psychology literature reveals a reoccurring theme of a social element to the environment and the notion that 'the influence of physical settings on behaviour is inextricably bound up with social aspects of the setting' Therefore, in this paper, healthscape is defined as the setting in which the service users experience the healthcare delivery. The healthscape is comprised of a combination of physical and non-physical elements. As such, it includes all those factors which frame the individual within that setting and which have some influence on their behaviour.

Therefore, it is about time the perspective was flipped to really dig deep for the exact requirement of the service user. The predominance of wrong methodologies would then seem to demonstrate that service user experience within the NHS is by no means achievable. Indeed, other than the work undertaken for the Health Commission Review (formerly CHI), there was no evidence of the adoption of reliable methodology.

The service excellence concept has evolved without corresponding evolution in the measurement tools. This in essence means that the service concept has reacted to the call for change, however the measuring tools have not done so. Most of the tools used to evaluate and improve service quality seem to neglect the role of the service user construct as well as other constructs that can contribute to a positive service user experience. These constructs include: staff delight, operational effectiveness, organisational culture, and continuous improvement.

There has been found to be no theoretical background for service excellence. The literature is shallow and underdeveloped. Probably, it may be the first and only field in which 'practice' has gone far ahead of the 'theory'. To bridge this gap, two approaches are suggested. The first approach here is to explore a rigorous ground for the service practice to better understand and improve what 'Service Excellence' is. The second one is to create a tool that systematically assesses and audits the excellent services responding to the multi-dimensions of excellence.

4.8 Conclusion

In order for the providers of healthcare to sustain survival in the ever-turbulent condition, they need to act more like an integrated business by paying a close attention to all constructs in a holistic approach.

The service excellence concept is still in its infancy - it has gotten as far as service quality and the promise of superior service delivery is far from being recognised. Therefore, there is a need for being more aware of the value- creating elements within the concept of service excellence and the supporting processes that would help develop those elements.

If the intent is to deliver and sustain service excellence within organisations around the needs of service users, obtaining feedback from them and taking account of their views and priorities is vital for bringing about improvements in the quality of service delivery which should help organisations move from service quality stage to service excellence.

The NHS will not need to focus on spending money but on really identifying and meeting service user's needs as well as forces of change such as growing public expectations, service user culture, medical advances and demographic changes. Quality should be a central issue in the commissioning and provision of healthcare. This requires a systematic approach to defining and monitoring quality. Such an approach should address: quality characteristics such as efficiency, accessibility, and effectiveness.

In the conditions created within the NHS in the UK, there is a need for new concepts, methodologies and tools for measuring and managing service

excellence. The current tools are inadequate and there is no real understanding of the ways in which service users perceive healthcare service and the role that facilities play - hence the need for research that addresses an understanding of how, in primary care settings, service users formulate their impressions.

Service organisations must realise that goods and services are no longer sufficient. People seek experiences. This is evidenced in the proposals put forward by the UK Government's wider reform programme, will allow to accelerate the move into a new era where the service is designed around the service user rather than the needs of the service user being forced to fit around the service already provided

Service user participation provides a challenge for today's public services. Thus far the focus has been on the relationship between providers and service users from a top-down perspective. Yet, the flipside of this relationship also raises some fundamental questions. Given the legacy of bureau professional paternalism followed by attempts to turn service users into customers, and the contested nature of the relationship between providers and service users, perhaps the key question is this: will service users be willing to take up the emerging opportunities and begin to participate?

The need to address service excellence in PCTs from an organisational perspective has been identified. Further, the researcher has recognised the need for healthcare providers to support and add value to the delivery of healthcare by engaging all stakeholders to better respond to the service user's demands.

Chapter 5: Research Design

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

5.1 Introduction

This chapter addresses the general issues related to the philosophical and methodological approach adopted in this research thesis including definitions of the philosophical main foundation upon which the research process is based. It further describes the principal approaches used in the research thesis.

5.2 Phenomenological Philosophy

The research philosophy addresses the beliefs, values and principles underlying a detailed study. There are two main and widely recognised generic traditional research philosophies employed within the research community: positivism and phenomenology, each of these philosophies relies on different concepts and methods for conducting research.

Both positivist and phenomenological approaches have their advantages and disadvantages, and so the researcher must be prepared to take advantage of every situation surrounding the research process. Furthermore, the selection of one paradigm or the other or even both may be determined simply by the nature of the research.

It is important to know about the methodological paradigms debate in order to appreciate why methods decisions can be highly controversial. The paradigm of choices acknowledges that different methods are appropriate for different situations.

Whilst positivist paradigm is confirmatory and uses deductive logic, it is experimental, statistical, and empirical and relies on numerical data.

Quantitative researchers generally distinguish between descriptive statistics and analytic statistics. The latter uses probabilistic methods in order to test hypotheses, analyse the strength of relationships, determine trends over time and make predictions for future marketplace behaviour (Mariampolski, 2001). Therefore, paradigm such as this would not be suitable here due to the nature of the research.

Phenomenology is at the other end of the conventional range and is believed to have started from the philosophical reflections of Edmond Husserl in the mid- 1980`s (Embree, 1997). This approach seeks to understand and explain phenomenon in their natural settings without manipulation or precise measurement rather than searching for external causes or fundamental laws (Patton, 1987). It uses qualitative and naturalistic approaches in order to inductively and to holistically understand the human experience in context-specific settings. Research is more concerned with emergent themes and descriptions rather than hypotheses and theories (Cassel & Symon, 1994).

The main differences between the positivist and phenomenological paradigms can be summarised as shown in table (5.1).

Table (5.1): Key features of positivist and phenomenological paradigms

	Positivist paradigm	**Phenomenological paradigm**
Basic beliefs:	The world is external and objective. Observer is independent. Science is value-free.	The world is socially constructed as subjective. Observer is part of what observed. Science is driven by human interests
Researcher should:	Focus on facts Look for causality and fundamental laws Reduce phenomenon to simplest elements Formulate hypotheses and then test them.	Focus on meanings. Try to understand what is happening. Look at the totality of each situation. Develop ideas through induction from data.
Preferred methods include:	Operationalising concepts so that they can be measured. Taking large samples.	Using multiple methods to establish different views of phenomena. Small samples investigated in depth or over time.

(Source: Easterby-Smith (1991)

Based on the aims and objectives of the research, Phenomenological paradigm has been adopted to meet the requirements of this research, since it uses qualitative and naturalistic approaches in order to inductively and to holistically understand the service user experience in NHS PCTs settings.

Further, phenomenology advocates that, service user experience is subjective, and socially constructed by the service user rather than objectively determined. Therefore, this study has adopted a number of research strategies and techniques for building a solid platform for understanding, measuring service user experience and further to test its validity. A triangulation approach was established to eliminate the biases inherent in the case study strategy if such strategy had to occur.

5.3 Applied Research

Despite the fact that there are many definitions of research the common strand is that research is essentially an investigation, a recording and an analysis of evidence for advancing knowledge. This research is motivated by the need to understand the service user experience in NHS PCTs.

This research can be classified as applied research because it seeks solutions as to how to assess service user experience as a component of service excellence in a healthcare setting. This involves working with Salford Primary Care Trust who identified the problem and are involved in the solution. The results are reported back to Salford Primary Care Trust, and are disseminated through journals and other publications.

5.4 Research Process

The process is the description of the research approach, strategies and design adopted in this research thesis including the knowledge acquired from the literature review undertaken about the phenomenon under investigation. A review of traditional research approaches and strategies is addressed for the justifications of the chosen alternatives.

In this context, the dominant philosophical views to be clarified though the research process will be the adoption of the qualitative and quantitative approach. In fact, this choice derives from the beliefs of the researcher to look for key elements that formulate service user experience in a primary healthcare setting. This is deemed appropriate for the manner in which the research question was formed. It was sought that empirical exploration would better clarify the elements of assessing service user experience.

This study consists of three separate but partly overlapping phases (figure 5-1). The first phase was a literature review the objective of which was to recognise and analyse the theoretical concepts related to service user experience. The second phase (i.e., the interview & focus group phase) was a qualitative one which consisted of semi-structured interviews and focus group interviews, and aimed to increase the empirical understanding of the aforementioned issues in the context of service user experience. Based on the findings of these two earlier phases, a questionnaire was drawn up. This constituted the third phase of this study (i.e., the survey phase), which endeavored to refine the findings and to increase the generaisability of the results.

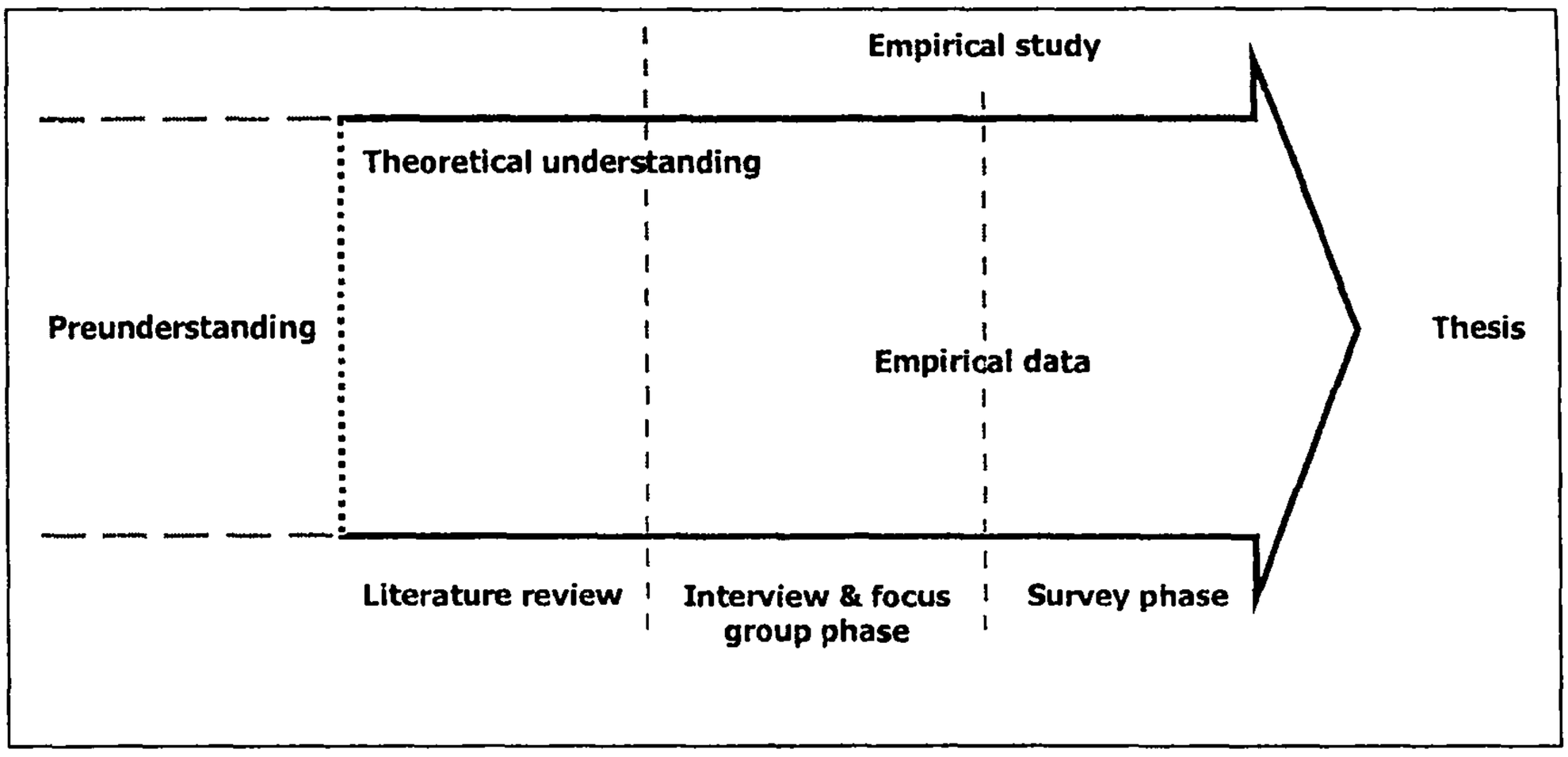


Figure (5-1) The Research process

5.4.1 Qualitative & Quantitative Research

According to Sekaran (2000), research is classified as either quantitative or qualitative. He stressed that a great deal of organisational research can be described as demonstrating many of the characteristics of quantitative research, where the research process resembles a scientific approach to the conduct of research. On the other hand, qualitative research implies that the researcher seeks to establish what is important in relation to individuals as well as their interpretations of the environment in which they work, through in depth investigations of individuals and their social environment. Research method as defined by Ghauri et al (1995) is the systematic focused orderly collection of data for the purpose of obtaining information to find solutions to research problem or answer research questions.

Ghauri et al (1995) asserted the fact that the suitability of techniques and methods is dependent on the research problem and its purpose. As

illustrated in (table 5.2), the difference between qualitative and quantitative research is viewed as being that whilst qualitative approach is subjective and uses language and description, quantitative approach is objective and relies heavily on statistics and figures. However, qualitative and quantitative approaches can be combined and used in the same research.

Table (5.2) Difference in emphasis of qualitative versus quantitative methods

Qualitative Methods	Quantitative Methods
Emphasis on understanding	Emphasis on testing and verification
Focus on understanding from respondents` / informants` point of view	Focus on facts and / or reasons of social events
Interpretation and rational approach	Logical and critical approach
Observations and measurements in natural settings	Controlled measurement
Subjective insider view and closeness to data	Objective outsider view and distance from data
Exploitative orientation	Hypothetical- deductive; focus on hypothesis testing
Process oriented	Result oriented
Holistic perspective	Particularistic and analytical
Generalisation by comparison of properties and context of individual organism	Generalisation by population membership

Source: Ghauri et al (1995)

Moreover, qualitative research depends on people's own words, official documents, field notes, audio/video-tapes, etc. for data gathering and collection. Moreover, Strauss and Corbin (1990) identified the tasks of qualitative research as "to uncover and understand what lies behind any phenomenon about which little is yet known or to gain novel and fresh slants on things about which quite a bit is already known".

Mariampolski (2001) further stresses that "the qualitative research, when used properly, can address numerous strategic information needs, such as creative ideation for new product development, conception and evaluation of marketing or communications tactics and insights into the culturally-based preferences of various racial and linguistic minorities". This paradigm is exploratory and uses inductive logic. It is word-oriented, descriptive and naturalistic. The sampling is small, theoretical and selected to take as much

context as possible. It uses techniques and methods such as observation, and conducting semi-structured interviews and circulating self administrated questionnaire survey.

Qualitative and quantitative methods can be seen as complementary, with different emphases in different disciplines, but sharing a heritage of logical thought and empiricism Preece (1994). Consequently, therefore, a mixed approach involving a combination of both qualitative and quantitative methods has been used for this research.

5.5 Case Study Approach

Research design as described by Yin (1994) is the logic that links the data to be collected and the conclusions to be drawn regarding the study questions, in a coherent manner. It can be perceived as an action plan to get from the study questions to conclusions. Research design however embraces a number of research strategies. Experiment, survey and case study are only some of the alternatives available for research. Why choose the case study strategy in particular?

Case studies differ from experiment and survey strategies in that they are inherently multi-method i.e. typically involving observation, interviewing and analysis of documents and records (Robson, 1993). The decision of the choice between different research strategies is based on the specific features of the different strategies.

Table (5.3) A comparison of case study with experimental and survey approaches.

Experiment	**Case Study**	**Survey**
Investigation of relatively small number of cases	Investigation of relatively small number of cases	Investigation of relatively large number of cases
Information gathered and analysed about a small number of features of each case	Information gathered and analysed about a large number of features of each case	Information gathered and analysed about a small number of features of each case
Study of cases created in such a way as to control the important variables	Study of naturally occurring cases; or, in ` action research' form, study of cases created by the action of the researcher but where the primary concern is not controlling variables to measure their effects.	Study of a sample of naturally occurring cases; selected in such a way as to maximise the samples` representativness in relation to some larger population.
Quantification of data is a priority	Quantification of data is not a priority. Indeed, qualitative data may be treated as superior.	Quantification of data is a priority
The aim is either theoretical inference- the development and testing of theory- or the practical evaluation of an intervention	The main concern may be with understanding the case studied in itself, with no interest in theoretical inference or empirical generalisation. However, there may also be attempts to at one or other, or both, of these. Alternatively, the wider relevance of the findings may conceptualised in terms of the provision of vicarious experience as a basis for naturalistic generalisation or transferability	The main aim is empirical generalisation, from a sample to a finite population, though this is sometimes seen as a platform for theoretical inference.

Source: Hammersley and Gomm in Gomm et al (2000)

As illustrated in table (5.3) experiment and survey are mainly to do with information gathering and analyses about a small number of features of each case. Therefore, they are not well suited to conduct a study such as this.

The use of case studies in this work will be acquired as a part of the research strategy embedded in a phenomenological framework (Yin, 1994) which does not show a concrete use of single or multiple case studies but it rather shows the whole research process as the case. By using multiple approaches, the researcher will be able to triangulate the data gathered in order to generate better judgement on their interpretation. Yin et al. (1983) supports this view stating that the case studies that adopt such methods are rated more highly than those that rely only on a single source of data. As the case study strategy is the main approach adopted in this

study, the following section will discuss in some detail the theoretical and practical aspects of this approach.

The approach used here is a case study strategy, which explores and analyses the context and the practices of service user experience in Salford PCT. There are many definitions of a case study. For Stake (1995), *'A case study is the study of the particularity and complexity of a single case coming to understand its activity within important circumstances'.* Yin (1994) emphasises that, '*The case study allows an investigation to retain the holistic and meaningful characteristics of real life events as individual life cycles, organisational and managerial processes, neighbourhood change, international relations and human maturation of industries'.*

Yin (1994) stressed that single and multiple case studies should be perceived within the same methodological framework. He also states that the principal distinctions can be noticed in their particular attributes as their use depends on the aims, objectives and the general research design.

The multiple case study evidence is more compelling and as a result, the whole research is considered as more robust. However, single case study method tends to be more appropriate to confirm or challenge a theory or to address a rare or an unusual situation. Single case studies may be also used for revelatory cases when the researcher has access to a situation that was previously inaccessible.

The limitations of a single case study including biases such as exaggeration of the importance of data item or misjudgement of the representativeness of a single event are well known but it is not the intention of the researcher to test the theory but to explore contemporary events to both confirm existing theory and to build theory. As Eisenhart (1989) stated,

theory building should begin as close as possible to the concept of no theory under consideration and no hypothesis to test.

As suggested by Yin (1994), case study methodology has a number of applications including:

- Explanation of complex causal links in real life intervention
- Description of real life context in which intervention has taken place
- Description of the intervention itself
- Exploration of these situations in which the intervention being investigated has ambiguous out comes.

Service user experience construct falls into all four categories. However, this research will only report on the second and third applications. Hence a single exploratory case study strategy will be adopted for the purpose of this study. This is considered necessary because it offers the possibility of a more holistic understanding of the nature and contexts of service user experience and contributes to the theory upon which this study is based.

As pointed out by Yin (1994), case study is the preferred strategy when "what", "how" or "why" questions are being posed and when the focus is on a contemporary phenomenon within a real life context. In this regard, the research will investigate how service users within Salford PCT formulate their impressions of the service and the environment in which the services are delivered.

Therefore, the nature of this research makes the case study approach the most appropriate. Multiple sources of data collection are employed. This provided extra input for the direction of the overall data analysis.

5.6 Research Techniques

When it comes to data collection, a researcher must be willing to use all available sources of evidence including but not limited to interviews, documentation and observation. Yin (1994) emphasised that there is no single source of evidence that has a complete advantage over all the others, however, interviewing is found to be the most widely used data collection technique in a qualitative approach thanks to its high level of flexibility and its capability of producing data of a great depth. The case studies that adopt triangulation methods are rated more highly than those that rely on single sources of data (Yin et al., 1983).

The use of multiple sources of evidence in case studies allows an investigator to address a broader range of historical, attitudinal, and behavioural issues. Thus any finding or conclusion in a case study is likely to be more convincing and accurate if it is based on different sources of information (Yin, 1994).

Triangulation is the application and combination of several research methodologies in the study of the same phenomenon by combining multiple observers, theories, methods, and empirical materials. Researchers can hope to overcome the weakness or intrinsic biases and the problems that come from single method, single-observer, single-theory studies.

Triangulation can result in greater confidence in results, creation of inventive research methods, better understanding of divergent results, enriched explanation of the research problem, and more effective integration and development of theories (Jick 1979). However, a common misunderstanding about triangulation is that the point is to demonstrate

that different data sources or inquiry approaches essentially yield the same result. Actually, the point is the testing for such consistency. Different kinds of data may yield different results since different types of inquiry are sensitive to different real world nuances. Thus, understanding inconsistencies in the findings across different kinds of data can be enlightening (Patton 2002).

There are four basic types of triangulation:

- data triangulation, involving time, space, and persons
- investigator triangulation, which consist of the use of multiple, rather than single observers;
- theory triangulation, which consists of using more than one theoretical scheme in the interpretation of the phenomenon;
- methodological triangulation, which involves using more than one method and may consist of within-method or between-method strategies.

Using methodological triangulation in this research will help contribute an additional piece to the puzzle and in that way different methods complement each other. Each of the different methods (interviews, focus groups, literature survey, questionnaire) will help capture a more complete, holistic and contextual portrayal and reveal the varied dimensions of the service user experience construct The researcher's bias can be minimised and the validity of the findings enhanced.

Moreover, methodological triangulation can be employed in both quantitative validation and qualitative inquiry studies.

- It is a method-appropriate strategy of founding the credibility of qualitative analyses.

- It becomes an alternative to " traditional criteria like reliability and validity"
- It is the preferred line in the social sciences
- Each type of data should be analysed separately in accordance with sound principles of analysis pertinent to the type of data examined (Mitchell, 1986).

Methodological triangulation often involves comparing the data collected through some kinds of qualitative methods with the data collected through some kind of quantitative methods (Patton 1999).

As illustrated earlier, the case study approach is the preferred strategy for this research. This approach is considered appropriate because it offers the possibility of a more holistic understanding of the nature and contexts of service user experience as a component of service excellence in healthcare settings. Hence, a multi dimensional case study strategy was adopted to gain a real understanding of the situation being studied through data triangulation process.

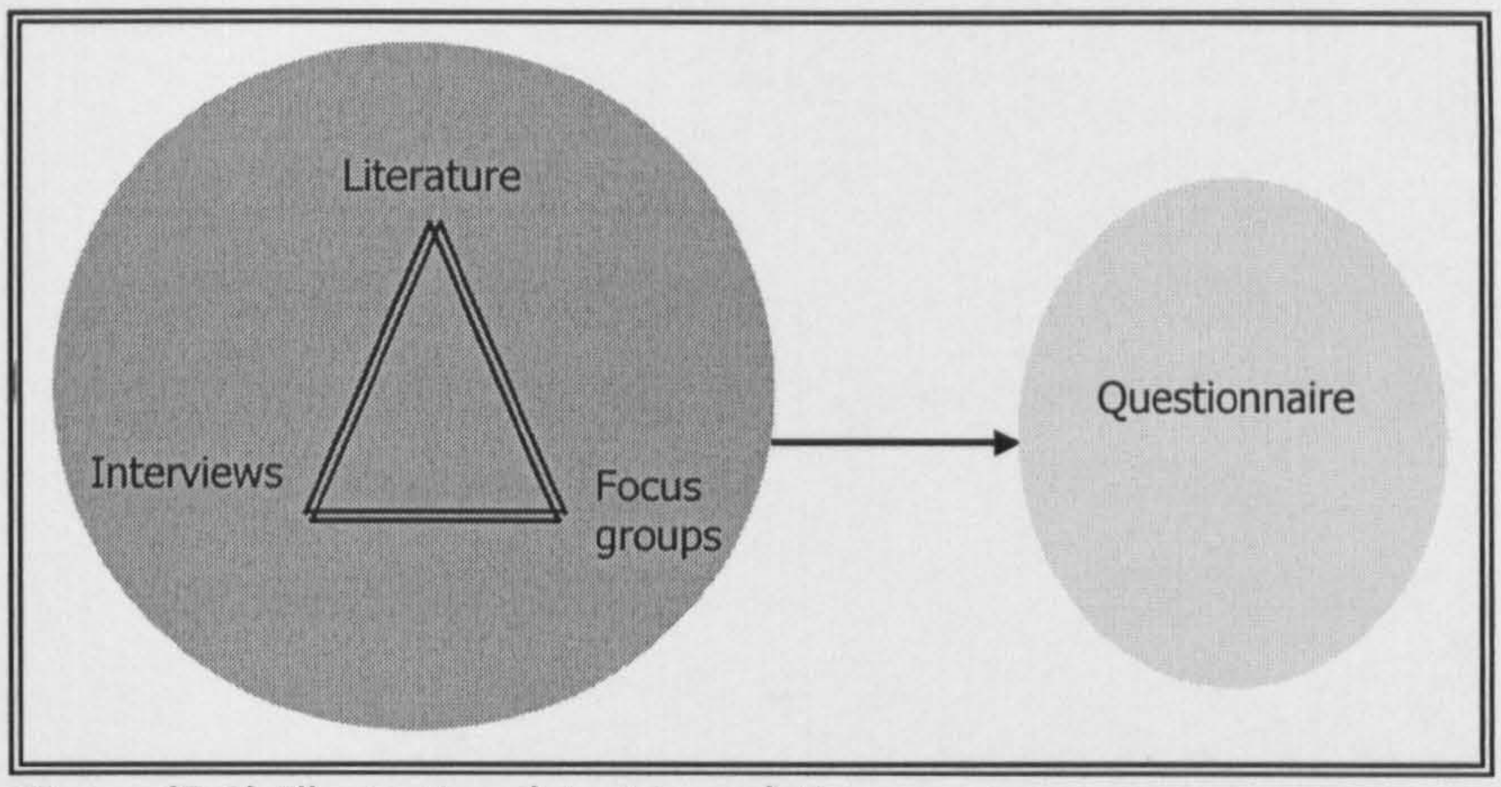


Figure (5-2) Illustrating data triangulation

As illustrated in (Figure 5-2), data collection involved a number of sources: literature survey, face-to-face interviews followed by focus groups leading to questionnaire formulation. This is deemed essential for a clear understanding of assessing service user experience.

Consequently, the aim of this research design is to define the methods, approaches, techniques and strategies through which the empirical research is undertaken in order to thoroughly answer the research questions.

The overall research methodology is therefore represented in Figure (5-3):

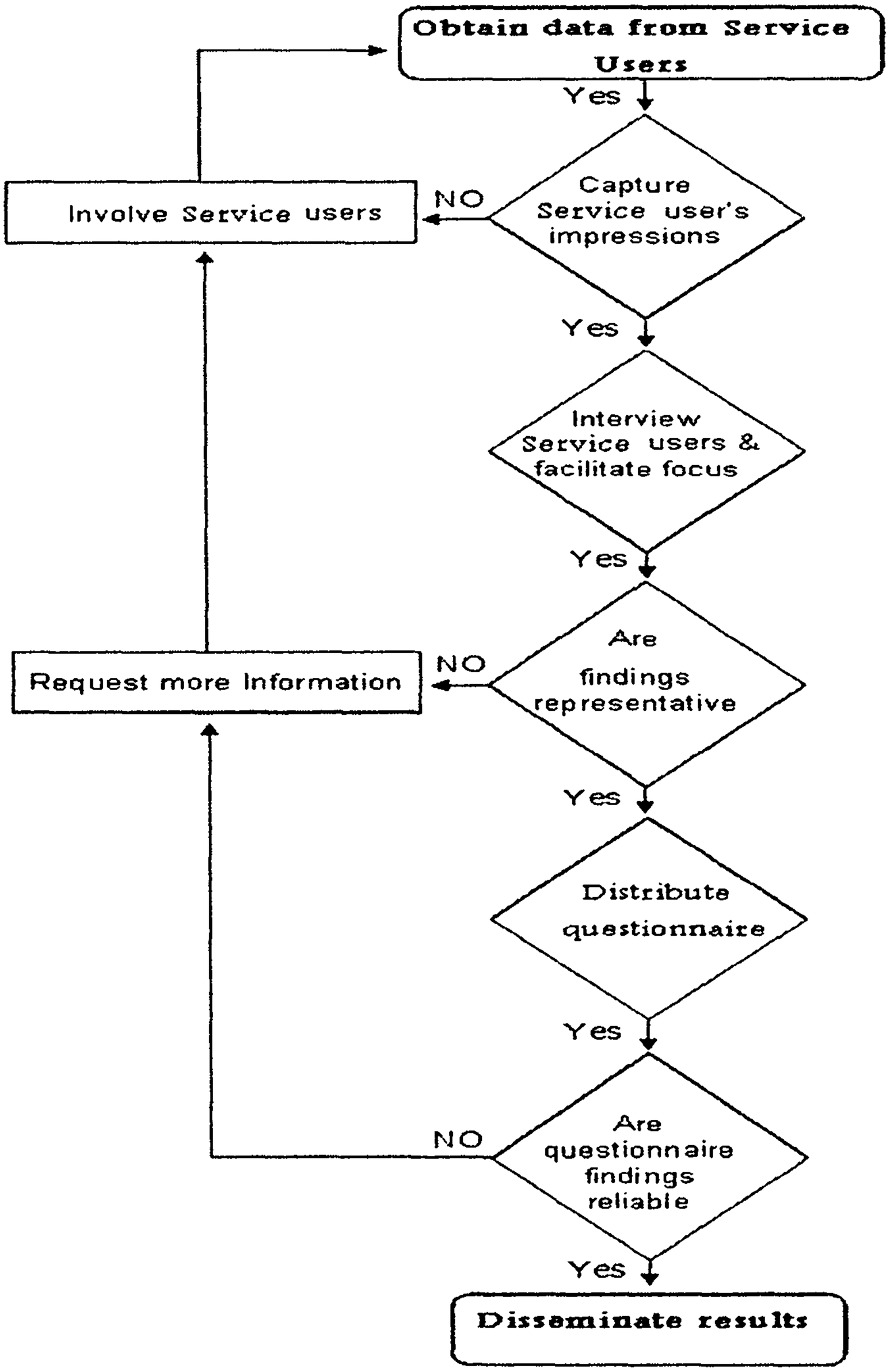


Figure (5-3) depicting integrated research methodology

In this study, in order to confirm and assess the findings of interviews, focus groups, a survey was carried out. According to Jick (1979), survey research may also contribute to the increased generaisability of the results.

Based on this discussion, the researcher has therefore concluded that, after reviewing a number of the abovementioned data collection techniques, semi-structured interviews along with focus groups and questionnaire surveys would be most appropriate to the advantage of assessing service user experience as a component of service excellence in healthcare settings.

5.6.1 Using content analysis

In order for content analysis of service user impressions to be empirically valid as a technique for gathering data, it involves codifying qualitative and quantitative information into pre-defined categories to derive patterns in the presentation and reporting of information. Content analysis is a method of codifying the text of writing into various groups or categories based on selected criteria. It assumes that frequency indicates the importance of the subject matter (Krippendorff, 1980).

(Guthrie and Mathews, 1985) have listed four technical requirements for content analysis to be effective:

- The categories of classification must be clearly and operationally defined.
- Objectivity is key– it must be clear that an item either belongs or does not belong to a particular category.
- The information needs to be able to be quantified.

- A reliable coder is necessary for consistency.

As emphasised by Milne and Adler (1999), reliability in content analysis involves the following issues:

- The researcher should prove that the coded set of data generated from the analysis is reliable. This is usually achieved by the use of multiple coders and reporting that the discrepancies between the coders are minimal.
- The researcher should establish the reliability of particular coding tools by ensuring well-identified decision themes with well-identified decision rules. This in turn can reduce the need for multiple coders.

The researcher has adopted a number of methods to enhance the reliability in recording and analysing data including:

- Selecting main themes from relevant literature, and clearly defining them.
- Selecting items that occur twice or more ensures that minimal items are missed out.
- Establishing a reliable coding instrument, with well-defined decision themes and decision rules.
- Showing that coding decisions made on the study have reached an acceptable level.

The next chapters (chapter 6, 7 and 8) illustrate in great detail methods of enquiry employed for data collection and analysis, and as a means of examining service user experience and views in pursuit of service excellence within the Salford PCT.

5.7 Research Design Evaluation Criteria

Any review of research methods will be incomplete without considering the fundamental issues related to evaluation of the value of any research outcomes. In many respects, an evaluation is often focused on measures to overcome the weaknesses inherent in the particular research strategy chosen to carry out a particular piece of research (Then, 1996). The technical language of such research evaluation includes terms such as validity, reliability and generalisability. The debate is rooted in philosophical differences about the nature of reality, and takes the form of qualitative versus quantitative methods, as described earlier. In general, the value of any research stems from the validity of its result and extent of its contribution to the body of knowledge. Research into the service user experience is no exception. These results are the outcomes from the collection, interpretation analysis and evaluation of data.

The basic difference between reliability and internal validity is that reliability deals with the data collection process to ensure consistency of results while internal validity focuses more on the way such results support conclusions (Then, 1996). It should also be noted that the above reflection reverse very much to the traditional evaluation criteria of validity and reliability that are governed by convention of the quantitative research paradigm. Although early qualitative researchers felt compelled to relate to traditional notions of validity and reliability to procedures in qualitative research, later writers (Miles and Huberman, 1994; Yin, 1994; Easterby-Smith et al, 1991) developed their own language to describe the quality criteria in a qualitative research.

According to Miles and Huberman, (1994) the best way to improve credibility and acceptance is through the improvement and the rigor of

techniques for data collation and analysis. Furthermore, Yin (1994) discussed that any research study to be valid should conform and pass certain design tests as with regard different levels of research validity namely:

- **Construct validity** refers to setting up correct operational measures for the area under investigation.
- **Internal validity** refers to founding causal relationship between different conditions
- **External validity** refers to founding the setting where a research findings would be generalised
- **Reliability** refers to the repeatability of the same study with the same findings

The question of validity in this case study dealt with establishing correct operational measures for the concept being studied (construct validity), truth-value for findings (internal validity, credibility) and the domain to which findings can be generalised (external validity) (e.g.Yin, 1994).

Some questions that are considered significant from the standpoint of keeping the large scope manageable are illustrated in table (5.4) overleaf.

Table (5.4) **So**me validity issues

Phase of research	**Issues related to scope and manageability**
Choice of approach	Was a case study method best? What does the Trust represent and where do the results apply?
Preparation	Was the sample representative enough within the Trust and what are its limitations?
Data Collection	Were interviewees honest in their responses?
Data arrangement	Did the open question produce summarisable realities to charaterise the phenomenon?
Data analysis	Did the researcher interpret the responses well? Did the analysis framework cover the entire phenomenon?
Reporting	When no theory what should be reflected up on? Did the researcher report with enough detail?

The validity of this research design was under threat due to the use of only selected quotes and examples and limited sample and repeatability of the same study. Some corrections of responses and various measures were taken to improve validity in this research design during the research process including:

- The phenomenon studied was derived from theory while the content of this phenomenon was formulated only through data.
- The researcher described in detail the Trust context and the sample used for studying the phenomenon. The field of application was therefore, made visible to the readers.
- Prior experience and skills of the researcher in language and data collection techniques strongly supported validity.
- Multiple sources of evidence were used as a form of data triangulation (see Yin,1994 and Stake,1995).

On the other hand, according to Yin (1994) reliability is demonstrating that the operations of the study such as the data collection procedures can be repeated with the same results. Reliability in this study was under threat by a number of factors such as the researcher's biases and methodology. Some of the reliability issues are illustrated in table (5.5).

Techniques, such as use of one interviewer across the study, ensured that recording took place consistently, as well as all notes were properly stored for improving the reliability adjustments of expressions occurred during the interviews, focus groups and questionnaire surveys. Also, some verification were asked for about some responses to obtain a more robust picture of the subject area and increase reliability.

Table (5.5) Some reliability issues

Phase of research	Issues related to scope and manageability
Choice of approach	Was the Trust willing and enthusiastic about the study?
Preparation	Was the sample representative enough within the Trust and what are its limitations?
Data Collection	Did the researcher create a confidential atmosphere so respondents responded reliably? Was note-taking reliable at all times? Were interviews, focus groups and questionnaire surveys handled correctly? Was enough done to minimise researcher's influence on outcomes?
Data arrangement	Were the notes handled properly?
Data analysis	Could the analysis be repeated?
Reporting	What important items remained unreported confirming or disconfirming the findings?

Emphasising the anonymity of respondents was another means of improving reliability of interviews, focus groups and questionnaire surveys. The spirit of the respondents seemed open, frank, warm and lively and no sign of falseness or secrecy was experienced.

5.8 Discussion

The approach used here is a case study strategy which explores and analyses the context and the practices of service user experience in Salford PCT. case study allows an investigation to retain the holistic and meaningful characteristics of real life events as individual life cycles, organisational and managerial processes, neighbourhood change, international relations and human maturation of industries.

The limitations of a single case study including biases such as exaggeration of the importance of data item or misjudgement of the representativeness of a single event are well known but it is not the intention of the researcher to test the theory but to explore contemporary events to both confirm existing theory and to build theory

Based on this discussion, the researcher has therefore concluded that, after reviewing a number of the abovementioned data collection techniques, semi-structured interviews along with focus groups and questionnaire surveys would be most appropriate to the advantage of assessing service user experience as a component of service excellence in healthcare settings.

5.9 Conclusion

The researcher has adopted an integrated methodology involving a number of research strategies and techniques contributing to assessing service user experience in a primary healthcare setting. The exploratory case study was identified as the most appropriate strategy to explore and better understand the different interpretations and practices of service user experience as a component of service excellence within a primary healthcare setting.

Triangulation techniques were used between the data obtained from the literature, the interviews, focus groups and questionnaire surveys in order to make sure that the final results are of a real value for this research. Triangulation methods are mainly employed during research to collect data in order to test the validity of the information collected for a case study. This includes the use of multiple sources of data (Patton, 1987).

Triangulation is based upon the fact that: "...no single method ever adequately solves the problem of rival casual factors... because each method reveals different aspects of empirical reality, multiple methods

must be employed... and should be used in every investigation" (Denzin Norman, 1978).

As emphasised by Yin et al (1983) and Yin (1994), case studies that adopt triangulation methods are rated more highly than those that rely on single sources of data. The use of multiple sources of evidence in case studies allows an investigator to address a broader range of historical, attitudinal, and behavioural issues. Thus any finding or conclusion in a case study is likely to be more convincing and accurate if it is based on different sources of information

Chapter 6: Literature Review Results

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter 4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

6.1 Introduction

This chapter reports on the use of service user experience within PCTs discusses and analysis the data collected through the results of the literature review.

Given the nature of the different elements set out in the study, and the need for more service user responsive approach, research on service user experience in the public primary healthcare sector to date has been viewed by the researcher as questionable. This is because it has not addressed issues that directly matter to the service users.

What's more, the researcher recognised that most established methods of measuring user experience are within the secondary healthcare sector, which have a different role to PCTs. In addition, the current measurement system imposes issues that are of concern from an NHS perspective, and not from the user perspective. This is an issue of concern for the rigour and reliability of the measurement instrument. Therefore, it has remained necessary to the researcher to obtain further specific data from real life contexts.

The research methodologies used for conducting these investigations are also illustrated in this chapter and in the following chapters (7 & 8) in the aim of demonstrating the issues encountered during this work and emphasising on the most commonly observed limitations of the research.

6.2 Data Collection Methods

Methodological triangulation in this research was utilised (see chapter 5) to contribute an additional piece to the puzzle and in that way, different methods complement each other. Each of the different methods (Literature review, interviews, focus groups, and questionnaire) helped capture a more complete, holistic and contextual portrayal and reveal the varied dimensions of the service user experience. The researcher's bias has been minimised and the validity of the findings enhanced.

The fundamental issue was the assessment of the service user experience. Therefore, the research intended to tackle this issue at four levels.

- Firstly, the research survey encompassed the key thesis area of service excellence with a bias placed upon healthcare delivery, and the environment in which the healthcare was delivered.
- Secondly, it would identify the key elements of the service user experience using interviews.
- Thirdly, the elements identified by the users would be cross-examined through focus groups.
- Fourthly, the elements that emerged from the analysis of the research survey, interviews, and focus groups were used as a basis for the construction of a questionnaire, as a means of in-depth analysis.

These were the Data Collection methods used:

- A full literature review has been made across the literature field, encompassing relevant contemporary texts, books, professional journals, and publications. This has resulted in an information base that articulates accepted conventional wisdom in the chosen subject area.

- Face-to-face interviews were used in this study because of the suitability of such a method at the exploratory stage of research, especially when the researcher was trying to assess key elements that formulate service user experience in PCTs.

- Focus groups were used in this study for confirming interviews findings

- A self-administered questionnaire was used in this study with the service users of the target, as it was imperative that a very high response rate was obtained for the target sample.

- In the case of the Salford PCT being studied, the samples were all located within the geographic boundaries of Salford City. The selected approach is ideal in the context of this study.

See figure (6-1) overleaf.

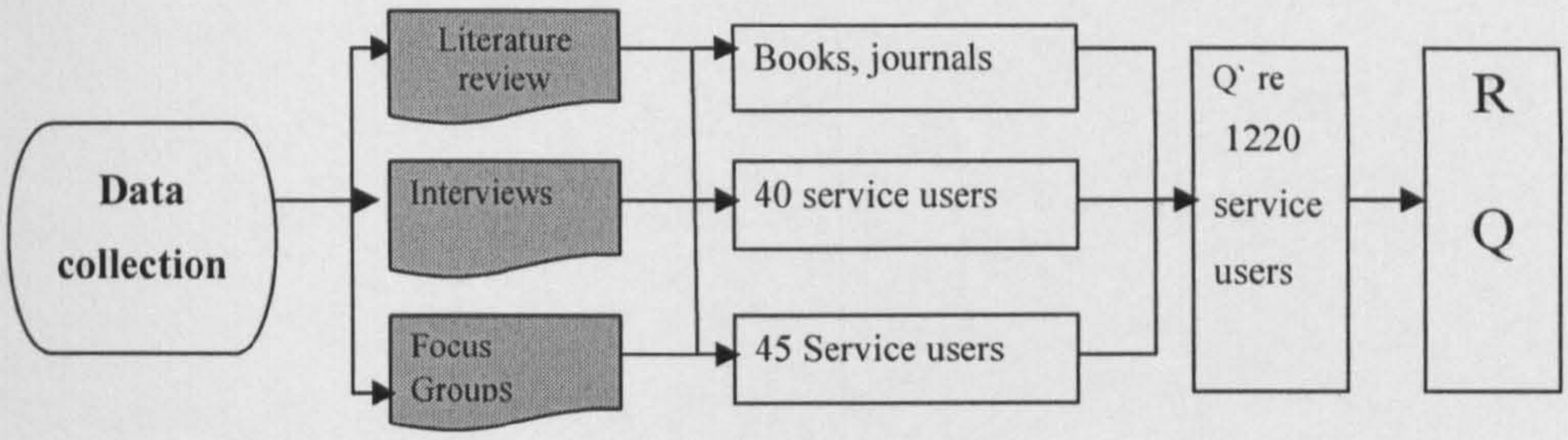


Figure (6-1) Depicting data collection methods

Therefore, this chapter will only illustrate the literature review findings as a method of enquiry employed for data collection, and as a means of examining service user experience and views in pursuit of service excellence within the Salford PCT. However, the following chapters (7 & 8) will illustrate the rest of findings obtained from interviews & focus groups and questionnaire survey consecutively.

6.2.1 Literature review

Throughout the entire research survey, all sources of reference have been critically appraised by the researcher. The literature review undertaken by the researcher in the subject area has been valuable in helping to determine and contribute towards this research thesis.

Therefore, the a mount of time expended by the researcher in reviewing the literature to assist in the composition of this research thesis has proved both necessary to realise a comprehensive and convincing data set that seeks to best support the concepts contained within this thesis and inform the reader accordingly.

6.2.1.1 Findings from the literature review

The literature review explored a range of literature inferred from disciplines of service related elements and environments related elements as well as commentaries and views on healthscape.

Suggestions that come out of the review of the service related literature suggested that the important elemental component of impressions of service users were:

Service related elements:

- Respect for service user' values
- Preferences
- Involvement in decision making
- Dignity, needs and autonomy
- Coordination and integration of care
- Information, and education
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Transition and continuity
- Interaction and communications with service users.

Environment related elements

The suggestions that came out of the review of the literature on environment related elements were as follows:

- Access

- Physical comfort
- Free or concessionary parking
- Automatic doors
- Security
- Bright and friendly décor
- Children's area,
- Layout of a surgery
- Signs
- Spatial layout
- Functionality
- Noise
- Dirt
- Smell
- Location
- Disability and rehabilitation

6.3 Discussion

As discussed in chapter four, the Picker Institute definition of service user experience is based on the following:

- Preliminary discussion with stakeholders in the NHS and Department of Health (DoH), about which issues to address in the surveys.
- Review of the existing literature and surveys.
- Focus groups with the Acute Trusts' users, used to identify what matters to them.
- Drafting, testing and piloting the questionnaire for 2003/2004 carried out with service users who recently experienced Acute Trust services.

The research has shown that the suggestions that emerged from the review of the service user experience related literature suggested that the important elemental component of impressions of service users were:

- Respect for service user' values
- Preferences
- Involvement in decision making
- Dignity, needs, and autonomy
- Coordination and integration of care
- Information, and education
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Transition and continuity
- Interaction and communications with service users
- Access
- Physical comfort
- Free or concessionary parking
- Automatic doors
- Security
- Bright and friendly décor
- Children's area,
- Layout of a surgery
- Signs
- Spatial layout
- Functionality
- Noise
- Dirt
- Smell
- Location
- Disability and rehabilitation

6.4 Conclusion

The literature review undertaken by the researcher in the subject area has been valuable in helping to determine and contribute towards this research thesis.

There remains a common challenge of service that large organisations like the NHS struggle with on daily basis. It struggles to build genuine and meaningful interactions with its service users, and frequently fails to build any kind of participation, flexibility, or ability to adapt into it's organisational structures.

Closing the gap between service providers and service users is still of paramount importance. This would be through creating new channels at the interface that demystify the majority of the main concerns related to the creation of service user experience within a given primary healthcare organisation.

Chapter 7: Interview & Focus Group Results

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter 4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

7.1 Introduction

This chapter reports on the use of service user experience within PCTs and discusses the results of the empirical study. It further analysis the data collected through semi-structured interviews and focus groups undertaken with the service users of Salford PCT.

The related data in this chapter were in fact collected through face-to-face interviews with forty service users and focus groups of forty-five service users.

7.2 Case Study Organisation

Salford is the fourth most deprived local authority area in the North West and 28th nationally. The city has considerable health inequalities because of lower educational attainment and unemployment, access to services and differences in lifestyle. Children born and raised in families of lower socio-economic groups are likely to experience declining health later in life and Salford residents have a life expectancy almost three years below the national average for men and almost two years below for women.

The City of Salford lies in the centre of the Greater Manchester conurbation. It is bounded by Bury to the north, Bolton to the northwest, Wigan to the west, Warrington to the southwest, Trafford to the south and Manchester to the east. The city is approximately 37 square miles in area and has a population of 230,500 (1995 estimates). Salford City was portrayed as 'a city of contrast' by the City of Salford's Community Plan (2001) and its Unitary Development Plan (1995). This is because Salford

City embraces a university and a hospital, which delivers local, regional and national services and is a major teaching facility. What is more, Salford City has the Lowry arts and theatre complex, which forms a focal point of the successful redevelopment of Salford Quays. On the other hand, Salford is the fourth most deprived local authority area in the Northwest of England and the twenty-eighth nationally (City of Salford, 2001).

The City of Salford is geographically dispersed despite its central location within the metropolitan area, stretching along two main corridors, from Blackfriars and Broughton through Swinton to Walkden and Little Hulton to the northwest and through Eccles, Barton and Winton to Irlam and Cadishead to the southwest. The major transport routes within the city are focused upon access through Salford to the central area of Manchester. This, together with the wards and districts within the city being characteristically dispersed, makes access to the central areas from across the city difficult. Access from the areas within the outer lying districts, such as in Irlam and Cadishead, Walkden and Little Hulton and even from within some of the inner-city areas, such as Blackfriars and Broughton, gave rise to health concerns arising from the infrequencies and difficulties of the public transport network.

The long-term unemployment rate in Salford has declined since 1996, although it is nevertheless of concern across the city. The highest unemployment among 16–19 year olds ranged through 16.9 per cent in Walkden North, 14.2 percent Kersal, 13.8 percent in Broughton and 13.5 percent in Blackfriars. Seven wards had over 20 percent of the population in long-term unemployment for greater than one year. Risk-taking behaviour, including crime, violence, vandalism and substance abuse, are examples of specific factors that affect personal/family circumstances and

lifestyle and social environment (Fleeman, 1997; Scott-Samuel et al., 2001).

The City of Salford had rapid economic growth and an arrival of people to the city during its early industrial period. However, following industrial restructuring across the country due to technological change and shifts in national and international economies, the city's traditional industrial base, which centred upon the docks, heavy engineering and chemicals, collapsed. The result was that between 1965 and 1991 the city lost 49, 000 jobs, or 32 per cent of its employment base (City of Salford, 1995). Some service sector expansion occurred during this and later periods but this did not compensate for the decline in the traditional economic base of the city.

Crime including violence, burglary, and theft is comparatively high in Salford. Coupled with unemployment, this has significant influence on health and therefore requires addressing by development programmes with a view to creating sustainable futures in the city.

Currently, a few of the members of the Salford Partnership, including Salford Royal Hospitals Trust (SRHT), Salford City Council and the University of Salford, provide much of the employment in Salford. Thereby, the main body of workers commuting into the city occupies the greater proportion of the skilled, professional and managerial posts within these organisations.

In considering the housing and social situations within the city, the poor quality and densely packed housing that was built during the 20th century in the period of expansion resulted in overcrowding, poor social conditions

and sanitary problems. By the 1960s, much of the city's housing stock had fallen into decay (Salford and Trafford Health Authority, 1999).

Large slum clearances during the 1960s required breaking up communities. This approach to urban regeneration was followed in the 1970s by the provision of high-rise blocks across the inner areas of Salford. As in many other UK towns and cities, this strategy did not provide a long-term solution to the city's housing and social problems. The result was that many of the inner-city wards of Salford are still among the worst affected by deprivation and ill health in the UK. Thus, communities in Salford have continued to experience economic and social problems that demand innovative responses and remedies to improve the underlying weaknesses and social malaise and move the city towards a path of sustainable developmental futures.

7.2.1 The Shift and Lift Projects in Salford

The SHIFT and LIFT projects come out of a new visionary approach in the healthcare sector that is based on the notion of a 'whole systems' model of care that puts the NHS plan into practice in transforming local health and social care infrastructure in Salford. The intention is to provide responsive and personalised 24-hour integrated health and social care across the city. This involves a complete redesign of services to improve service users' experience and to deliver more accessible, effective and responsive care.

The investment project of approximately £200 million comprises separate aspects of redevelopment and shift in service provision. First, there is a physical aspect, which will involve the redevelopment of the main hospital and provision of four new primary healthcare and social centres. Second is

a service delivery aspect that is based on a model that calls for a shift in healthcare from central hospital sites to local sites based in the communities. This latter aspect therefore will enable the development of a decentralised health-service delivery process across the city.

The complete project has radical implications for the health and sustainable potentials of Salford communities. The meaning of health used by the joint project's Partnership Board nevertheless rested upon the biophysical definitions typical of the medical profession and the healthcare sector as opposed to that of the health-status-determined definition discussed above.

In December 2005, Salford Local Strategic Partnership, 'Partners IN Salford', launched "Making the Vision Real" - Salford's Community Plan. According to this plan, Salford will be a beautiful and welcoming city in 2016, driven by energetic and engaged communities of highly skilled, healthy and motivated citizens.

The Community Plan is about organisations and communities including Salford City Council working together to make the city a better place to live. The document outlines the strategic vision for Salford over the next ten years (2006-2016).

Salford City Council anticipate to achieve three star status during 2006 even though, the Audit Commission acknowledged the improvement of Salford City Council in December 2005 when they rated them as two star authority (Life in Salford 2006).

Salford PCT provides healthcare via 61 GP and 41 dentist practices (see appendix 2). The PCT is a key participant in Britain's biggest ever

project to improve frontline health and social care facilities and services This initiative has driven radical plans for new health and social care centres, which are being funded via the Manchester Salford and Trafford Local Improvement Finance Trust (LIFT).

Salford Primary Care Trust is a teaching PCT. It's main stakeholders include:

- Learning skills council seeks to connect (local strategic health authorities, members of primary care, police and Salford local authority).
- strategic health authorities
- Voluntary sector
- Hope hospital
- Local people
- NHS university
- WDC (workforce development confederation)
- Local authority (Salford Council)

7.3 Data Collection Methods

Methods of enquiry employed in this chapter for data collection, and as a means of examining service user experience and views in pursuit of service excellence within the Salford PCT include the following:

7.3.1 Interviews

To test the effectiveness of the research methodology, a pilot study was carried out involving service users within Salford PCT. The aim of this pilot study was to identify the key elements for service user experience. Pilot

studies refer to either a mini-version of a full-scale study, or a specific pre-testing of a research tool or method (van Teijlingen and Hundley, 2002). Preliminary data was acquired through face-to-face semi-structured interviews from forty service users in the Salford catchment area through four different avenues, namely:

- Salford Healthy Fair – An annual social and health gathering attended by residents from all walks of life within Salford City
- Ordsall Healthy Fair – An annual social and health gathering attended by residents from all walks of life within Ordsall area
- Broughton Healthy Fair – An annual social and health gathering attended by residents from all walks of life within Broughton and Higher/ Lower Broughton area
- Prospect Housing (Black ethnic minority groups) – Holds social gatherings aiming to solve problems of housing, work opportunities and health for people living in the Salford area, especially the less privileged ones.

This provided an opportunity to explore and gain insights into, and clarification of how, service users experience healthcare.

As stated by Fowler (1988), any interviewer has three main tasks to carry out in conducting any interview.

These tasks are:

1. To locate and enlist the co-operation of selected respondents
2. To encourage respondents to do a good job of being a respondent
3. To be a good question asker and answer recorder.

The locations of interview respondents were annual events organised within the City of Salford in the form of fairs or gatherings. Many residents from different walks of life in Salford attend these events to exchange views and participate in some activities. Different Salford residents were selected randomly for interviews. As far as the last two criteria of Fowler (1988) are concerned, the following techniques were adopted in all interview sessions:

- **Relevant questions**

All interviews were conducted to address the interview question in a manner that enabled the respondents to fully understand the question being asked and express their views in relation to that question. There is no point in getting the views of Salford healthcare service users according to a prepared list of elements. Therefore, consulting the service users by giving them a chance to say what mattered most to them in ensuring a service user experience is extremely important in realising a positive response from respondents.

- **Application of interview technique methodologies**

An examination of accepted interview technique methodologies was undertaken for the preparation of the interviews to be conducted.
This meant that in all interviews the following criteria was sought:

- To understand the subject area being investigated
- To ask a good question so that answers may be correctly interpreted
- To be a good listener and let the respondents express their views
- To be flexible to explore new avenues of discussion when they arose

- To be unbiased and receptive to the respondent's point

As stated, the interviews carried out in this study were semi-structured ones. For interviewing purposes, an interview guide was developed (see table 6.1). According to Patton (2002), an interview guide lists the questions or issues to be explored in the course of an interview. An interview guide is prepared to ensure that the same basic lines of inquiry are pursued with each person interviewed. The advantage of an interview guide is that it makes sure that the interviewer has carefully decided the best ways of using the limited time available in an interview situation. The guide helps in making interviewing a number of people more systematic and comprehensive by in advance delimiting the issues to be explored.

The duration of the interview varied between ten to fifteen minutes. The researcher took some notes during interviews, and furthermore, all interviews were recorded, as it is best to record fully and accurately in the situation as the data emerges. Later, interviews were transcribed into written form and these transcripts were then coded manually to produce a categorisation of the data. As Robson (1993) states, qualitative data cumulate rapidly, and even with regular processing and summarising it is easy to get overwhelmed. The material is unstructured and difficult to deal with. To prevent and solve this problem, coding was needed. At first, the categorising of the answers was conducted following the question themes of the interview guide. Under these themes, several subcategories were developed. As a result, subcategories were classified under numerous categories and these categories were classified under two core categories, namely service related element and environment related elements.

The semi-structured interviews guide illustrated the service users' overall impressions of PCT healthcare delivery in Salford. It addressed the key

elements related to both the service as well as to the environment in which services were delivered.

Table (7.1) Interview guide for service users' impressions of PCT healthcare delivery.

Healthcare Provider		**Impressions of Service**	**Impressions of Environment**
GP	Single-handed ( )		
	Group practice ( )		
Practice Nurse	Single handed ( )		
	Group practice ( )		
Dentist's Practice	NHS ( )		
	Private ( )		
Chemist's Shop	Incorporated ( )		
	Not incorporated ( )		
Opticians	NHS ( )		
	Private ( )		
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives			

This phase of the research sought to identify the key elements enabling the assessment of service user experience in healthcare. Semi-structured Interviews were undertaken with forty service users from Salford city to obtain a broad view of their impressions of the healthcare delivery and environment. Each service user was given an in-depth interview. The service users interviewed were encouraged to discuss among themselves to ensure the accuracy of information recorded on the table. Subsequent contacts were also made to clarify points that were not clearly recorded during the interviews.

7.3.1.1 Interviews Sample

The sample size decision (like most other design decisions) must be made

on a case-by-case basis, with researchers bearing in mind the variety of goals to be achieved by a particular study and taking into an account several other aspects of the research design (Fowler, 1988). For preliminary investigations and for some parts of the pilot work, researchers sometimes draw judgment samples. This explanation really means that precise parameters for the population are lacking but that the investigators have done their best to gain as wide a spread of individuals as possible (Oppenheim, 1996).

It is further argued by Oppenheim (1996) that the accuracy of drawing a sample is more important than the size of a sample itself. Preliminary data was acquired through face-to-face semi-structured interviews from forty service users in the Salford catchment area. This provided an opportunity to explore and gain insights into, and clarification of how service users experience healthcare delivery.

7.3.2 Focus Groups

Focus groups provided the opportunity for a group of people to share their thoughts, experiences and ideas on a wider range of issues than would arise in individual interviews (Hibbert, 1996). This allowed the researcher to gain understanding of how service users thought about the quality of healthcare and to obtain insight into their personal experience situation. The focus groups were facilitated by the researcher and two more facilitators with experience in conducting focus groups, whose main role was to encourage an open and relaxed discussion, keep the discussion relevant and probe into areas that needed clarification.

According to Patton (2002), focus group interviews have several advantages for qualitative inquiry:

- Data collection is cost-effective: significantly increasing sample size.
- Interactions among participants improve the data quality. Participants tend to provide checks and balances on each other, which weeds out false or extreme views.
- The extent to which there is a relatively consistent, shared view or great diversity of views can be quickly assessed.
- Focus groups tend to be enjoyable to participants, drawing on human tendencies as social animals.

(Morgan, 1997) identified three types of uses for focus groups namely:

- Self-contained method in studies in which they serve as principal source of data.
- Supplementary source of data studies that they rely on some other primary method such interview.
- Multi-method studies that combine two or more means of gathering data in which no primary method determines the use of the others.

Therefore, Focus groups may be used either as a method in its own right or to complement other methods, especially for triangulation and validity checking purposes. In this context, focus groups were used to discuss, confirm and augment findings yielded through semi-structured interviews.

In this regard, the focus groups were carried out by the researcher with the help of tow professional co-coordinators as a supplementary source of data studies to recognise the interviews findings. This provided an

opportunity for investigators to observe and interact with the groups. A trained interviewer facilitated all groups. Prior to commencement of the focus groups, the study team developed an interview guide that covered the key objectives of the study. As it was anticipated that many participants would not have knowledge about service user experience, summary materials were prepared to describe the concept of service user experience.

Each group commenced with discussing elements that would form service user experience. Group participants were asked about their current awareness of positive service user experience practices. The groups jotted down on the provided flip chart paper what they thought was important for them to achieve positive service user experience. The interviewer reviewed each flip chart paper and extracted key themes along with relevant quotations. Thematic analysis was conducted to identify areas of common concern. An independent researcher reviewed the flip chart papers independently to identify the key themes. A theme is characterised as shared by the majority or most members of a group when at least half expressed the thought. Few is characterised as a theme shared by one or two individuals in a group, while some is more than a few but not the majority.

7.3.2.1 Focus Groups Sample

A combination of convenience and purposive sampling was used in this exploratory research. Purposeful sampling involved consciously seeking participants who could contribute to the subject area. This method of sampling, therefore does not intend to provide a statistically representative

sample (Ashbury, 1999).

In order to answer the research question, it was important to recruit service users who had sufficient interaction with healthcare delivery.

Anyone who attended the open day facilitated by Salford PCT was eligible to participate.

The forty five service users were divided into five groups and asked the same open-ended questions/prompts to allow development of ideas as deemed relevant by the interviewees. A relaxed atmosphere was created to enhance interaction and the free flow of ideas and opinions is essential for the success of focus groups (Smith, 1998). The question used at the focus group session to start the discussions was derived from current literature and enquiries about the impressions of the service users of the healthcare service and the environment in which theses service are delivered, and structured in such a way as to not lead the participants to pre-defined answers.

7.4 Data Analysis

7.4.1 Analysis of interviews

All interviews that have been undertaken have been transcribed word for word. By using a content analysis as a means of analysing data collated from forty-five healthcare service users. See table (6.3). This is in line what Merriam (2002) who states about the nature of data collection in qualitative research. Based on her opinion, in qualitative research, data

analysis occurs simultaneously with data collection. That is, one begins analysing the data with the first interview, the first observation, the first document accessed in the study. Simultaneous data collection and analysis allows the researcher to make adjustments along the way, even to the point of redirecting data collection, and to test emerging concepts, themes, and categories against subsequent data. By waiting until all data are collected, one loses the opportunity to gather more reliable and valid data.

By using pre-defined keyword analysis in respect of transcription, it has been possible to link sections of interview data with previous data sets. Theses links have enabled relevant commentary to be inserted within the construction of this thesis thereby adding value at the appropriate point.

It is clear to the researcher, therefore, that the key elements tabulated below can help reveal important facts as to whether Salford PCT is responding to the needs and desires of the healthcare service users and helping facilitate the provision of healthcare services. However, as with any investigative process, there are always potential difficulties to be encountered somewhere along the line.

Thus, an evaluation was made by the researcher to identify any difficult elements to the study that could hamper the progress and successful outcome of the research. It was found that some of the service related elements detailed below might be difficult to determine because of the subjectiveness of some of the measurement criteria. For example, in determining how polite and friendly the receptionist is, it may be difficult to analyse real-life scenarios and quantify how much politeness and friendliness have been dedicated by the receptionist.

Table (7.2) Salford Healthy Fair

Healthcare Provider		**Impressions of Service**	**Impressions of Environment**
GP	Single handed ( )	Long waiting time Limited choice Quality of service Understanding Attitude of staff	Cleanness, Furniture Spaciousness, Car parking, Disabled facilities, Children play area, Entertaining facilities
	Group practice ( )		
Practice Nurse	Single handed ( )	Friendliness	
	Group practice ( )		
Dentist's Practice	Community ( )		
	Private ( )		
Chemist's Shop	Incorporated ( )	Information giving	
	Not Incorporated ( )		
Opticians	Community ( )	Understanding	
	Private ( )		
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives			

As can be seen from table (7.2), most of the impressions formed (Salford Healthy Fair) from visiting the GP. Other PCT outlets such as the Practice Nurse, Chemist Shops and the Opticians had less service related elements. Obviously, healthcare is delivered more via GP's than any other ways.

However, what is surprising, bearing in mind that the healthcare experience is a mixture of both service related and environment related elements, is as follows. For these service related elements such as:

Long waiting times,
Limited choice,
Quality of service,
Understanding,
Attitude of staff,

Friendliness,
Information giving, and
Understanding of staff.

All of these have been mentioned by the service users to show that these 'soft issues' are of more or greater significance than 'hard issues'.
'Hard issues' such as:

Cleanness,
Furniture,
Spaciousness,
Car parking,
Disabled facilities,
Children's play area and
Entertaining facilities.

In terms of the impressions formed by the service users (Ordsall Healthy Fair) towards creating service user experience, GPs still had more elements than any other Salford PCT outlets. However, this time, environment related elements (table 7.3) appear to take precedence over service related elements.

Service related elements constituted of: Quantity of care, Varity of service, Dignity and respect, Variety of service, Friendliness.

On the other hand, environment related elements included: Tidiness, Quietness, Decoration, Cleanliness, Smell of surgery, Toilets, Car parking, Furniture, Spaciousness of surgery, Accessibility, Accessibility Entertainment facilities and Pleasantness.

Table (7.3) Ordsall Healthy Fair

Healthcare Provider		**Impressions of Service**	**Impressions of Environment**
GP	Single handed ( ) Group practice ( )	Quantity of care Varity of service Dignity and respect Variety of service	Tidiness, Quietness, Decoration, Cleanliness Smell of surgery, Toilets Car parking, Furniture
Practice Nurse	Single handed ( ) Group practice ( )		Spaciousness of surgery
Dentist's Practice	Community ( ) Private ( )		Accessibility Entertainment facilities
Chemist's Shop	Incorporated ( ) Not Incorporated ( )		Cleanliness
Opticians	Community ( ) Private ( )	Friendliness	Pleasantness
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives			

Whilst it is obviously that environment related elements appear to take precedence over service related elements, the point that seems to emerge is that service users (Ordsall Healthy Fair) appear to assess service user experience in terms of hard issue rather than soft issues.

In terms of the impressions formed by the service users (Broughton Healthy Fair) towards creating service user experience, GPs still had more elements than any other Salford PCT out lets. However, again this time, environment related elements (table 7.4) appear to take precedence over service related elements.

Table (7.4) Broughton Healthy Fair

Healthcare Provider		**Impressions of Service**	**Impressions of Environment**
GP	Single handed ( )	waiting time Friendliness Variety of service Politeness of reception staff	Children play area Small waiting area Tidiness Cleanliness Signage Car parking Ventilation Lighting Magasines and news papers
	Group practice ( )		
Practice Nurse	Single handed ( )	Promptness privacy	Vending machines Telephones Colour of surgery Smell of surgery
	Group practice ( )		
Dentist's Practice	Community ( )	Quality of care Quantity of care	Accessibility Disabled facilities
	Private ( )		
Chemist's Shop	Incorporated ( )		
	Not Incorporated ( )		
Opticians	Community ( )		Car parking
	Private ( )		
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives			

In a very similar manner, Service related elements constituted of: waiting time, Friendliness, Variety of service, Politeness of reception staff, Promptness, privacy, Quality of care and Quantity of care. . On the other hand, environment related elements included: Children play area, Small waiting area, Tidiness, Cleanliness, Signage, Car parking, Ventilation, Lighting, Magasines and news papers, Vending machines, Telephones, Colour of surgery, Smell of surgery, Accessibility, Disabled facilities and Car parking.

Again, environment related elements appear to be of slightly higher importance as more elements were mentioned than in previous cases. This does not mean to say that service related elements should be neglected in order to create service user experience.

Further, in terms of the impressions formed by the service users Prospect Housing (Black ethnic minority groups) towards creating service user experience, GPs still had more elements than any other Salford PCT outlets. However, unlike previous cases this time, service related elements (table 7.5) appear to take precedence over environment related elements.

Service related elements constituted of: Access, Openness, Understanding, Helpfulness, Sympathy, Long waiting times, Approachability, Friendliness, Politeness, Communication, Privacy, Choice, Quality of care, Quantity of care, Dignity and respect, Quality of care, Communication, Staff attitude, Choice, Communication and Promptness of health visitor.

On the other hand, environment related elements included: Accessibility, Signage, Waiting area, Location and Children play area.

Table (7.5) Prospect Housing (Black ethnic minority groups)

Healthcare Provider		**Impressions of Service**	**Impressions of Environment**
GP	Single handed ( )	Access, Openness, Understanding Helpfulness, Sympathy, Long waiting time, Approachability Friendliness, Politeness, Communication, Privacy, Choice Quality of care, Quantity of care Dignity and respect	Accessibility Signage Waiting area Location Children play area
	Group practice ( )		
Practice Nurse	Single handed ( )	Quality of care Communication	
	Group practice ( )		
Dentist's Practice	Community ( )	Staff attitude Choice Communication	Accessibility Children play area
	Private ( )		
Chemist's Shop	Incorporated ( )		
	Not Incorporated ( )		
Opticians	Community ( )		
	Private ( )		
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives		Promptness of health visitor	

Whilst it is obviously that service related elements appear to take precedence over environment related elements, the point that seems to emerge is that service users Prospect Housing (Black ethnic minority groups) appear to assess service user experience in terms of soft issues rather than hard issues.

7.4.2 Findings from the interviews

The interviews (table, 7.6) revealed that service user experience is made by a combination of elements. These elements are service related and environment related. With reference to the content analysis conducted in respect of this research question, it can be seen that these elements truly represent the views of the service users within the Salford PCT area.

Table (7.6) Key elements of the semi-structured interviews

Issue	**Service**	**Environment**
Politeness of receptionist	√	
Access	√	
Friendliness, understanding and politeness of receptionist	√	
Car parking	√	
Waiting time	√	
Quality of healthcare	√	
Quantity of healthcare		√
Children play area		√
Choice	√	
Cleanliness		√
Waiting area		√
Attitude of staff		√
Signage		√
Communication		√
Magazines and news papers		√
Disabled facilities		√
Promptness		√
Lighting		√
Colour of surgery		√
Smell of surgery		√
Toilets		√
Telephones		√
Privacy	√	
Variety of service	√	
Dignity and respect	√	
Ventilation		√
Location of surgery		√
Vending machines		√

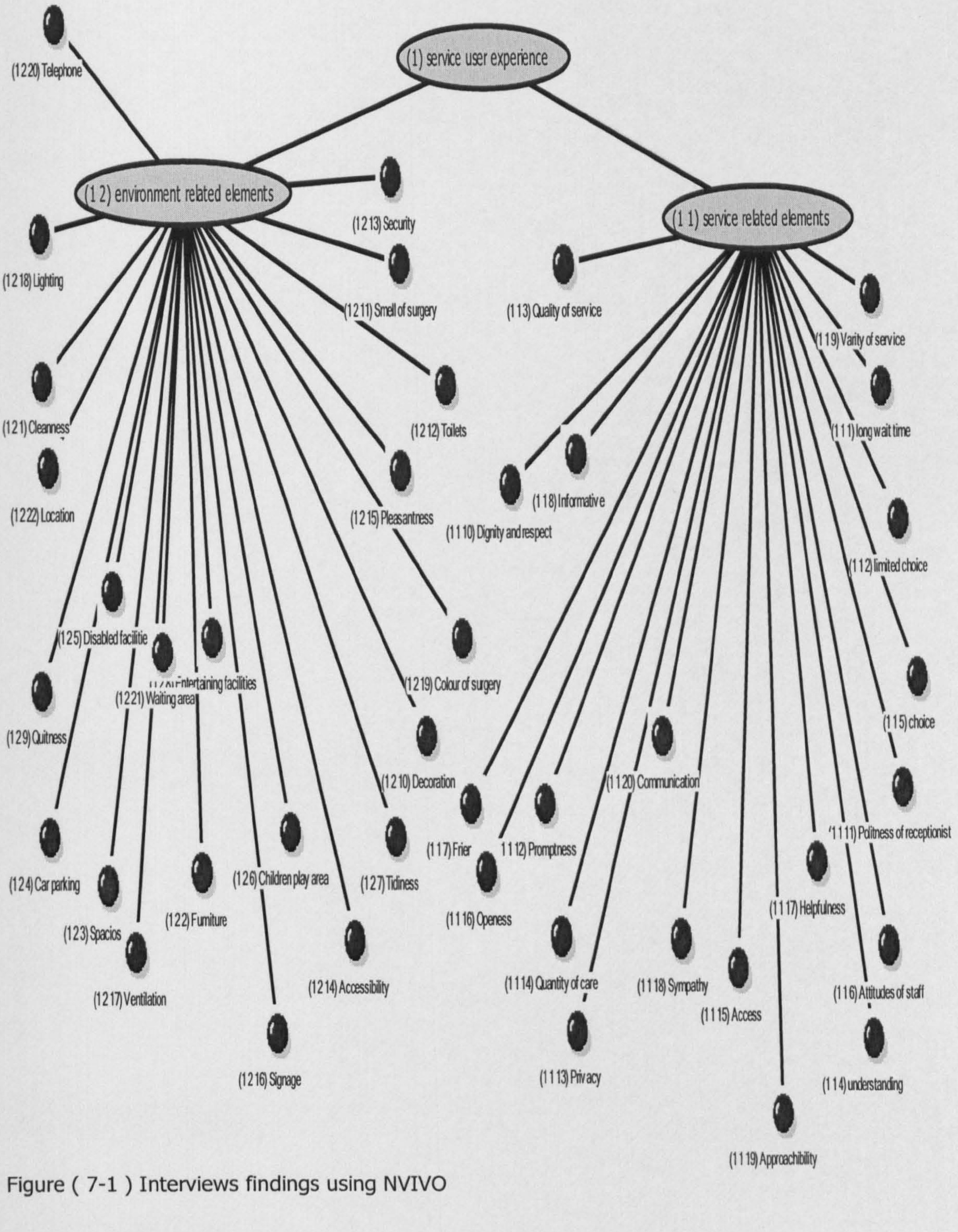


Figure (7-1) Interviews findings using NVIVO

Looking at the data sets, it was possible to show the service delivery as well as environment related elements. In order for healthcare providers to be more service user responsive, they must have the vision to inspire and the courage to take in to account the true views of the service users.

There is obviously more scope to help re-shape and consequently create service user experience through these views within the two sets of elements than anything else.

7.4.3 Analysis of focus groups

Thematic analysis was conducted to identify areas of common concern. An independent researcher reviewed the flip chart papers independently to identify the key themes. A 'theme' is characterised as, 'shared by the majority, or most members of a group when at least half expressed the thought'. Few are characterised as a theme shared by one or two individuals in a group, while some are more than a few, but not the majority (see table 7.6).

7.4.3.1 Findings from the focus groups

All focus group discussions were fully transcribed by the researcher. The transcriptions were examined by an external researcher independently. The information was analysed in order to identify emergent themes, which were then agreed on by discussion. All data was then categorised, and agreement over classification was achieved by discussion amongst the two researchers. Data were tabulated into themes and comparisons were made within and between service user groups, and the emerging themes were

reorganised.

Table (7.7) Key elements of the focus groups.

Issue	Service	Environment
Access		√
Car park		√
Helpfulness, understanding and politeness of receptionist	√	
Comfort	√	
Better information	√	
Skilful staff	√	
Spaciousness	√	
Enough time		√
Security		√
Quality treatment	√	
Disabled facilities	√	
Communication	√	
Privacy		√
Confidentiality		√
Signage	√	
Cleanliness		√
Waiting time		√
Promptness	√	
Children play area		√
Appropriate furniture		√
Colour		√
Ventilation		√
Magazines and news papers	√	
Location of surgery		√
Waiting area		√
Opening hours	√	
Variety of service	√	
Respect	√	
Telephones		√

Focus groups results show that the analysis of the empirical evidence obtained clearly advocates that although there is some indication that a proportion of the NHS Trusts does place an emphasis on the role that can be played by the service users, in the main the NHS appears to concentrate and adopt wrong methodologies. This predominance of wrong

methodologies would then seem to demonstrate that a positive service user experience within the NHS is by no means achievable. Indeed, other than the work undertaken for (formerly CHI), there was no evidence of the adoption of methodology noted previously.

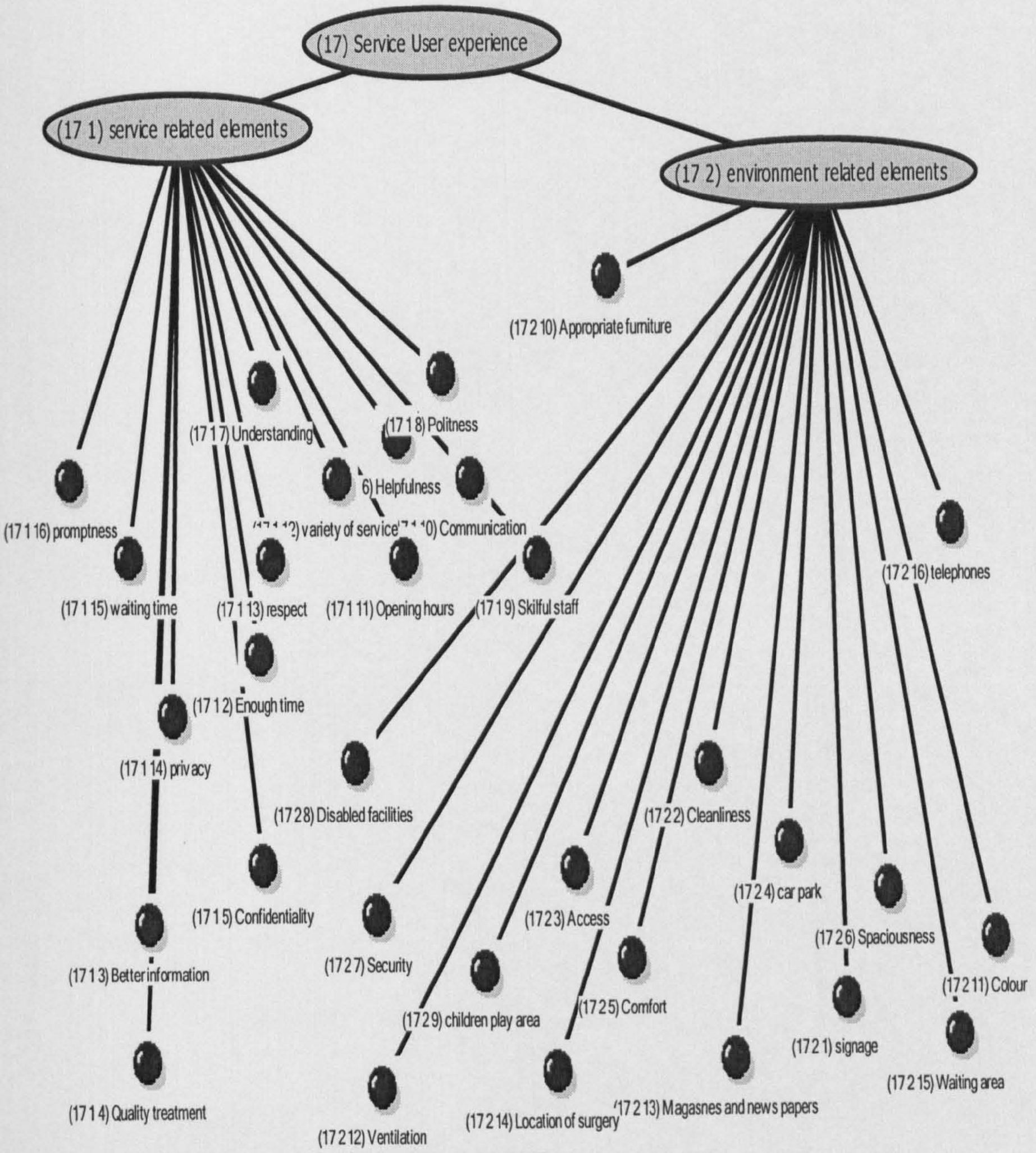


Figure (7-2) Focus groups findings using NVIVO

7.4.4 Interviews & focus groups findings

The research suggests that understanding of service user experience developed from respondents` impressions as represented by the common themes discusses earlier was accredited with:

- Car parking
- Access
- Signage
- Staff attitudes
- Waiting time
- Entertaining facilities
- Communication
- Waiting area
- Cleanliness
- Comfort
- Quality of healthcare
- Quantity of healthcare
- Privacy/confidentiality
- Security/safety
- Variety of service and choice
- Children play area.

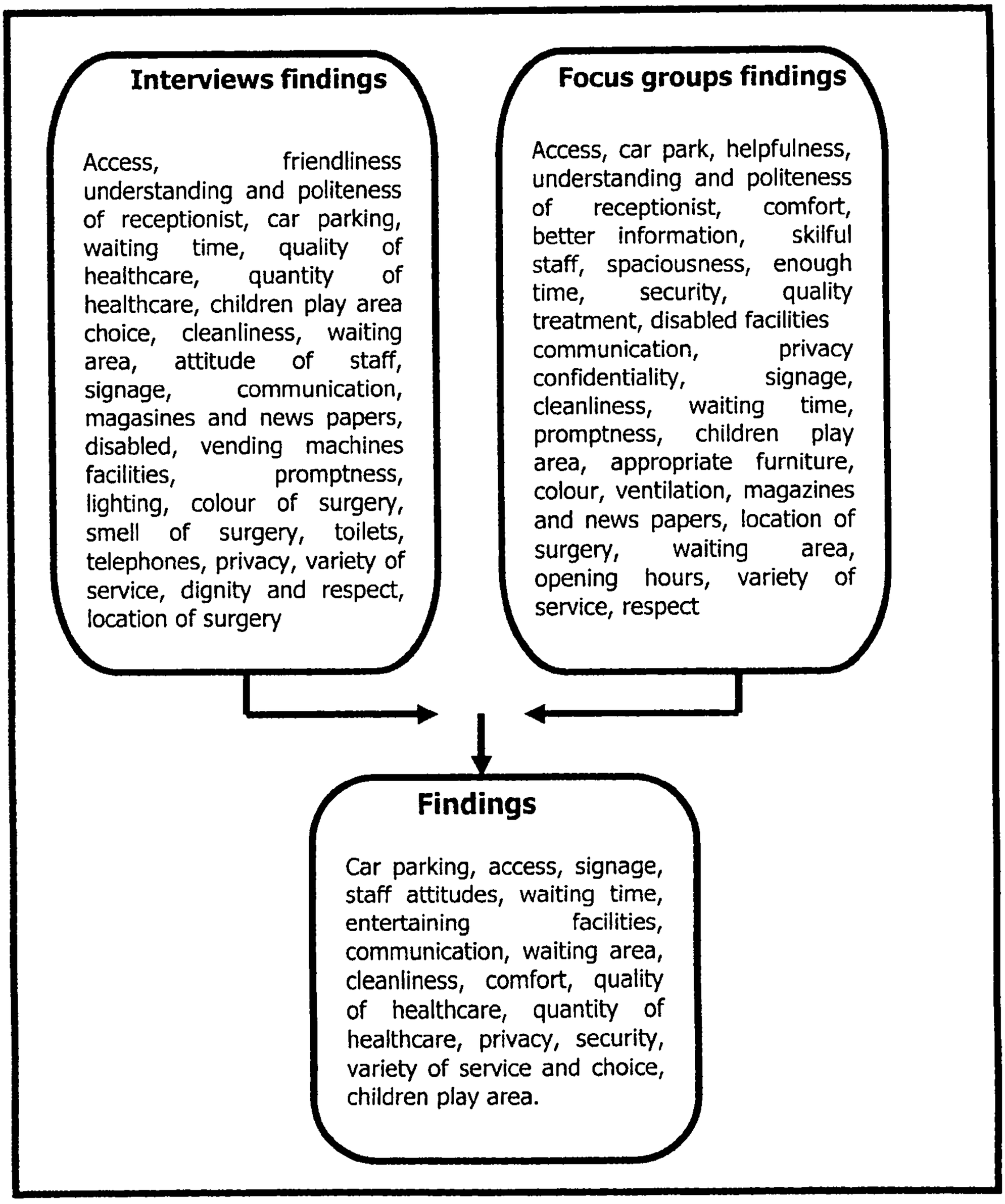


Figure (7-3) Data triangulation

The set of impressions representing principal service and environment related elements of a positive service user experience in figure 7-3 formed the basis up on which the questionnaire survey was constructed.

7.5 Discussion

In order to achieve and maintain a high level of robustness and validity, the researcher triangulated data by facilitating a focus group sessions for two good reasons. Firstly, to detect any variances that emerged from the interviews. Secondly, to validate that what has been raised in the interviews is representative enough and can be diffused into a bigger sample through a questionnaire survey.

The research has shown that understanding of service user experience developed from the respondents' impressions, as represented by the common themes discussed earlier, was accredited with: Car parking, Access, Signage, staff attitudes, waiting time, entertaining facilities, communication, waiting area, cleanliness, comfort, quality of healthcare, quantity of healthcare, privacy/confidentiality, security/safety, variety of service and choice, and children's play area.

There is some similarity between the findings of the Picker Institute Service user surveys (2005). The development of the questionnaire used by CHI to assess user experience within PCTs has followed the same developmental process as for other NHS Trusts. This process is regarded by the researcher as highly alarming, because it did not address issues that directly matter to the service users in PCTs.

7.6 Conclusion

The interviews provided an opportunity to gain insight into, and clarify how, service users experience healthcare. Focus groups provided the

opportunity for a group of people to share their thoughts, experiences and ideas on a wider range of issues than would arise in individual interviews.

This chapter has outlined the findings of the empirical investigations and discussed the results obtained from the interviews and focus groups conducted with a number of Salford PCT service users. It has to some extent clarified the majority of the main concerns related to the investigations of the capturing impressions and creation of service user experience within a given primary healthcare organisation.

The forty interviews and forty five focus groups conducted with the service users in Salford PCT identified the impressions of service users that could be translated into creating an assessment tool that supports service excellence which could further contribute to a complete shift of cultural change within the organisation as endorsed by this thesis.

Chapter 8: Questionnaire Survey Results

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter 4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

8.1 Introduction

This chapter reports on the use of service user experience within PCTs and discusses the results of the empirical study. The research involved the development of a questionnaire and the use of questionnaire survey to explore the impressions of the service user experience in Salford PCT, based on issues identified in the interviews and focus groups. The data collected through questionnaire survey conducted with the service users of Salford PCT has been analysed and inferences have been made.

8.2 Questionnaire survey

This phase of research involved the development of a questionnaire and the use of questionnaire survey to explore the impressions of the service user experience in Salford PCT, based on issues identified in the interviews and focus groups. Questionnaire surveys are a powerful, effective, and efficient alternative to the telephone survey and personal interviews. The use of questionnaire survey was deemed appropriate as it enables specific segments of the population to be easily accessed, and respondents provide more honest answers to questionnaire surveys than they do to other interviewing methods.

According to Fowler and Mangione (1990), there are several features of surveys designed to provide descriptive statistics about a population that distinguish them e.g., from interviews:

- The individual respondents are of interest only because they are members of the population to be described. Typically, they belong to a

representative sample of that population. Regardless of the manner in which they were chosen, the answers of individuals are of interest because they will help the researcher describe the population from which they originate, not because there is any intrinsic interest in the answers of these individuals per se.

- The product of the survey will be a quantitative description of the population. A typical product of a survey is a statement such as, "4% of the labour force is currently unemployed." Descriptions may also identify relationships among characteristics such as: "Workers who are dissatisfied with their jobs are more often on sick leave than workers who are satisfied."

The results of the measurement process and the data to be analysed, are the answers given by the respondents. The descriptions are a direct result of the distribution of respondents who gave particular type of answers.

To gain a deeper understanding of the way service users formulate their experiences of healthcare and for the purposes of investigating the impressions of the service users in creating service user experience, a questionnaire was composed. The target group was all service users who visited their health centre/ practice during the questionnaire distribution period.

The researcher has adopted the self-administered questionnaire technique in order to gain a broader understanding of the way service users formulate their experiences of healthcare delivery by leaving the questionnaire survey in an accessible place at all healthcare centre/surgery for fifteen working days. The researcher thereafter called back in and collected the completed questionnaires. To maintain privacy and

confidentiality, the questionnaire surveys were submitted and received in sealed envelopes.

The questionnaire was divided into two parts:

- The first part of the questionnaire consisted of questions related to general information such address, age, income, etc.
- The second part examined the service user experience. It contained questions about staff attitudes, waiting experience, treatment experience, etc.

8.2.1 Scaling

The rating of the responses was based on the Likert Scale, (Easterby-Smith et al., 1991; Openheim, 1966; Preece, 1994) as this scaling method was the most appropriate to be adopted in this questionnaire survey due to the nature of the questions being asked. In this method, five categories of answers were provided for each question starting with "Disagree strongly or Very poor" as the most negative answer, to "Agree strongly or Very satisfactory" as the most positive answer. Further, the Likert Scale is not limited to five categories of answers only, however, in the present study, provision of five choices was believed to be most appropriate.

8.2.2 Sampling

Sampling mainly aims at obtaining reliable and accurate information from which a generalisation to the whole population under consideration maybe done. The values of variables found for the sample are used as estimates for the values of the whole population. The ideal approach to providing an accurate description of the characteristics of a group is to collect data on the whole population. However, in some contexts, this approach to sampling is often impossible to frame out because it can be found to be both costly and time consuming. Furthermore, this approach is unnecessary because the sample survey method can provide estimates of population values that are reliable and accurate enough for most purposes. Moreover, there are situations when a variation of the judgment sampling method can be argued to be appropriate.

Erlandson (1993) suggested that the purposive sampling technique is preferred for random or representative sampling, because the major concern of the researcher is to maximise discovery of the problem, and the heterogeneous patterns that occur within the context of the particular study.

Thus, purposive sampling was employed to provide estimates of the impressions of the service user experience within Salford PCT.

8.2.3 Description of the Questionnaire Survey

Having considered a number of best practice and survey design publications (Fowler Floyd, 1995; Hague Paul, 1993; Remenyi et al., 1998), the questionnaire (Appendix 3) was composed of two main sections as

follows:

Section I - General Information: This section was concerned with gathering basic demographic information about the respondent's educational level, income, ethnic minority groups, marital status and so forth.

Section II – Service user experience: This section was composed of twenty questions. The main objective of this section was to assess the healthcare journey from start to end.

8.2.4 Questionnaire validation

The questionnaire was pre-tested with twenty-five respondents. The pilot survey was carried out in order to test the validity of the questionnaire and make sure that all the questions posed are relevant and well defined as to provide answers to the main research question and the development of the set of elements.

The following subsections will describe the results achieved from the questionnaire survey carried out between June 2005 and July 2005 in relation to the development of a set of elements for Salford PCT. Prior to discussing these results in great detail, the researcher suggests that all percentages given in the text are rounded up for a practical reading purpose only.

8.2.5 Questionnaire Survey Summary

Sixty-one PCT outlets within Salford were selected for the survey bringing the number to one thousand and two hundred twenty respondents. However, a random sample of twenty-five was selected to conduct the pilot survey. The results obtained from the pilot questionnaires were later removed from the statistical analysis database (see table 8.1).

Table (8.1) Survey Summary

Summary	Piloted Questionnaires	Distributed Questionnaires	Collected Questionnaires
Total	25	1220	343
%			%28

Therefore, the total number of the distributed questionnaires that served as the base for the data analysis was brought down to three hundred and forty three respondents.

8.2.6 Analysis of Questionnaire Survey

As explained earlier in this chapter, the total number of the distributed questionnaires that served as the base for the data analysis was brought down to three hundred and forty three respondents.

The quantitative analytical methods used in this thesis are fairly standard at this level of investigation. It is possible, however, that the data collected from the questionnaire survey could be analysed using other techniques.

Data analysis involved converting a series of observations into descriptive

statements about variables. But before analysing data using SPSS (release 8.0), it needed to be reduced by getting the data ready for analysis and the calculation of summarising statistics.

Further, the raw data from the respondents needed to be edited before coding to make sure that the data was present, readable and accurate. Variables were coded as nominal numbers. For most of the categories variables or answers were ordinal ranking scaled and therefore coding simply involved scoring from 1 to 5, that is, from 1 ="Agree strongly or Very satisfactory" to 5 = "Disagree strongly or Very poor"

8.2.6.1 Section One: General Information

Q1 This question was designed to investigate the address of the respondents and the number of years they have lived within their respective communities. It is subdivided into two sub-sections. The first sub-section shows the areas of Salford City in which the study took place.

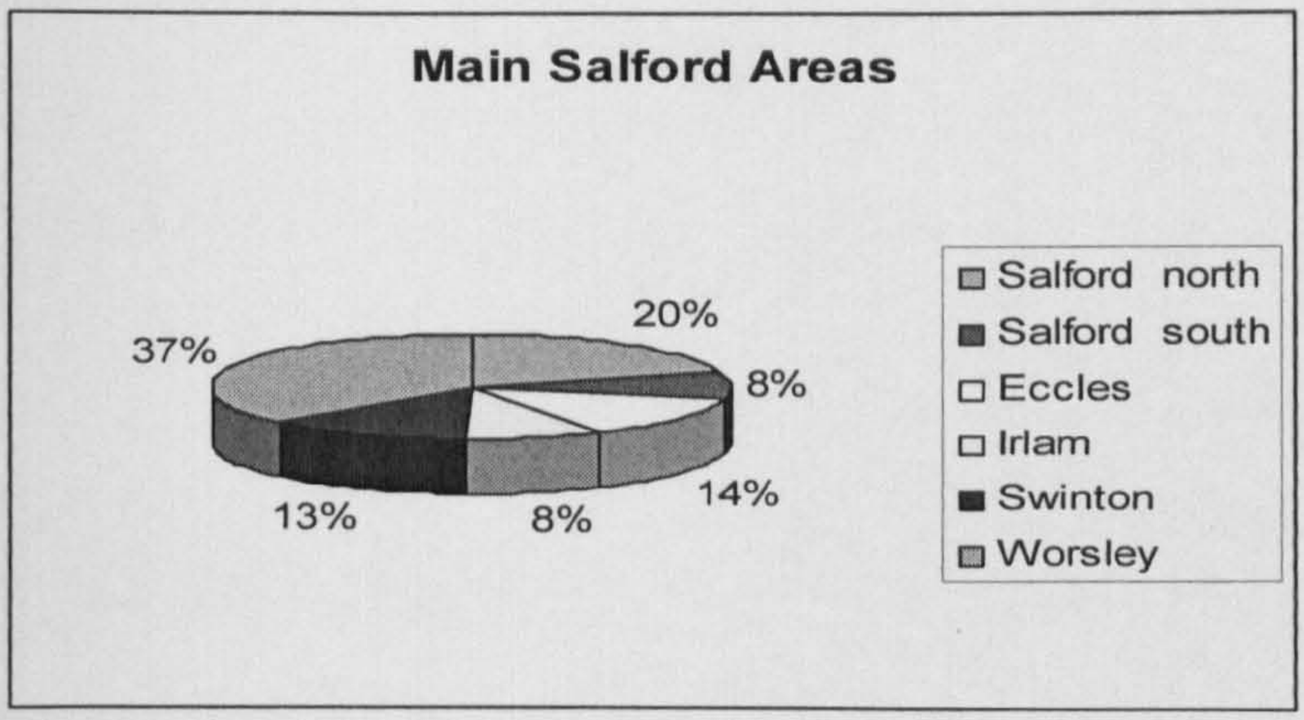


Figure (8-1) main Salford areas

Figure (8-1) shows that the questionnaire survey was distributed to all of

the Salford City areas and thus it should have be able to cover a very well established representation sample from each of these areas. This information is very important as to maintain a balance of adequate responses aiming at involving as many service users as possible of Salford PCT that could later influence the way in which healthcare is designed and delivered.

The second sub-section of the first question indicates the average number of years the respondents have resided in their respective communities.

Table (8.2) number of years in the community

	Number of Years in the community
N	311
Mean	30
Range	84

As shown in table (8.2), the average number of years the respondents have resided in the respective communities is between 30-84 years. This should guarantee that the respondents have the ability to understand and discuss the main issues related to positive service user experience within their communities.

Q2 This question is also subdivided into two sub-sections. The first sub-section addressed the number of males and females that took part in the questionnaire survey.

Table (8.3) analyses the profile of the respondents and indicates clearly that a percentage represented by 58% of the respondents (Salford North), 62% of the respondents (Salford South), 77% of the respondents (Eccles), 69% of the respondents (Irlam), 88% of the respondents (Swinton), and 71% of the respondents (Worsley) who participated in the study, were

females.

Table (8.3) gender of respondents

	Male %	Female %	Total %
Salford North	42	58	100
Salford South	38	62	100
Eccles	23	77	100
Irlam	31	69	100
Swinton	32	68	100
Worsley	29	71	100

This shows that more females than males visited their healthcare surgery or health centre.

The second sub-section of the second question table (8.4) shows that the average age of the respondents was between 47 - 70 years.

Table (8.4) average age of respondents

		AGE
N	Valid	325
	Missing	18
Mean		47
Range		70

This can indicate that respondents have been around for long enough to have the ability to understand and discuss the main issues related to the Salford PCT healthcare experience.

Q3 This question looks at the marital status of the respondents.

Table (8.5) marital status of the respondents

	Single %	Married %	Divorced %	Separated %	Co- habiting %	Total %
Salford North	25	46	8	4	17	100
Salford South	28	52	12	0	8	100
Eccles	23	52	11	3	11	100
Irlam	24	60	4	0	12	100
Swinton	15	51	24	3	7	100
Worsley	19	52	10	4	15	100

As shown in table (8.5), 46% of the respondents (Salford North) followed equally by 52% of the respondents (Salford South, Eccles, Worsley), and a further percentage represented by 60% of the respondents (Irlam), and 51% of the respondents (Swinton) who participated in the study were married. This indicates that the majority of the respondents were married.

Q4 This question investigated the ethnic minority groups table (8.6) of the respondents.

Table (8.6) ethnic minority of the respondents

Group	**Percent**
White	96.7
Black Caribbean	0.3
Black other	0.3
Bangladeshi	0.3
Indian	0.3
Pakistani	1.8
Chinese	0.3
Total	100

The vast majority described their ethnicity as being white 97%. Much smaller numbers belonged to a range of minority ethnic groups including Black Caribbean 0.3%, Black Other 0.3%, Bangladeshi 0.3%, Indian 0.3%, Pakistani 1.8% and Chinese 0.3%.

Q5 This question is also sub-divided into two sections. The first sub-section describes the average household income per year.

Table (8.7) Respondents household income

Household income level	**Percent**
Up to £7000	24
£7000-£9999	22
£10000-£14999	9
£15000-£19999	7
£20000-£24999	6
£25000-£29999	4
£30000 and above	3
Refused	25
Total	100

Table (8.7) analyses the profile of the respondents and indicates clearly that a quarter of the sample declined to provide information about household's income. Of the remainder, over half of the respondents 55% had less than £15000 per year. Only 10% reported they had up to £30000. In contrast, 3% had an annual income in excess of £30000.

The second sub-section of the question looks at the occupation status of the respondents. As illustrated in table (8.8), just under a third 29% of the respondents (Salford North) followed by just over a quarter 27% of the respondents (Salford South) described themselves as self employed and slightly under one fifth 19% (Eccles) described them selves as being in part time employment.

Table (8.8) Occupation status

	Full time %	Retired %	Part time %	Self employed %	Not applicable %	Full time Student %	Un employed %	Total %
Salford North	8	10	29	14	17	8	14	100
Salford South	15	10	12	27	12	5	19	100
Eccles	10	13	19	14	17	10	17	100
Irlam	4	4	23	12	15	4	38	100
Swinton	10	22	17	7	10	10	24	100
Worsley	10	24	23	13	7	8	15	100

Just over one third of the respondents 38% (Irlam) and a further 24% (Swinton) described themselves as unemployed, where as 24% of the respondents (Worsley) reported that were retired.

Q6 This question addressed the highest levels of education reached by the respondents at the time of the survey.

Table (8.9) Education level

	Secondary school %	College %	University %	Other %	Total %
Salford North	55	30	8	7	100
Salford South	72	20	8	0	100
Eccles	56	14	26	4	100
Irlam	42	33	21	4	100
Swinton	42	42	8	8	100
Worsley	55	26	11	8	100

Table (8.9) analyses the profile of the respondents and indicates clearly over half of the respondents represented equally by 55% (Salford North, Worsley) and 72% of the respondents (Salford South), followed equally by 42% of the respondents (Irlam, Swinton) were of secondary school qualifications. This illustrates how low the education attainment is spread amongst the citizens in Salford city.

Q7 This question investigated when respondents last visited their local health centre/healthcare practice.

Table (8.10) Last visit to health centre/healthcare practice

Last visit	Percent
Within last month	55
Within the last two three months	23
Other	22
Total	100

Over half of the respondents 55% reported that they visited their health centre/healthcare practice within last month. Where as, over one fifth 23% of the respondents within the two to three last months. Smaller numbers (table 8.10) visited their health centre/healthcare practice in other ways, accounted for 22%.

Q8 This question addressed the long-term illness/ condition the respondents suffered from. All respondents were asked (table 8.11) to provide details of the kind of long-term illness they suffered from.

Table (8.11) service user's impressions of Illness conditions

Type of illness	**Percent**
Sight impairment	4
Hearing impairment	3
Physical impairment	11
Learning impairment	2
None	46
Other	34
Total	100

Four per cent of the respondents reported that they suffered from sight impairment, 3% suffered from hearing impairment, 11% suffered from physical impairment and only 2% suffered from learning impairment. In contrast, under half of the sample 46% did not suffer from any long-term illness and a further 34% suffered from other kinds of long-term illness.

8.2.6.2 Section Two: Service User Experience (Frequency counts)

This section is related to the assessment of service user experience and its presence, use, and exploitation within the Salford PCT so that each of the sub-sections described below defines a particular phase through out the service user journey.

8.2.6.2.1 Assessment of the service user experience in Salford PCT

A thorough analysis of service user experience within Salford PCT is gathered through this part. In fact, it identifies the main interests of the overall respondents of service user experience. In this regards, the respondents were presented with 12 inter-related questions that describe various phases of positive service user experience. These answers were rated according to the Likert Scale approach, whereas five options were defined. These ranged from "Strongly agree or Very satisfactory" as the most positive answer, to "Strongly disagree or Very poor" as the most negative one.

The results of this analysis are given below. It is important however to note that all scales without any result will be dismissed in this analysis, and all percentages will be rounded to the nearest figures:

Q9 - Respondents were asked to state whether they contacted their health centre/ practice by telephone or in person at the reception desk to arrange an appointment. This question was meant to establish a first contact of the respondents with their healthcare centre or health practice and capture their understanding of what service user experience would mean to them.

Table (8.12) Service user's impressions of means of contact with healthcare/practice

	By telephone %	In person %	Total %
Salford North	80	20	100
Salford South	72	28	100
Eccles	82	18	100
Irlam	92	8	100
Swinton	79	21	100
Worsley	81	19	100

80% of the respondents (Salford North), 72% of the respondents (Salford South), 82% of the respondents (Eccles), 92% of the respondents (Irlam) followed by 79% of the respondents (Swinton) and 81% of the respondents (Worsley) contacted (table 8.12) their healthcare centre/practice by telephone instead of coming in person at the reception desk. Therefore, one should understand that telephone contact was a strong means that helped respondents within Salford PCT get in touch with their healthcare centre/ practice.

Q10. This question is divided into four sub sections. Respondents were asked to rate their views as to enough parking spaces, good directional signs, secure parking facilities, and easy access to the healthcare centre/practice.

- **Enough parking spaces**

In this regards, 47% of the respondents (Salford North) answered that they agree with this statement. Thirty-six per cent (table 8.13) of the respondents (Salford South) have expressed their agreement to this issue and 42% of the respondents (Eccles) disagree with it. Thirty-six per cent of the respondents (Irlam) however disagree with this statement where as 32% of the respondents (Swinton) have expressed their agreement

followed by 47% of the respondents (Worsley) who also agree with it.

Table (8.13) Service user's impressions of enough parking space

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	10	9	16	47	18	100
Salford South	10	27	18	36	9	100
Eccles	21	42	19	18	0	100
Irlam	8	36	20	32	4	100
Swinton	16	15	13	32	24	100
Worsley	14	21	9	47	9	100

This shows mixed feelings, respondents from healthcare centre/practice with enough car parking space expressed agreement where as respondent from healthcare centre/practice with small parking space expressed otherwise.

- **Good directional signs**

A percentage represented by 38% of the respondents (Salford North) indicates that they agree that their healthcare centre/practice has good directional signs followed by another 68% of the respondents (Salford South) agree with this statement.

Table (8.14) Service user's impressions of directional signs

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	7	23	17	38	15	100
Salford South	0	9	18	68	5	100
Eccles	11	22	39	28	0	100
Irlam	0	12	48	36	4	100
Swinton	7	16	24	29	24	100
Worsley	7	19	24	43	7	100

As shown in table (8.14) 39% of the respondents (Eccles) followed by another 48% of the respondents (Irlam) could not decide, 29% of the

respondents (Swinton) and 43% of the respondents (Worsley) have expressed their agreement to this statement. This shows that the vast majority agreed that their healthcare centre/practice had good directional signs.

- **Secure parking facilities**

As shown in table (8.15) 34% of the respondents (Salford North) simply disagreed that parking facilitates were secure and only 36% of the respondents (Salford South) simply agreed with the statement.

Table (8.15) Service user's impressions of security of parking facilities

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	3	34	28	26	9	100
Salford South	14	18	23	36	9	100
Eccles	21	29	26	24	0	100
Irlam	8	8	48	32	4	100
Swinton	14	19	31	19	17	100
Worsley	14	22	27	30	7	100

On the other hand, 29% of the respondents (Eccles) disagreed where as 48% of the respondents (Irlam) followed by another 31% of the respondents (Swinton) could not decide. 30% of the respondents (Worsley) have expressed their agreement to this statement. It can be said here that parking facilities in Salford North are more secure when compared to those in Eccles.

- **Accessibility of healthcare centre/practice**

A large number represented by 70% (table 8.16) of the respondents (Salford North) followed by 58% of the respondents (Salford South), 80%

of the respondents (Eccles), 76% of the respondents (Irlam), 46% of the respondents (Swinton) and 66% of the respondents (Worsley) indicated that they simply agreed that their healthcare centre / practice was easily accessible.

Table (8.16) Service user's impressions of accessibility of health centre/practice

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford Nnorth	4	2	1	70	23	100
Salford South	0	0	13	58	29	100
Eccles	7	0	6	80	7	100
Irlam	4	4	8	76	8	100
Swinton	8	5	5	46	36	100
Worsley	2	2	8	66	22	100

The consensus here is that accessibility has been taken into consideration in most of the healthcare centres/practices, and that people with accessibility problems are looked after in most of the cases.

It is clear to the researcher from the results that respondents are well aware of the elements mentioned above and pleased with them reasonably well. This is evidenced in their answers with 'simply agree' instead of 'strongly agree'. The risk that Salford PCT may face if fast responses are not provided, is that many of the respondents may run out of patience, and become displeased, due to the lack of a responsive and service user-centred approach provided for this purpose.

Q11. Respondents were asked about the length of time they had to queue before being spoken to by the reception staff. A large number represented by 70% (Salford North) (table 8.17) of the respondents followed by 75% (Salford South), 54% (Irlam) and 59% (Worsley), indicated that they did not have to queue before being seen by the reception staff in their healthcare centre / practice. On the other hand, just over half of the

respondents respectively 52% (Eccles) and 51% (Swinton) had to queue.

Table (8.17) Service user's impressions of queuing time at reception desk

	Did not have to queue %	Had to queue %	Total %
Salford North	70	30	100
Salford South	75	25	100
Eccles	48	52	100
Irlam	54	46	100
Swinton	49	51	100
Worsley	59	41	100

This can indicate that some healthcare centres / practices are under staffed, or that the number of service users is higher than those with no queues, which makes queuing up inevitable.

Q12. Respondents were asked to rate to what extent they agreed that the reception staff were, approachable, polite, friendly and helpful, knowledgeable about their services, and understanding of the health needs of the service users.

- **Approachable**

As illustrated in table (8.18) a large number represented by 51% of the respondents (Salford North) followed by 62% (Eccles), 83% (Irlam), and 54% (Swinton) and 55% (Worsley) indicated that they simply agreed that reception staff were approachable

Table (8.18) Service user's impressions of approachable staff

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	2	0	0	51	47	100
Salford South	0	0	0	48	52	100
Eccles	0	5	0	62	33	100
Irlam	0	0	0	83	17	100
Swinton	5	0	5	54	36	100
Worsley	1	0	4	55	40	100

Just over half of the respondents 52% (Salford South) strongly agreed with this statement. It is evident that the vast majority of the respondents were fairly impressed by staff approachability.

- **Polite**

This statement was established to assess the extent of politeness that the respondents were impressed by. 51% (table 8.19) of the respondents (Salford North) and a further 62% (Salford South), indicated that they strongly agreed that reception staff were polite.

Table (8.19) Service user's impressions of polite staff

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	0	0	0	49	51	100
Salford South	0	0	0	38	62	100
Eccles	2	3	7	56	32	100
Irlam	0	0	0	79	21	100
Swinton	5	0	5	55	35	100
Worsley	3	1	1	53	42	100

Over half 56% (Eccles) followed by 79% (Irlam), 55% (Swinton) and 53% (Worsley) simply agreed with this statement. As illustrated above and regardless of the varying levels of agreement, the majority were fairly impressed that reception staff were polite.

- **Friendly and helpful**

This statement was established to assess the extent of friendliness and helpfulness that the respondents were impressed by. Half of the respondents (Salford North) 50% (table 8.20) followed by 57% of the respondents (Salford South) indicated that they strongly agreed that

reception staff were friendly and helpful.

Table (8.20) Service user's impressions of friendly and helpful staff

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	0	2	2	46	50	100
Salford South	0	0	0	43	57	100
Eccles	0	4	0	60	36	100
Irlam	0	0	0	80	20	100
Swinton	5	0	2	55	38	100
Worsley	1	1	5	50	43	100

A large percentage of the respondents represented by 60% (Eccles) followed by even larger percentage 80% (Irlam), 55% (Swinton) and 50% (Worsley) simply agreed that the reception staff were friendly and helpful.

This can show that the majority of the respondents were fairly impressed by the friendliness and helpfulness of staff.

- **Knowledgeable**

This statement was established to assess to which extent the respondents were impressed by the spectrum of knowledge the reception staff had. 54% (table 8.21) of the respondents (Salford North) followed by 50% (Salford South) indicated that they strongly agreed that reception staff were knowledgeable.

Table (8.21) Service user's impressions of knowledgeable staff

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	2	0	7	37	54	100
Salford South	0	0	5	45	50	100
Eccles	0	5	18	59	18	100
Irlam	0	4	21	58	17	100
Swinton	6	0	11	51	32	100
Worsley	1	2	8	48	41	100

59% of the respondents (Eccles) followed by 58% (Irlam), 51% (Swinton) and 48% (Worsley) simply agreed that the reception staff were knowledgeable. It is clear that the majority were fairly impressed by the spectrum of knowledge the reception staff had.

- **Understanding**

This statement was established to assess to which extent the respondents were impressed by the understanding of the reception staff of their health needs. Forty-Nine per cent (see table 8.22) of the respondents (Salford North) indicated that they strongly agreed that reception staff were understanding of their health needs.

Table (8.22) Service user's impressions of understanding staff

	Disagree strongly %	Disagree %	Neither agree nor disagree %	Agree %	Agree strongly %	Total %
Salford North	0	4	11	36	49	100
Salford South	0	0	14	48	38	100
Eccles	0	8	23	54	15	100
Irlam	0	8	29	46	17	100
Swinton	5	2	13	49	31	100
Worsley	1	2	16	42	39	100

The remaining respondents simply agreed with this statement. Forty-Eight per cent of the respondents (Salford South), followed by 54% (Eccles), 46% (Irlam), 49% (Swinton) and 42% simply agreed that that reception staff were understanding of their health needs.

In the same manner as for the previous question, this statement was established to ensure that respondents were aware of the attitudes of the reception staff. The results obtained from all the sub sections of the question imply the following. That although the majority of the

respondents agreed that the reception staff were understanding of their health needs, the numbers are not sufficient to show that Salford PCT has yet moved towards the delivery of excellent healthcare in this aspect of service delivery.

Q13. Respondents were asked to provide details of the person they went to see for treatment.

A large number represented by 61% (table 8.23) of the respondents (Salford North) followed by 72% (Salford South), 70% (Eccles), 69% (Irlam), 78% (Swinton) and 69% (Worsley) indicated that the vast majority of the respondents went to see their GP for their treatment.

Table (8.23) Service user's impressions of treating person

	GP %	Dentist %	Optician %	Practice nurse %	Health visitor %	Physio-therapist %	Total %
Salford North	61	1	0	23	5	10	100
Salford South	72	0	0	28	0	0	100
Eccles	70	5	0	16	0	9	100
Irlam	69	4	0	27	0	0	100
Swinton	78	0	0	15	0	7	100
Worsley	69	1	2	19	2	7	100

This clearly shows that GPs were the most frequently visited by the respondents. This in turn, implies that if there is an improvement to support the overall development of staff skills such as, being approachable, polite, friendly and helpful, knowledgeable and understanding of the health needs of the service users within Salford PCT. Such development would establish itself as an important asset that could significantly contribute to revamp the image that the respondents hold of the healthcare delivered within Salford PCT.

Q14 Respondents were asked to state whether they had to wait or immediately seen before receiving treatment.

As illustrated in table (8.24), 79% of the respondents (Salford North) followed by 83% (Salford South), 93% (Eccles), 78% Irlam, 100% (Swinton) and a further 90% (Worsley) had to wait before treatment.

Table (8.24) Service user's impressions of waiting time before being seen

	Immediately %	Had to wait %	Total %
Salford North	21	79	100
Salford South	17	83	100
Eccles	7	93	100
Irlam	22	78	100
Swinton	0	100	100
Worsley	10	90	100

Although the majority of the respondents mentioned in table (8.24) that telephone contact was a strong means that helped respondents make appointment in advance, the vast majority had to wait before being seen for medical treatment.

This is very alarming as waiting time is regarded as a very important element towards creating service user experience.

Q15 Respondents were asked a series of questions about their last waiting experience in terms of typical length of time they had to wait, the effort made by the staff to reduce waiting time, staff apologising about the wait, entertaining facilities such as news papers and magasines and the way the staff kept them informed.

- **The typical length of time the service user had to wait**

A large number represented by 44% (Salford North) followed by 42%

(Salford South), 39% (Swinton) reported that the typical length (table 8.25) of time they had to wait was average.

Table (8.25) Service user's impressions of typical length of time

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	7	3	44	20	26	100
Salford South	3	0	42	38	17	100
Eccles	4	10	29	43	14	100
Irlam	8	8	28	31	25	100
Swinton	7	8	39	34	12	100
Worsley	5	5	31	38	21	100

In contrast, 43% (Eccles), 31% (Irlam) and 38% (Worsley) said it was very satisfactory.

It is clear that respondents were willing to wait for a reasonable length of time.

- **The effort made by the staff to reduce waiting time**

In terms of respondents` impressions (table 8.26) of the effort made by the staff to reduce waiting time, 43% of the respondents (Salford North) followed by 57% (Salford South), 39% (Irlam), 38% (Swinton) and 45% (Worsley) reported that the effort was satisfactory,

Table (8.26) Service user's impressions of effort made by the staff to reduce waiting time

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	2	6	27	43	22	100
Salford South	0	0	19	57	24	100
Eccles	2	6	46	43	3	100
Irlam	0	14	30	39	17	100
Swinton	6	14	36	38	6	100
Worsley	1	4	26	45	24	100

In contrast, 46% of the respondents (Eccles) said it was average. It is clear

most of the respondents` impressions were satisfactory.

Again, this is not good enough for creating service user experience. More is still needed to aim for excellence.

- **Staff apologising about the wait**

Just over one third 32% of the respondents (Salford North) followed by half 50% (Salford South), 38% (Eccles), 41% (Swinton) and 47% (Worsley) reported (table 8.27) that their impressions were satisfactory.

Table (8.27) Service user's impressions of staff apologising about the wait

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	1	10	30	32	27	100
Salford South	0	5	20	50	25	100
Eccles	9	25	25	38	3	100
Irlam	18	5	36	23	18	100
Swinton	9	22	22	41	6	100
Worsley	6	9	16	47	22	100

In contrast, 36% of the respondents (Irlam) said that it was average.

As can be seen, more work is needed in order to create service user experience.

- **Entertaining facilities**

One quarter 25 % of the respondents (Salford North) followed by half 43% (Salford South), 54% (Eccles), 38% (Swinton) and 44% (Worsley) reported (table 8.28) that their impressions were satisfactory.

Table (8.28) Service user's impressions of entertaining facilities

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	5	27	23	25	20	100
Salford South	9	17	5	43	26	100
Eccles	8	11	22	54	5	100
Irlam	8	21	33	21	17	100
Swinton	7	21	26	38	8	100
Worsley	4	14	17	44	21	100

In contrast, just over one third 33% of the respondents (Irlam) said that it was average.

As illustrated above respondent's impressions of the entertaining facilities were so low especially in Irlam for creating service user experience.

- **The way the staff were keeping service users informed**

Similarly, just over one third 34% of the respondents (Salford North) followed by 33% (Salford South), 40% (Eccles), 44% (Swinton) and 42% (Worsley) reported (table 8.29) that their impressions were satisfactory.

Table (8.29) Service user's impressions of the way the staff kept them informed

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	5	11	25	34	25	100
Salford South	0	19	19	33	29	100
Eccles	17	14	26	40	3	100
Irlam	13	9	39	22	17	100
Swinton	3	19	31	44	3	100
Worsley	4	16	19	42	19	100

In contrast, 39% of the respondents (Irlam) said that it was average. As illustrated above, the respondent's impressions of the way the staff kept service users informed (especially in Irlam), were very low for creating an excellent service user experience.

Looking specifically at respondent's impressions of the service users of the issues raised above, the general pattern is that PCTs have not yet reached a stage where service users are completely impressed by the healthcare service. On the other hand, in relation to the same issues raised above, a smaller proportion of service users rated them as merely satisfactory or poor. These responses are minor, and prove that the gaps can be bridged if service users are taken on board at early enough stage.

Q16. Respondents were asked a series of questions about their impressions of the waiting area in terms of location, size, layout, directional signs, ease of access, fresh air, pleasant decoration, access to telephone, smell, cleanliness, lighting, comfort, facilities for people with special needs, privacy levels, toilets, and the children's play areas.

- **Location of waiting area**

In relation to the rating by the respondents of the location of the waiting area (table 8.30) a greater proportion commented on it, again the tendency was to rate these as being satisfactory 47% of the respondents (Salford North), followed by 43% (Salford South), 45% (Swinton) and 50% (Worsley) said it was satisfactory.

Table (8.30) Service user's impressions of location of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	4	28	47	21	100
Salford South	0	1	17	43	39	100
Eccles	2	7	29	26	36	100
Irlam	3	4	32	30	31	100
Swinton	1	2	13	45	38	100
Worsley	1	3	18	50	28	100

In contrast, a smaller proportion 29% (Eccles) followed by 32% of the

respondents (Irlam) rated the location as average.

It is clear that the rating by the respondents of the location of the waiting area should have been much higher especially in Eccles and Irlam to create a positive service user experience.

- **Size of waiting area**

In terms of service users` impressions of the waiting area size (table 8.31), while 45% of the respondents (Salford North) followed by 38% (Salford South), 31% (Irlam), 38% (Swinton) and a further half 50% (Worsley) have said it was very satisfactory.

Table (8.31) Service user's impressions of size of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford north In relation to the rating by the respondents	1	13	23	45	18	100
Salford south	0	4	25	38	33	100
Eccles	7	4	37	20	32	100
Irlam	3	8	27	31	31	100
Swinton	2	3	13	38	44	100
Worsley	0	4	17	50	29	100

In contrast, just over one third 37% of the respondents (Eccles) said it was average. As noted in Eccles in particular, the size of waiting area was rated much less than what it should have been if the intent is to create service user experience.

- **Layout of waiting area**

A number represented by 43% (table 8.32) of the respondents (Salford North) followed by 52% (Salford South), 35% (Irlam), 47% (Swinton) and a further 52% (Worsley) said that the layout of the waiting area was satisfactory. Only 33% of the respondents (Eccles) said it was average.

Table (8.32) Service user's impressions of layout of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	11	25	43	21	100
Salford South	0	4	16	52	28	100
Eccles	2	8	33	26	31	100
Irlam	3	4	31	35	27	100
Swinton	2	3	11	47	37	100
Worsley	0	7	14	52	27	100

Although the general pattern was that the vast majority rated the layout of the waiting area as satisfactory, Eccles rated it as average. One should note that more work is needed to improve the layout of the waiting area.

- **Directional signs**

In a quite similar manner, respondents (table 8.33) were asked to express their impressions of the directional sign within the healthcare centre/ practice. 46% (Salford North), 57% (Salford South), 36% (Eccles) and a further 47% (Swinton) followed 49% reported that the directional signs were satisfactory. In contrast, only 30% (Irlam) said it was average.

Table (8.33) Service user's impressions of directional signs

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	4	2	31	46	17	100
Salford South	0	0	10	57	33	100
Eccles	0	9	33	36	22	100
Irlam	8	9	30	28	25	100
Swinton	3	0	19	47	31	100
Worsley	2	10	19	49	20	100

Although the general pattern is that the vast majority rated the directional signs within the healthcare centre/ practice as satisfactory, Irlam rated it as average. One should note that more work is needed to improve the directional signs.

- **Easy access**

Again as with regard easy access to the healthcare centre / practice, a great proportion represented by 38% (Salford North) of the (table 8.34) respondents followed by 48% (Salford South), 61% (Eccles), 42% (Irlam), 53% (Swinton) and a further 53% (Worsley) said that it was satisfactory.

Table (8.34) Service user's impressions of easy access

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	3	4	29	38	26	100
Salford South	0	0	16	48	36	100
Eccles	0	0	17	61	22	100
Irlam	0	4	23	42	31	100
Swinton	2	5	8	53	32	100
Worsley	1	3	13	53	30	100

As shown above that the vast majority rated the healthcare centre/ practice as satisfactory in terms of easy access. Regardless of the fairly positive results, more work is needed to improve access issue

- **Fresh air**

In terms of service users` impressions of the fresh air within the waiting area (table 8.35), 40% of the respondents (Salford North) followed by 46% (Salford South), 49% (Eccles), 32% (Swinton) and a further half 50% (Worsley) reported that it was satisfactory. In contrast, 35% (Irlam) said it was average.

Table (8.35) Service user's impressions of fresh air

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	4	16	26	40	14	100
Salford South	0	4	25	46	25	100
Eccles	2	5	24	49	20	100
Irlam	3	12	35	27	23	100
Swinton	2	13	24	32	29	100
Worsley	2	11	14	50	23	100

Again, the results point out that even though the general pattern was that the vast majority rated the fresh air within the healthcare centre/ practice as satisfactory, Irlam rated it as average.

One should note that more work is needed to improve the fresh air issue.

- **Pleasant decoration**

A number represented by one third 33% of the respondents (Salford North) followed by 35% (Salford South), 30% (Eccles), 45% (Swinton) and 50% (Worsley) said that the decoration of the waiting area (table 8.36) was satisfactory.

Table (8.36) Service user's impressions of pleasant decoration

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	5	18	24	33	20	100
Salford South	0	13	22	35	30	100
Eccles	2	10	28	31	29	100
Irlam	8	3	27	27	35	100
Swinton	2	5	24	45	24	100
Worsley	1	8	12	55	24	100

Only 35% of the respondents (Irlam) said it was very satisfactory.
While pleasant decoration was rated as satisfactory. It is interesting to note that Irlam respondents have rated this element much higher than any one else.

- **Access to a telephone**

In relation to accessing a telephone (table 8.37) within the healthcare centre / practice, one third 33% of the respondents (Salford North) said that it was poor, where as 43% of the respondents (Salford South) followed by 31% (Eccles), 24% (Swinton) and a further 40% (Worsley) reported that it was satisfactory.

Table (8.37) Service user's impressions of access to telephone

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	2	33	20	29	16	100
Salford South	0	14	17	43	26	100
Eccles	10	17	25	31	17	100
Irlam	14	14	29	19	24	100
Swinton	17	20	22	24	17	100
Worsley	13	16	18	40	13	100

In contrast, 29% of the respondents (Irlam) said it was average.

While access to a telephone was rated satisfactory to average, Salford North rated it as poor. This is indicative of how limited access to a telephone was. This needs more attention.

- **Smell of the waiting area**

Again, as with regard to the smell of the waiting area, slightly over half (51%) of the respondents (Salford North) reported that it was satisfactory (table 8.38), followed by 58% (Salford South), 49% (Eccles), 33% (Irlam), 58% (Swinton) and a further 56 % (Worsley).

Table (8.38) Service user's impressions of smell of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	1	11	24	51	13	100
Salford South	0	0	17	58	25	100
Eccles	2	0	30	49	19	100
Irlam	4	4	31	33	28	100
Swinton	2	3	16	58	21	100
Worsley	1	5	12	56	26	100

As shown above, the vast majority rated the healthcare centre/ practice as satisfactory in terms of the smell of the waiting area. Regardless of the fairly positive results, more work is needed to improve this element.

- **Cleanliness of the waiting area**

In a quite similar manner, respondents (table 8.39) were asked to express their impressions of the cleanliness of waiting area within the healthcare centre/ practice. 58% (Salford north), 52% (Salford south), 46% (Eccles) and a further 38% (Irlam) followed by 51% (Swinton) and 54% (Worsley) reported that the cleanliness of waiting area was satisfactory.

Table (8.39) Service user's impressions of cleanliness of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	1	25	58	16	100
Salford South	0	0	20	52	28	100
Eccles	0	0	26	46	28	100
Irlam	0	4	23	38	35	100
Swinton	3	0	13	51	33	100
Worsley	0	3	12	54	31	100

It is clear from the above analysis that the vast majority rated the healthcare centre/ practice as satisfactory in terms of cleanliness of waiting area. Regardless of the fairly positive results, more work is needed to improve this element.

- **Lighting of the waiting area**

Slightly over half of the respondents 53% of the respondents (Salford North) followed by 54% (Salford South), 53% (Eccles), 36% (Irlam), 55% (Swinton) and a further 52% (Worsley) reported that the lighting of the waiting area was satisfactory (table 8.40).

Table (8.40) Service user's impressions of lighting of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	8	23	53	16	100
Salford South	0	5	8	54	33	100
Eccles	1	0	18	53	28	100
Irlam	0	0	32	36	32	100
Swinton	3	0	8	55	34	100
Worsley	0	3	13	52	32	100

It is clear from the above that the vast majority rated the healthcare centre/ practice as satisfactory in terms of lighting of the waiting area. More work is needed to improve this element.

- **Comfort of the waiting area**

In relation to the comfort of the (table 8.41) waiting area, slightly under half of the respondents (47%) of the respondents (Salford North) followed by 40% (Salford North), 44% (Eccles), 31% (Irlam), 47% (Swinton) and a further 50% (Worsley), reported that the comfort of the waiting area was satisfactory.

Table (8.41) service user's impressions of comfort of waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	2	7	29	47	15	100
Salford South	0	8	24	40	28	100
Eccles	2	5	27	44	22	100
Irlam	8	11	19	31	31	100
Swinton	2	3	16	47	32	100
Worsley	0	4	15	50	31	100

As can be seen, the vast majority rated the healthcare centre/ practice as satisfactory in terms of comfort of waiting area. Regardless of the fairly positive results, more work is needed to improve this element.

- **Facilities for people with special needs**

A number represented by 42% of the respondents (Salford North) followed by 50% (Salford South), 50% (Eccles), 49% (Swinton) and a further 42% (Worsley), reported that the facilities for people with special needs were (table 8.42) satisfactory. In comparison just over one third (35%) in Irlam said it was average.

Table (8.42) Service user's impressions of facilities for people with special needs

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	2	16	27	42	13	100
Salford South	0	10	10	50	30	100
Eccles	0	8	28	50	14	100
Irlam	4	9	35	30	22	100
Swinton	2	3	29	49	17	100
Worsley	4	12	20	42	22	100

Again, the results point out that even though the general pattern was that the vast majority rated the facilities for people with special needs within the healthcare centre/ practice as satisfactory, Irlam rated it as average.

One should note that more work is needed to improve this element.

- **Privacy level**

Similarly, just under one third 31% (table 8.43) of the respondents (Salford North) followed by 39% (Salford South), 37% (Eccles), 44% (Swinton) and a further 42% (Worsley) reported that their impressions of privacy levels were satisfactory. In comparison, just 29% (Irlam) said it was average.

Table (8.43) Service user's impressions of privacy levels

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	8	13	28	31	20	100
Salford South	0	13	13	39	35	100
Eccles	8	21	18	37	16	100
Irlam	4	13	29	25	29	100
Swinton	7	0	31	44	18	100
Worsley	3	7	27	42	21	100

As illustrated above, the results point out that even though the general pattern was that the vast majority rated the privacy levels within the

healthcare centre/ practice as satisfactory, Irlam rated it as average. One should note that more work is needed to improve this element.

- **Toilets in the waiting area**

As with regard to the state of toilets (table 8.44) within the waiting area, 46% (Salford North) followed by 42% (Salford South), 55% (Eccles), 61% (Swinton) and a further 49% (Worsley) reported that their impressions of toilets in the waiting area were satisfactory. In comparison, just 43% in Irlam said it was average.

Table (8.44) Service user's impressions of toilets in the waiting area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	4	4	28	46	18	100
Salford South	0	0	16	42	42	100
Eccles	0	5	20	55	20	100
Irlam	4	0	43	22	30	100
Swinton	3	0	13	61	24	100
Worsley	1	4	20	49	26	100

The results point out that even though the vast majority rated the toilets in the waiting area within the healthcare centre/ practice as satisfactory, Irlam rated it as average. One should note that more work is needed to improve this element.

- **Children play area**

The level of impressions varied (table 8.45) 29% (Salford North) followed by 41% (Salford South), 22% (Eccles) reported that their impressions of the children's play areas were satisfactory. While one third (31%) of the respondents in Irlam said it was average as opposed to 31% (Swinton) who said it was poor.

Table (8.45) Service user's impressions of children play area

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	14	24	23	29	10	100
Salford South	9	4	23	41	23	100
Eccles	18	19	20	22	21	100
Irlam	18	9	33	9	31	100
Swinton	24	31	7	24	14	100
Worsley	8	13	32	26	21	100

While children play area was rated satisfactory to average, Swinton rated it as poor. This indicates that this element also needs more attention

It is interesting to note that while some respondents expressed their impressions as satisfactory towards some elements such as the waiting area in terms of location, size, layout, directional signs, ease of access, fresh air, pleasant decoration, access to telephone, smell, cleanliness, lighting, comfort, facilities for people with special needs, privacy levels, toilets and children play area., others still feel that a lot needs to be done in many areas.

This statement (in line with the previous ones) still confirms that Salford PCT has along way to go if the intent is to deliver a healthcare service designed around the true needs of it's service users.

Q17 A number of issues relating to the medical treatment were presented and respondents were asked to rate each of them. These features were: sufficient time, respect and dignity, the variety of service and choice, the quality of healthcare, the promptness displayed by the GP, Practice nurse, the health visitor, the Dentist and the Optician.

- **Sufficient time**

In relation to the sufficient time the respondents were receiving (table 8.46) from their treating person, slightly over one third of the respondents 36% (Salford North) followed by 44% (Salford South), 49% (Eccles), 40% (Irlam), 50% (Swinton) and a further 46% (Worsley) reported that the time the respondents were receiving from their treating person was satisfactory.

Table (8.46) Service user's impressions of sufficient time

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	1	0	27	36	36	100
Safford South	0	4	24	44	28	100
Eccles	0	2	13	49	36	100
Irlam	0	4	28	40	28	100
Swinton	3	3	15	50	29	100
Worsley	0	3	19	46	32	100

As can be seen, the vast majority rated the healthcare centre/ practice as satisfactory in terms of sufficient time. Regardless of the fairly positive results, more work is needed to improve this element.

- **Respect and dignity**

A number represented by 43% (Salford North) of the respondents (table 8.47) followed by 48% (Salford South), said that the way they were treated with respect and dignity was very satisfactory, while 49% (Eccles) followed by 54% (Irlam), 56% (Swinton) and a further 44% (Worsley) said that respect and dignity levels were satisfactory.

Table (8.47) Service user's impressions of respect and dignity

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	1	23	32	43	100
Salford South	0	0	8	44	48	100
Eccles	0	3	10	49	38	100
Irlam	0	4	17	54	25	100
Swinton	3	0	8	56	33	100
Worsley	0	0	17	44	39	100

It is worth mentioning that this is the first time throughout the data analysis that a 'very satisfactory' rating was used. This statement confirms that respect and dignity levels were very satisfactory in many cases. However, one cannot be misled by this, as the negative impressions should also be considered in order to create service user experience.

- **Variety of services and choice**

Just under half of the respondents, 49% (Salford North) as per table 8.48, followed by 48% (Salford South), 47% (Eccles), 46% (Irlam), 58% (Swinton) and a further half 50% (Worsley) said that the variety of services and choice was satisfactory.

Table (8.48) Service user's impressions of variety of services and choice

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	2	18	49	31	100
Salford South	0	0	16	48	36	100
Eccles	0	3	11	47	39	100
Irlam	0	8	25	46	21	100
Swinton	3	0	14	58	25	100
Worsley	0	0	24	50	26	100

The above analysis shows that the vast majority rated the healthcare

centre/ practice as 'satisfactory' in terms of variety of services and choice. Regardless of the fairly positive results, more work is needed to improve this element.

- **Quality of healthcare**

A large number represented by 43% (Salford North) reported that their impressions of quality of care were satisfactory (table 8.49) followed by 54% (Salford South). In contrast, 47% (Eccles) followed by 48% (Irlam), 52% (Swinton) and a further 45% (Worsley) said it was satisfactory.

Table (8.49) Service user's impressions of quality of healthcare

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	2	15	40	43	100
Salford South	0	0	13	33	54	100
Eccles	0	0	8	47	45	100
Irlam	0	4	20	48	28	100
Swinton	3	0	9	52	36	100
Worsley	0	0	19	45	36	100

In a quite similar manner, the vast majority rated the healthcare centre/ practice as satisfactory/ very satisfactory in terms of quality of healthcare. Regardless of the fairly positive results, more work is needed to improve this element.

- **Promptness displayed by the GP**

In terms of service users` impressions of the promptness of the GP (table 8.50), 38% (Salford North) reported that it was very satisfactory followed by 54% (Salford South) and 43% (Eccles). In contrast, 42% (Irlam), 46% (Swinton) and a further 43% (Worsley) said it was satisfactory.

Table (8.50) Service user's impressions of promptness of the GP

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	4	2	20	36	38	100
Salford South	0	0	8	38	54	100
Eccles	2	3	11	41	43	100
Irlam	4	0	21	42	33	100
Swinton	3	0	14	46	37	100
Worsley	1	2	16	43	38	100

Again, the vast majority rated the healthcare centre/ practice as satisfactory or very satisfactory in terms of the promptness of the GP. Regardless of the fairly positive results, more work is needed to improve this element.

- **Promptness displayed by the Practice Nurse**

In terms of the service users` impressions of the promptness of the Practice Nurse (table 8.51), 43% of the respondents (Salford North) followed by 56% (Swinton) and 46% (Worsley) reported that it was satisfactory. In contrast, 59% (Salford South) followed by 46% (Eccles). A further 42% (Irlam) said it was very satisfactory.

Table (8.51) Service user's impressions of promptness of the practice Nurse

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	20	43	37	100
Salford South	0	0	5	36	59	100
Eccles	0	0	10	44	46	100
Irlam	0	0	20	38	42	100
Swinton	3	0	15	56	26	100
Worsley	0	2	8	46	44	100

As shown, the level of impressions ranged from satisfactory to very satisfactory, depending on the type of experience that the service user went through. However, the call for improvement is still necessary to

improve this element.

- **Promptness displayed by the Health visitor**

As with regard the service users` impressions of the promptness of the Health visitor (table 8.52), just over half (54%) of the respondents in Salford North reported that it was satisfactory. This was followed by 58% (Salford South), 44% (Eccles), 50% (Swinton) and a further 45% (Worsley). Just 33% in Irlam, of the respondents, said it was very satisfactory.

Table (8.52) Service user's impressions of promptness of the health visitor

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	27	54	19	100
Salford South	0	0	9	58	33	100
Eccles	6	0	11	44	39	100
Irlam	0	7	33	27	33	100
Swinton	5	6	22	50	17	100
Worsley	0	1	22	45	32	100

The results point out that even though the general pattern was that the vast majority rated the promptness of the health visitor as satisfactory, Irlam rated it as very satisfactory. One should note that more work is needed to improve this element

- **Promptness displayed by the Dentist**

In relation to the service users` impressions of the promptness of the Dentist (table 8.53), 38% of the respondents (Salford North) reported that it was satisfactory, followed by 54% (Salford South), 53% (Eccles), 50% (Swinton) and a further 48% (Worsley). Just 37% of the respondents in Irlam said it was very satisfactory.

Table (8.53) Service user's impressions of promptness of the dentist

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	35	38	27	100
Salford South	8	0	15	54	23	100
Eccles	0	0	15	53	32	100
Irlam	6	0	29	29	36	100
Swinton	5	0	18	50	27	100
Worsley	3	3	17	48	29	100

Again, the results point out that even though the general pattern was that the vast majority rated the promptness of the health visitor as satisfactory, Irlam rated it as very satisfactory. One should note that more work is needed to improve this element

- **Promptness displayed by the Optician**

As with regard the service users` impressions of the promptness of the Optician (table 8.54), 45% of the respondents (Salford North) followed by 67% (Salford South), 60% (Eccles), 34% (Irlam), 45% (Swinton) followed by half 50% (Worsley) reported that it was satisfactory.

Table (8.54) Service user's impressions of promptness of the Optician

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	30	45	25	100
Salford South	0	0	8	67	25	100
Eccles	0	0	7	60	33	100
Irlam	9	0	25	34	32	100
Swinton	5	0	20	45	30	100
Worsley	0	0	17	50	33	100

In a quite similar manner, the vast majority rated the healthcare centre/ practice as satisfactory in terms of promptness of the Optician. Regardless

of the fairly positive results, more work is needed to improve this element.

Looking explicitly at the respondents impressions, the vast majority reported 'satisfactory' results across the features of their medical treatment journey. This is another proof that Salford PCT still has a long way to go if service excellence is to be achieved.

Q18 Respondents were asked a series of questions about their leaving experience in terms of: reception staff being responsive to the service user's needs, reception staff giving service users 100% of their attention, reception staff meaning it when they said (have a nice day), and reception staff treating service users as individuals.

- **Reception staff were responsive to the service user's needs**

Just under half 47% of the respondents (Salford North) followed by 55% (Salford South), 51% (Eccles), 50% (Swinton) and a further 43% (Worsley) said that their impression of the responsive reception staff was very satisfactory. In contrast, just over one third (36%) in Irlam, of the respondents (table 8.55) reported that their impressions of the responsiveness of reception staff were average.

Table (8.55) Service user's impressions of responsive reception staff

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	6	18	47	29	100
Salford South	0	0	0	55	45	100
Eccles	0	5	13	51	31	100
Irlam	8	0	36	24	32	100
Swinton	2	0	24	50	24	100
Worsley	0	2	13	43	42	100

The results point out that even though the general pattern was that the

vast majority rated the responsiveness of reception staff as satisfactory. Irlam rated it as average. One should note that more work is needed to improve this element.

- **Reception staff gave service users 100% of their attention**

In terms of service users` impressions of the full attention of the reception staff (table 8.56), 41% of the respondents (Salford North) followed by 39% (Eccles) and a further 42% (Swinton) reported that it was satisfactory. In contrast, 46% of the respondents (Salford South) followed by 44% (Worsley), said it was very satisfactory, as opposed to 36% (Irlam) who said it was very average.

Table (8.56) Service user's impressions of full attention by reception staff

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	2	7	16	41	34	100
Salford South	0	0	10	44	46	100
Eccles	0	4	20	39	37	100
Irlam	0	12	36	24	28	100
Swinton	2	0	31	42	25	100
Worsley	0	3	16	37	44	100

As illustrated above, the results point out that even though the general pattern was that the vast majority rated the full attention by reception staff as satisfactory/ very satisfactory, Irlam rated it as average. One should note that more work is needed to improve this element.

- **Reception staff did mean it when they said (have a nice day)**

In terms of service users` impressions of the statement made by the reception staff " have a nice day" 42% of the respondents (Salford North) followed by 53% (Salford South), and a further 43% (Irlam) reported that

it was satisfactory (table 8.57). In contrast, 38% of the respondents (Eccles) and 40% (Worsley) rated it as very satisfactory, as opposed to 36% (Swinton) who said it was average.

Table (8.57) Service user's impressions when reception staff said (have a nice day)

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	18	42	40	100
Salford South	0	0	0	53	47	100
Eccles	2	3	22	35	38	100
Irlam	0	5	33	43	19	100
Swinton	7	0	36	34	23	100
Worsley	2	5	18	35	40	100

In a quite similar manner, the vast majority rated the healthcare centre/ practice as satisfactory in terms of reception staff meant (have a nice day). Regardless of the fairly positive results, more work is needed to improve this element especially in Swinton who said it was very average.

- **Reception staff treated service users as individuals**

In relation to the service users` impressions that the reception staff treated them as individuals, 45% of the respondents (Salford North) followed by just over half 52% (Salford South) and another 42% (Worsley) reported (table 8.58) that it was very satisfactory. In contrast, 40% (Eccles), 38% (Irlam) and 43% (Swinton) said it was very satisfactory.

Table (8.58) Reception staff treated as an individual

	Very poor %	Poor %	Average %	Satisfactory %	Very satisfactory %	Total %
Salford North	0	0	15	40	45	100
Salford South	0	0	0	48	52	100
Eccles	0	7	18	40	35	100
Irlam	0	8	25	38	29	100
Swinton	3	0	31	43	23	100
Worsley	0	3	15	40	42	100

As illustrated above, the results point out that even though the general pattern was that the vast majority rated this statement as satisfactory or very satisfactory. One should note that more work is needed to improve this element.

While the general pattern was for the respondents to be satisfactory on the majority of the features contained in the above question, the negative views made by the remaining sample cannot be ignored. Indeed Salford PCT is trying their best with their service users; however, there is more to be done to reach a stage where most of the negative and average comments are changed to very positive ones.

Q 19 Taking every thing into an account, respondents were asked to indicate their overall impressions as to the extent by which they were extremely impressed, very impressed, impressed, unimpressed, very unimpressed. The findings are highlighted in table (8.59) below.

Table (8.59) overall impressions

	Ex impressed %	Very impressed %	Impressed %	Un Impressed %	Very unimpressed %	Total %
Salford North	13	34	41	11	1	100
Salford South	17	35	48	0	0	100
Eccles	17	31	33	17	2	100
Irlam	18	30	26	26	0	100
Swinton	13	29	50	5	3	100
Worsley	22	23	48	6	1	100

The statistics from this question (Table 8.59) show that 41% (Salford North), 48% (Salford South) followed by a 33% of the respondents (Eccles), 50% (Swinton) and 48% (Worsley) were impressed by the healthcare delivery provided by Salford PCT. This is also supported by further 30% (Irlam) of the respondents who are very impressed.

It is clear to the researcher that respondents were not extremely impressed by the healthcare delivery regardless of some positive results which themselves translate an urgent need for Salford Pct to react to these views in an effective manner.

Q 20 Respondents were also given the opportunity to suggest their own future preferences and comments. One of the comments made by some respondents was that the use of mobile phones. There was suggestion that there should be more vending machines, which could provide arrange of items including snacks and drinks.

8.2.7 Section Three: Service User experience (Cross tabulation)

The main objective of this section was to assess the over all impressions of the service users by gender, marital status, ethnicity, household income,

education levels, occupation, and illness conditions.

❖ By Gender

In terms of the gender profile and their impression of the healthcare experience, respondents were asked to rate to what extent they were impressed by the overall experience. The largest male proportion, equating to 44.6 %, was impressed by their overall experience. A similar female proportion of 45.1% was also impressed.

Table (8.60) Impressions of male/female* overall experience

			Overall impressions					**Total**
			Ex impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Gender	Male	Count	17	26	45	10	3	101
		% Within Gender	16.8%	25.7%	44.6%	9.9%	3.0%	100.0%
	Female	Count	37	61	96	16	3	213
		% Within Gender	17.4%	28.6%	45.1%	7.5%	1.4%	100.0%
Total		Count	54	87	141	26	6	314
		% within gender	17.2%	27.7%	44.9%	8.3%	1.9%	100.0%

There was only a minor difference in the gender profile of the male and female in relation to their impressions of the overall experience (see Table 8.60).

❖ By marital status

In terms of the respondent's impressions of their over all experience, 44.8% of the single service users were impressed.

Table (8.61) Impressions of marital status* over all experience

			Overall impressions					**Total**
			Ex Impressed	Very Impressed	Impressed	Unimpressed	Very unimpressed	
Marital Status	Single	Count	10	21	30	5	1	67
		% Within marital status	14.9%	31.3%	44.8%	7.5%	1.5%	100.0%
	Married	Count	32	45	81	13	3	174
		% Within marital status	18.4%	25.9%	46.6%	7.5%	1.7%	100.0%
	Divorced	Count	6	12	14	3	0	35
		% Within marital status	17.1%	34.3%	40.0%	8.6%	0%	100.0%
	Separated	Count	2	0	3	1	2	8
		% Within marital status	25.0%	0%	37.5%	12.5%	25.0%	100.0%
	Co habiting	Count	3	10	12	4	0	29
		% Within Marital status	10.3%	34.5%	41.4%	13.8%	0%	100.0%
Total		Count	53	88	140	26	6	313
		% Within marital status	16.9%	28.1%	44.7%	8.3%	1.9%	100.0%

Similarly, 46.6 % of the married service users were also impressed. This compares (Table 8.61) with 40 % of the divorced service users who held a similar view, followed by 37.5 % of the separated and 41.4 % of the cohabiting service users were impressed by the overall experience. It is interesting to note that all marital status groups share the same views with regard to their impressions of the healthcare delivery.

- **By ethnicity**

As illustrated in (table 8.62), the largest proportion of the white service users being 44.3% reported that they were impressed by the overall experience, followed by 100% of other Black service users who expressed

the same views. In comparison, a large number represented by 100 % of the black Caribbean service users followed consecutively by 100 % of Bengali and a further 100 % of Indian service users reported that were extremely impressed by the overall experience.

(Table 8.62) Impressions of ethnic minority groups *overall experience

			Overall impressions					**Total**
			Ex Impressed	Very impressed	Impressed	Un Impressed	Very unimpressed	
Ethnic Minority Groups	White	Count	51	84	131	24	6	296
		% Within E.m. group	17.2%	28.4%	44.3%	8.1%	2.0%	100.0%
	Black Caribbean	Count	1	0	0	0	0	1
		% Within E.m. group	100.0%	0%	0%	0%	0%	100.0%
	Black Other	Count	0	0	1	0	0	1
		% Within E.m. group	0%	0%	100.0%	0%	0%	100.0%
	Bengali	Count	1	0	0	0	0	1
		% Within E.m. group	100.0%	0%	0%	0%	0%	100.0%
	Indian	Count	1	0	0	0	0	1
		% Within E.m. group	100.0%	0%	0%	0%	0%	100.0%
	Pakistani	Count	0	3	3	0	0	6
		% Within E.m. group	0%	50.0%	50.0%	0%	0%	100.0%
	Chinese	Count	0	0	0	1	0	1
		% within E.m. group	0 %	0 %	0 %	100.0%	0%	100.0%
Total		Count	54	87	135	25	6	307
		% within E.m. group	17.6%	28.3%	44.0%	8.1%	2.0%	100.0%

Half of the Pakistani sample reported that they were impressed followed by a further half who said they were very impressed by the overall experience.

In contrast, 100% of the Chinese ethnicity group said they were unimpressed by the overall experience.

The general consensus is that the majority of the respondents tended to be impressed to extremely impressed. With the exception of the Chinese ethnicity, who said they were unimpressed.

- **By annual house hold income groups**

Respondents were asked to rate their over all experience based on their annual household income.

1) In terms of respondents` impressions for those who had an annual house hold income between £7000-£10000 (Table 8.63a), If 50% of the respondents who had (£7000) reported being very impressed, followed by a further half 50% who had (£8000) reported being impressed and a further 100% who had (£8500) reported that being very impressed.

   In comparison, 54.5% of the respondents who had (£9000) said they were impressed followed by 100% who had (£ 9200) said they were very impressed, as compared to 50% who had (£10000) said they were impressed.

(Table 8.63 a) Impressions of income groups*overall experience

			Overall impressions					Total
			Ex impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Income	7000.00	Count	1	2	1	0	0	4
		% Within Income	25.0%	50.0%	25.0%	0%	0%	100.0%
	8000.00	Count	0	3	4	0	1	8
		% Within Income	0%	37.5%	50.0%	0%	12.5%	100.0%
	8500.00	Count	0	1	0	0	0	1
		% Within Income	0%	100.0%	0%	0%	0%	100.0%
	9000.00	Count	1	4	6	0	0	11
		% Within Income	9.1%	36.4%	54.5%	0%	0%	100.0%
	9200.00	Count	0	1	0	0	0	1
		% Within Income	0%	100.0%	0%	0%	0%	100.0%
	10000.00	Count	4	2	6	0	0	12
		% Within Income	33.3%	16.7%	50.0%	0%	0%	100.0%

2) In terms of respondents` impressions for those who had an annual household income between £11000-£15000 (Table 7.63 b), 40% of the respondents (who had £11000) reported equally being very impressed and extremely impressed. Similarly, a further 33.3% (who had £2000) reported equally being very impressed and extremely impressed and a further 100% (who had £12400 & £12500) said they were impressed.

In comparison, 50% of the respondents (who had £13000) said they were impressed, followed by 100% (who had £13500) said they were impressed as opposed to 100% (who had £13700) said they were unimpressed, followed by 55.6% of the respondents (who had £14000) reported being very impressed and a third (33.3%), (who had £15000) said they were extremely impressed.

(Table 8.63 b) Impressions of income groups*overall experience (continued)

			Overall impressions					Total
			Ex impressed	Very Impressed	Impressed	Unimpressed	Very unimpressed	
Income	11000.00	Count	2	2	1			5
		% Within Income	40.0%	40.0%	20.0%	0%	0%	100.0%
	12000.00	Count	4	4	3	1	0	12
		% Within Income	33.3%	33.3%	25.0%	8.3%	0%	100.0%
	12400.00	Count	0	0	1	0	0	1
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	12500.00	Count	0	0	2		0	2
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	13000.00	Count		3	4	1		8
		% Within Income	0%	37.5%	50.0%	12.5%	0%	100.0%
	13500.00	Count	0	0	1	0	0	1
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	13700.00	Count	0	0	0	1	0	1
		% Within Income	0%	0%	0%	100.0%	0%	100.0%
	14000.00	Count	3	5	1	0	0	9
		% Within Income	33.3%	55.6%	11.1%	0%	0%	100.0%
	15000.00	Count	4	2	3	3	0	12
		% Within Income	33.3%	16.7%	25.0%	25.0%	0%	100.0%

3) In terms of respondents` impressions for those who had an annual household income between £15500-£20000 (Table 8.63c), 100% of the respondents (who had £15500) reported being impressed and, similarly a further two thirds 6607% (who had £16000) reported being very impressed and a further 100% (who had £16500) said they were unimpressed.

In comparison, 57.1% of the respondents (who had £17000) said they were impressed, followed by 100% (who had £17400) who said they were impressed, as compared to 100% (who had £17500) said they were very impressed. This was followed by 50% of the respondents who had (£18000), who equally reported being impressed and very impressed, two

thirds 66.7% (who had £19000) said they were impressed, 100% of the respondents (who had £19200) said they were impressed and only 29% of the respondents (who had £20000) said they were very impressed

(Table 8.63 c) Impressions of income groups*overall experience (continued)

			Overall impressions					Total
			Ex impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Income	15500.00	Count	0	0	2	0	0	2
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	16000.00	Count	0	2	1	0	0	3
		% Within Income	0%	66.7%	33.3%	0%	0%	100.0%
	16500.00	Count	0	0	0	1	0	1
		% Within Income	0%	0%	0%	100.0%	0%	100.0%
	17000.00	Count	0	2	4	1	0	7
		% Within Income	0%	28.6%	57.1%	14.3%	0%	100.0%
	17400.00	Count	0	0	1	0	0	1
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	17500.00	Count	0	1	0	0	0	1
		% Within Income	0%	100.0%	0%	0%	0%	100.0%
	18000.00	Count	0	2	2	0	0	4
		% Within Income	0%	50.0%	50.0%	0%	0%	100.0%
	19000.00	Count	0	0	2	1	0	3
		% Within Income	0%	0%	66.7%	33.3%	0%	100.0%
	19200.00	Count	0	0	1	0	0	1
		% Within Income	0%	0%	100.0%	0%	0%	100.0%
	20000.00	Count	2	5	8	1	1	17
		% Within INCOME	11.8%	29.4%	47.1%	5.9%	5.9%	100.0%

4) In terms of the respondents` impressions for those who had an annual household income between £21000-£35000 (Table 8.63 d), 100% of the respondents (£21000) had reported being extremely impressed and, similarly a further two-thirds (66.7%) who had £22000 reported being very impressed. Half of the respondents (50%), who had £23000, said they were unimpressed, followed by 62.5% (who had £25000), and said they were very impressed.

(Table 8.63 d) Impressions of income groups*overall experience (continued)

			Overall impressions					Total
			Ex impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Income	21000.00	Count	1	0	0	0	0	1
		% Within INCOME	100.0%	0%	0%	0%	0%	100.0 %
	22000.00	Count	1	4	1	0	0	6
		% Within INCOME	16.7%	66.7%	16.7%	0%	0%	100.0 %
	23000.00	Count	1	1	2	0	0	4
		% Within INCOME	25.0%	25.0%	50.0%	0%	0%	100.0 %
	25000.00	Count	0	5	2	1	0	8
		% Within INCOME		62.5%	25.0%	12.5%	0%	100.0 %
	26000.00	Count	0	1	0	0	0	1
		% Within INCOME		100.0%	0%	0%	0%	100.0 %
	27000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	30000.00	Count	1	2	4	1	0	8
		% Within INCOME	12.5%	25.0%	50.0%	12.5%	0%	100.0 %
	32000.00	Count	0	0	3	0	0	3
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	33000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	34000.00	Count	1	0	0	0	0	1
		% Within INCOME	100.0%	0%	0%	0%	0%	100.0 %
	35000.00	Count	0	3	1	1	0	5
		% Within INCOME	0%	60.0%	20.0%	20.0%	0%	100.0 %

In comparison, 100% of the respondents (who had £26000) reported being very impressed and a further 100% (who had £27000) said they were impressed, followed by half 50% of the respondents (who had £30000) said they were impressed. 100% of the respondents (who had £32000 & £33000) reported being impressed, a further 100% of the respondents (who had £34000) said they were extremely impressed and 60% of the respondents (who had £35000) said they were very impressed.

5) In terms of respondents` impressions for those who had an annual house hold income between £36000-£45000 (Table 7.63 e), 100% of the respondents (who had £36000) reported being extremely impressed, a further two thirds 66.7% (who had £37000) reported being very impressed.

(Table 8.63 e) Impressions of income groups*overall experience (continued)

			Overall impressions					**Total**
			Ex impressed	Very Impressed	Impressed	Unimpressed	Very unimpressed	
Income	36000.00	Count	1	0	0	0	0	1
		% Within INCOME	100.0%	0%	0%	0%	0%	100.0 %
	37000.00	Count	0	2	1	0	0	3
		% Within INCOME	0%	66.7%	33.3%	0%	0%	100.0 %
	38000.00	Count	0	1	2	0	0	3
		% Within INCOME	0%	33.3%	66.7%	0%	0%	100.0 %
	39000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	40000.00	Count	1	2	2	0	0	5
		% Within INCOME	20.0%	40.0%	40.0%	0%	0%	100.0 %
	42000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	45000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %

A further two thirds (66.7%) of the respondents (who had £38000) said they were unimpressed, followed by 100% (who had, consecutively, (£39000, £42000 & £45000), said they were impressed. This was opposed to 40% of the respondents (who had £40000) who reported equally being very impressed and impressed.

6) In terms of the respondents` impressions for those who had an annual household income between £47000-£130000 (Table 8.63 f), 100% of the respondents (who had £47000) reported being very

impressed, and a further 75% (who had £60000) reported being impressed.

(Table 7.63 f) Impressions of income groups*over all experience (continued)

			Over all impressions					**Total**
			Ex impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Income	47000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
	60000.00	Count	0	0	3	1	0	4
		% Within INCOME	0%	0%	75.0%	25.0%	0%	100.0 %
	65000.00	Count	0	1	0	0	0	1
		% Within INCOME	0%	100.0%	0%	0%	0%	100.0 %
	90000.00	Count	0	0	0	1	0	1
		% Within INCOME	0%	0%	0%	100.0%	0%	100.0 %
	100000.00	Count	0	0	0	1	0	1
		% Within INCOME	0%	0%	0%	100.0%	0%	100.0 %
	120000.00	Count	1	0	0	0	0	1
		% Within INCOME	100.0%	0%	0%	0%	0%	100.0 %
	130000.00	Count	0	0	1	0	0	1
		% Within INCOME	0%	0%	100.0%	0%	0%	100.0 %
Total		Count	29	63	82	16	2	192
		% Within INCOME	15.1%	32.8%	42.7%	8.3%	1.0%	100.0 %

In comparison, 100% of the respondents (who had £65000) reported being very impressed. 100% of the respondents (who had £90000 & £100000) reported being unimpressed. A further 100% of the respondents (who had £120000) said they were extremely impressed, and 100% of the respondents (who had £130000) said they were impressed.

❖ By education levels

Service users were asked to rate their overall experience based on their education levels.

The vast majority of the service users reported that they were impressed by the overall healthcare experience.

(Table 8.64) Education levels * Overall impressions

			Overall impressions					**Total**
			ex Impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Education Levels	Secondary school	Count	34	44	71	12	2	163
		% Within Education Level	20.9%	27.0%	43.6%	7.4%	1.2%	100.0%
	College	Count	7	25	37	9	2	80
		% Within Education Level	8.8%	31.3%	46.3%	11.3%	2.5%	100.0%
	University	Count	8	8	15	4	0	35
		% Within Education Level	22.9%	22.9%	42.9%	11.4%		100.0%
	Other	Count	2	4	8	1	1	16
		% Within Education Level	12.5%	25.0%	50.0%	6.3%	6.3%	100.0%
Total		Count	51	81	131	26	5	294
		% Within Education Level	17.3%	27.6%	44.6%	8.8%	1.7%	100.0%

As shown in (table 8.64) a proportion, equating to 43.6% (secondary school) was impressed, followed by a larger proportion, 46.3% (College) said they were also impressed. Slightly smaller numbers 42.9% (University) described their overall healthcare as impressive. Half of the respondents 50 %(other) were also impressed by the overall healthcare experience.

❖ By occupation

Service users were asked to rate their over all experience based on their employment status.

(Table 8.65) occupation* Overall impressions

			Overall impressions					Total
			Ex Impressed	Very impressed	Impressed	Unimpressed	Very unimpressed	
Occupation	Full time	Count	6	7	15	1	1	30
		% Within Occupation	20.0%	23.3%	50.0%	3.3%	3.3%	100.0%
	Retired	Count	15	23	32	2	3	75
		% Within occupation	20.0%	30.7%	42.7%	2.7%	4.0%	100.0%
	Part time	Count	14	21	30	6	1	72
		% Within Occupation	19.4%	29.2%	41.7%	8.3%	1.4%	100.0%
	Self Employed	Count	6	10	19	3		38
		% Within Occupation	15.8%	26.3%	50.0%	7.9%		100.0%
	Not applicable	Count	8	17	26	10		61
		% Within Occupation	13.1%	27.9%	42.6%	16.4%		100.0%
	Full time Student	Count	1	4	10	3		18
		% Within Occupation	5.6%	22.2%	55.6%	16.7%		100.0%
	Un-employed	Count	4	6	9	1	1	21
		% Within Occupation	19.0%	28.6%	42.9%	4.8%	4.8%	100.0%
Total		Count	54	88	141	26	6	315
		% Within Occupation	17.1%	27.9%	44.8%	8.3%	1.9%	100.0%

Half (50%) of the service users who described themselves as in full time employment (Table 8.65) reported being impressed by the overall healthcare experience. A further 42.7% who described themselves as retired from work said they were impressed. A proportion represented by 41.7% of those in some form of paid employment said they were impressed as well. In comparison, half (50%) of the self-employed reported being impressed, as compared to 42.6% of those who described their economic status in other ways, said they were impressed. A further

55.6% who described themselves as full-time students reported being impressed, and 42.9% of the respondents who described themselves as unemployed also said they were impressed by the overall healthcare experience.

- **By Illness conditions**

Service users were asked to rate their over all experience based on their illness conditions.

(Table 8.66) Illness conditions* Overall impressions

			Overall impressions					**Total**
			Ex Impressed	Very Impressed	Impressed	Unimpressed	Very unimpressed	
Illness Conditions	Sight impairment	Count	4	3	5	2	1	15
		% Within Illness Conditions	26.7%	20.0%	33.3%	13.3%	6.7%	100.0%
	Hearing impairment	Count	3	2	7	1	0	13
		% Within Illness Conditions	23.1%	15.4%	53.8%	7.7%	0%	100.0%
	Physical impairment	Count	4	12	12	2	3	33
		% Within Illness Conditions	12.1%	36.4%	36.4%	6.1%	9.1%	100.0%
	Learning impairment	Count	0	0	3	0	1	4
		% Within Illness Conditions	0%	0%	75.0%		25.0%	100.0%
	None	Count	22	47	67	15	0	151
		% Within Illness Conditions	14.6%	31.1%	44.4%	9.9%		100.0%
	Other	Count	21	21	38	6	1	87
		% Within Illness Conditions	24.1%	24.1%	43.7%	6.9%	1.1%	100.0%
Total		Count	54	85	132	26	6	303
		% Within Illness Conditions	17.8%	28.1%	43.6%	8.6%	2.0%	100.0%

One-third (33.3%) of the service users who suffered from sight impairment

reported that they were impressed by the overall healthcare experience. Just over half (53.8%) of the service users (Table 8.66) who suffered from hearing impairment reported that they were impressed.

In comparison, those who suffer physical impairment, 36.4% said they were very impressed followed by the same percentage (36.4%) who reported being impressed. Three-quarters of the service users who suffered from learning impairment said they were impressed. A large proportion equating to 44.4% of the service users who did not suffer from any form of disability reported being impressed. Similarly, 43.7% of the service users who suffered from other form of disability said that they were impressed as well.

8.2.8 Section Four: Service User experience (Importance)

The main objective of this section was to assess the importance of the impressions of the service users.

As illustrated (in table 8.67), a friendly receptionist was the most highly rated element with a mean of 4.3281. A polite receptionist came second (with a mean of 4.3247). An approachable receptionist came third (scoring a mean of (4.3003), and so forth. This highlights that service related elements are of more importance to service users and an improvement in the friendliness, politeness and approachability of receptionist, will greatly improve the impressions of healthcare services in the PCT.

Table (8.67) Importance of elements for service user experience

Element	**Mean**	**N**
Friendly	4.3281	317
Polite	4.3247	308
Approachable	4.3003	303
Promptness of Practice Nurse	4.2727	264
Quality of healthcare	4.2167	300
Respect and dignity	4.1947	303
Knowledgeable	4.1887	302
Promptness of Gp	4.1433	300
Individual treatment	4.1409	298
Responsive	4.0997	301
Full attention	4.0731	301
Understanding	4.0660	303
Variety of service	4.0655	290
Promptness of Optician	4.0640	172
Cleanness of waiting area	4.0635	315
Have a nice day	4.0554	271
Lighting of waiting area	4.0447	313
Easy access	4.0189	317
Sufficient time	4.0391	307
Promptness of health visitor	4.0000	179
Location of waiting area	3.9658	322
Promptness of Dentist	3.9548	177
Toilets	3.9183	306
Comfort of the waiting area	3.9091	319
Layout of waiting area	3.9035	311
Size of waiting area	3.8833	317
Smell of waiting area	3.8721	305
Directional signs	3.7973	291
Pleasant decoration	3.7710	310
Fresh air	3.7025	316
Staff effort to reduce waiting time	3.6969	287
Facilities for people with special needs	3.6526	285
Privacy levels	3.6184	304
Staff appologising for the wait	3.5056	267
Sufficient information	3.4386	285
Entertaining facilities	3.4172	302
Access to telelephone	3.3144	264
Children play area	3.1875	272
Parking space	3.1301	292
Parking facilities	2.9757	288
Waiting time	1.8793	323

On the other hand, the analysis also shows that key environment-related elements were of less importance. Cleanliness of waiting area came fourteenth, (with a mean of 4.0635), along with Lighting of the waiting

area, which came sixteenth with a mean of 4.0447.

The general consensus is that the service related elements were of more significance than the environment related elements. This indicates that service users get more impressed by the soft issues of service user experience than by the hard issues.

8.3 Findings from the questionnaire survey

The results from the three hundred and forty three valid questionnaire surveys revealed how important theses impressions are in order to maintain a proper implementation of service user experience within a given organisation. A number of common themes that emerged can be categorised as follows:

- Views of respondents varied considerably.
- Most of the positive views related to the excellence of service were rated good rather than very good.
- The results obtained in relation to assessing respondent's views as to enough parking spaces, good directional signs, secure parking facilities and easy access to healthcare centre/practice show that respondents were well aware of the elements mentioned above and pleased with them reasonably well. This is evidenced in their answers with simply agree instead of strongly agree. The risk that Salford PCT may face if fast response is not provided is that many of the respondents may run out of patience and become displeased due to the lack of a responsive and service user-centred approach provided for this purpose.
- The results obtained from all the sub-sections of the question in

relation to staff attitudes imply that even though the general consensus of the respondents agrees that the reception staff were approachable, polite, friendly and helpful, knowledgeable about their services and understanding of the health needs of the service users. However, this is not sufficient if the intent of Salford PCT is moving from delivering quality healthcare stage to excellent healthcare stage.

- GPs were the most frequently visited by the respondents. This in turn, implies that if there is an improvement to support the overall development of staff skills (such as being approachable, polite, friendly and understanding of the health needs of the service users, etc.) then such development would establish itself as an important asset that could significantly contribute to revamp the image that the respondents hold of the healthcare delivered within Salford PCT.
- Although the majority of the respondents mentioned that telephone contact was a strong means that helped respondents make appointment in advance, the vast majority had to wait before being seen for medical treatment. This is very alarming, as waiting time is regarded as a very important element towards creating a positive service user experience.
- Looking specifically at respondent's impressions of the service users of their last waiting experience in terms of typical length of time they had to wait, the effort made by the staff to reduce waiting time, staff apologising about the wait, entertaining facilities such as news papers and magazines and the way the staff kept them informed.
- The general pattern is that PCTs have not yet reached a stage where service users are completely impressed by the healthcare service. On the other hand, in relation to the same issues raised above a smaller proportion rated them as satisfactory or poor. These

responses are minor and prove that the gaps can be bridged if service users are taken on board at early enough stage.

- It is interesting to note that while some respondents expressed their impressions as satisfactory towards some elements, e.g. the waiting area location, size, layout, cleanliness, signage and lighting, others still feel that a lot needs to be done in many areas. This statement (in line with the previous ones) still confirms that Salford PCT has along way to go if it's intent is to deliver a healthcare service designed around the true needs of it's service users.
- Looking explicitly at the respondents' impressions of a number of issues relating to the medical treatment (looking at sufficient time, respect and dignity, the variety of service and choice, the quality of healthcare, the promptness displayed by the GP, Practice nurse, the health visitor, the Dentist and the Optician), the following applies. The vast majority reported satisfactory results across the features of their medical treatment journey. This is another proof that Salford PCT still has a long way to go if service excellence is to be achieved.
- While the general pattern was for the respondents to be satisfactory on a series of questions about their leaving experience (in terms of, reception staff was responsive to the service user's needs, reception staff gave service users all of their attention, reception staff meant when they said 'have a nice day', and they treated service users as individuals), there are negative views. These cannot be ignored. Indeed, Salford PCT is trying their best with their service users. However, there is more to be done to reach a stage where most of the negative and average comments are changed to very positive ones.
- Other issues suggested by the service users included use of mobile phones and vending machines.

- There was only a minor difference in the gender profile of the male and female in relation to their impressions of the over all experience
- The general consensus is that the service related elements were of more significance than the environment related elements. This indicates that service users get more impressed by the soft issues of service user experience than by the hard issues.

8.4 Discussion

The general pattern through out the research is that the service related elements were of more significance than the environment related elements. This indicates that service users get more impressed by the soft issues of service user experience than by the hard issues.

Furthermore, the other general pattern is that PCTs have not yet reached a stage where service users are completely impressed by the healthcare service as most of the issues raised by the service users were rated as satisfactory or poor. These responses prove that the gaps can be bridged if service users are taken on board at early enough stage.

Even though, service users had a low expectation of healthcare as delivered by the NHS, Salford PCT has along way to go if their intent is to deliver a healthcare service designed around the true needs of the service users.

8.5 Conclusion

It is important to note the validity criteria for the statistical results. The use of quantitative methods in the field of FM field, service excellence in particular is non-existent. Therefore, the criteria for accepting as opposed to rejecting statistical results is less strict than for other academic areas where quantitative methods are more productive than qualitative methods, such as in financial disciplines.

While the general pattern for the service users was that satisfactory on the majority of the features contained in the questionnaire survey, the negative views made by the remaining sample cannot be ignored. Indeed Salford PCT is trying their best with their service users. However, there is more to be done to reach a stage where most of the negative and average comments are changed to very positive ones.

Finally, service users were not extremely impressed by the healthcare delivery regardless of some positive results which themselves translate an urgent need for Salford PCT to react to these views in an effective manner.

Chapter 9: Conclusion & Recommendations

POSITION OF THE THESIS

Chapter 1 Introduction to the research	**Chapter 2** Service concepts	**Chapter 3** Service user experience	**Chapter4** Application of service concepts within NHS
Chapter 5 Research design	**Chapter 6** Literature review results	**Chapter 7** Interview & Focus Group results	**Chapter 8** Questionnaire results
Chapter 9 Conclusions & recommendations			

9.1 Introduction

This thesis reports on applied research undertaken to understand the impressions of the service users of healthcare in pursuit of service excellence within a primary healthcare setting. This approach was judged the most appropriate, as it enabled the researcher to find solutions, report back the results and disseminate them through publications.

Phenomenology involves understanding the human experience in context-specific settings. This stance was particularly appropriate to assess service user experience. This involved the investigation of the phenomenon as a set of constructs whose sum made up a whole.

9.2 Aims

The aim of this thesis was to assess service user experience as a component of service excellence in primary healthcare settings as a means of bridging some of the gaps identified in this field. This thesis explored literature on service user experience in other healthcare settings and sought to understand the implications and the benefits to be derived in FM by adopting this approach.

These set the context for the assessment of service user experience as a component of service excellence in primary healthcare settings through the Salford PCT case study. The study showed that the methods for assessing service user experience in the PCT were initially developed for other healthcare settings, which have different roles to PCTs.

The research grew out of identified gap in knowledge in this subject area, and the need for a tool to assess service excellence in FM. It identified that this need was brought about by a number of factors including:

- Tools used to evaluate and improve service delivery neglect the role of the service user construct as well as other constructs that can contribute to service user experience.

- Although, SERVQUAL and SERVPERF instruments aim to measure service quality, they measure service quality according to their understanding and interpretation based on statements/questionnaires designed according to their judgement and evaluation rather than to the exact needs of the service users themselves.

- Lack of standardised approaches to service user satisfaction surveys research.

- Lack of clarity and consistency in understanding the determinants of service user satisfaction.

- Lack of an accepted conceptual or theoretical model of service user processes.

- Lack of consensus within the medical professions on the role that service user satisfaction should play in the assessment of quality of healthcare.

- Service user experience research in the public primary healthcare sector to date has been questioned by this research, because it

has failed to identify and address issues that matter the most to service users.

- Established methods of measuring user experience are secondary healthcare-based. A sector which has a different role to PCTs.

- Current measurement methods impose issues that are professionally rather than user oriented.

The study attempted to clarify the factors listed above, except the one related to the lack of consensus within the medical professions on the role that service user satisfaction should play in the assessment of quality of healthcare. This was on the pretext that it is out of the remit of the study surrounding the concept and practice of introducing, measuring service user experience within the primary healthcare sector.

9.3 Achievement of goals and objectives

Although the importance of the service user experience as a component of service excellence in FM has now been recognised, little research is being undertaken in this field. In addition, little documentary evidence exists of service user experience initiatives or successes in FM.

The results from this research are expected to be of a great benefit to top managers, service user executives, strategic planner, Facilities managers, business managers, and other practitioners who are implementing or planning to move from a 'service quality' phase to a 'service excellence' phase with the following objectives in mind:

Objective one: Explore the need for service user experience within a primary healthcare setting

There are several benefits that the healthcare organisations can derive from the creation of service user experience within a primary healthcare setting. The present research systematically attempted to measure the benefits that could be derived as a consequence of service user concept.

The benefits can be translated by the following:

- Innovating and delivering excellent healthcare services to the service users;
- Improving innovation and developing new services;
- Providing healthcare around the exact needs of the service users;
- Being proactive towards change;
- Ensuring service user loyalty to their healthcare provider;
- Capturing information and creating knowledge;
- Sharing and learning;
- Improving communications with the community;

and

- Enhancing service user's retention rate by recognising their values.

Objective two: Demonstrate how service user experience can help NHS healthcare providers move from a 'service quality' phase to a 'service excellence' phase.

Chapter 4 has shown that one of the key NHS Primary Care Trust (PCT) roles is the commissioning, development, administration, provision and delivery of healthcare to the local community. Improving the health of

the community is not only about providing the best healthcare services but also about delivering the right mix of health promotion activities and social care services to create healthy communities. A shift in management within PCTs is required. PCTs have to take a holistic approach to service user experience. This in turn should help understand and exceed the exact needs of service users. Service excellence through service user experience can be achieved and maintained by understanding service user impressions, obtaining feedback and taking an account of user views and priorities. This is vital for bringing about improvements in the quality of healthcare. This would be a first step towards the NHS moving from delivering service quality to service excellence. Service users are in fact essential pillars in a given organisation; therefore, they must be involved in the decision-making process from the start as implied by the service user experience concept.

Objective three: Highlight the value to be gained by better designing healthcare around the true needs of the service users.

As service user experience varies with individual service user's impressions, these impressions need to be managed to improve healthcare delivery. The excellent way to go about this is to solve ambiguity of service user experience that extends to its role within the evaluation process of service excellence itself being conceptualised as driven by the user experience. Users do form impressions about a range of service excellence constructs and these impressions vary across service providers and individual users, what is not clear is the extent to which these impressions are used, if at all, once the service has been experienced in a user's evaluation of service excellence.

The key is the interaction and communication that could help the impressions of service users to be better understood. In order to survive

in the next decade, PCTs will need to better define the impressions of the service users, and encourage the process of interaction and communication, as it is deemed crucial.

Objective four: Develop and propose a set of user-centred elements in order to create service user experience in a primary healthcare setting.

The results from the interviews, focus groups and questionnaire survey revealed how important is to engage with all stakeholders, especially the service users, in order to create service user experience as a component of service excellence within healthcare organisations.

The interviews and focus groups conducted with Salford PCT service users revealed that the new approach has to come from a different perspective. This is by measuring the service user experience rather than service user satisfaction. This is achieved by providing service users with the opportunity to define the issues which directly matter most to them as they experience their service.

The benefits of providing a set of elements that take into consideration the true needs of the service users could be translated into a continuous learning cycle, in order to further create a culture that supports innovation, and sharing and exchanging views. This could further contribute to a complete shift of cultural change within Salford PCT, and help create service excellence as endorsed by this piece of work.

9.4 Interpretation

The empirical evidence emphasises that the impressions of service user experience held by the service users are made up of an appropriate mixture of three ingredients. They are the environment, such as

buildings lay out, furnishing and light, the behaviour and attitudes of staff whose job is to deliver healthcare, and the interaction and communication between users and healthcare providers within the healthcare setting.

This study has identified and described elements that make up a holistic approach to measuring service user experience within a given primary healthcare setting. It has provided, not only an empirical assessment of the essential elements in service user experience, but it has also assessed the importance of deploying service user experiences as could be expressed by the service users themselves, as well as found in the varied literature.

The study also attempted to clarify the misinterpretations surrounding the concept and practice of introducing and measuring service user experience within the primary healthcare sector. It has shown that successful service user experience implementation is a crucial part in the primary healthcare sustainable competitiveness, which calls for the participation of all share holders, and most significantly the service users and the top managers.

This research is the first of its kind dedicated to the use of service user concept as a component of service excellence within NHS PCTs settings. Prior to undertake this research, it did not appear to the researcher that there were any explanations being they are theoretical or empirical concerning the understanding of the adoption or rejection of service user experience by the healthcare practitioners in the Salford PCT or in healthcare sector. Therefore, this research provides a significant step forward by giving a comprehensive and detailed concept grounded and supported by theoretical and empirical investigations to the development of service user experience as a component of service excellence in healthcare sector.

This thesis has identified that the service user experience concept can be used as a conceptual instrument. This could permit researchers to assess the different and complex elements and variables that could potentially determine the true needs and requirements of the service users within a primary healthcare setting. Hence, the instrument should help identify the set of variables that are likely to influence such implementation, by providing the researchers with a tool that contributes to further investigations, and potential problems, related to the implementation of the service user experience in a primary healthcare context.

The study has also provided a dynamic piece of work towards building an instrument for measuring service user experience in the primary healthcare sector, which takes into consideration the interaction of healthcare delivery between the service user and the healthcare provider. Factors that are regarded as crucial, through which service user experience is created include:

I. Service users only can judge the experience obtained from healthcare delivery whose characteristics are such that they will create the right experience.
II. Service attributes that add a more distinguished value to the healthcare delivery should be highlighted and analysed during the activity deign stage.
III. The process of improvement journey should contain regular cycles of planning, execution and evaluation.
IV. Healthcare care providers should have a committed and well-trained workforce. They could be trained through reward and recognition systems for the encouragement of full participation towards user-centred objectives.

V. To achieve a service user-centred workforce, top management commitment is crucial.

VI. Use of service excellence indicators that best represent indicators affecting customer experience to meet the service excellence targets set by the organisation.

VII. Endorsement of the importance of the service user-centred approach in the definition of the characteristics of the process

Salford PCT has not yet been able to fully achieve the benefits of service user experience concept at an acceptable level. The findings have also shown that the realisation of service user experience concept benefits tends to increase as service user-experience concept implementation becomes more successful.

9.5 Contribution and recommendations

This study can serve as a basis to research and practice. Research could therefore derive a better understanding of the activities that are undertaken by Salford PCT, and the way these activities are being dealt, which can result in different forms of results in terms of benefits, to exploiting service user experience. The service user experience concept proposed in this research should enable the FM practitioners to assess and manage service excellence much more effectively, particularly in the healthcare sector.

The most straightforward contribution of this research as stated earlier should be reserved to the benefits of the public healthcare sector. On the other hand, the theoretical contribution concerns the service user experience in general and its implementation in a primary healthcare setting in particular.

Therefore, the contribution of this research can be categorised into four areas namely:

- New knowledge to measure service user experience
- A critical appraisal of the instruments used to measure service quality
- Methodological contribution
- Proposal for a new tool called ServExcel

The following section illustrates each sub-contribution in greater detail.

- **New knowledge to measure service user experience**

The research has identified that the service concept evolution model can only be applied up to the service quality stage. The service excellence concept is still in its infancy, and has developed as far as service quality.

This in essence means that the service excellence concept has to come from a different perspective. Therefore, the evolution of the service concept diagram should not contain the service excellence concept any longer due to the fact that service excellence concept is a step change.

Research has also identified that Standardised tools such as SERVQUAL, SERVPERF that are in place tend to be supply pull not demand push, i.e. providers frame the questions to the service users in such a way to get answers of them according to their interpretations. It is about time that this perspective is flipped to really dig deep for the exact requirement of the service user.

- **A critical appraisal of the instruments used to measure service quality**

The critical appraisal has emphasised that the instruments used to evaluate and improve the quality of healthcare seem to neglect the impact that healthcare provision may have on the service user's experience, as well as other domains that can contribute to service excellence within the NHS.

The research has also shown that despite the fact that service excellence has evolved in practice, measurement tools have remained the same. However, measuring tools such as SERVQUAL (Parasuraman et al.1985, 1988,), SERVPERF (Cronin & Taylor, 1992), LODGSERV (Knutson et al 1990), ISQM (Catherine and Law, 1998) and others have not followed suit. The best known tools identified from use in practice to measure service quality are SERVQUAL and SERVPERF.

Confusion is also associated with respondents' interpretations of the expectation measure, and the lack of discriminate validity between the SERVQUAL expectation measure and the other expectation concepts used in marketing (Teas, 1993). Based on the findings of Buttle (1996), the criticisms were summarised as theoretical and operational.

Cronin & Taylor (1992) also criticised SERVQUAL in that it is not based on theoretical or empirical evidence that supports the expectation/perception gap. In addition to the number of criticisms, Williams (1998) debated the factors that influence the formulation of the service user's expectation judgment (word of mouth, personal needs, external communications and past experience). She concluded that there is no way of knowing what the concept of excellence is to the individual service user.

A team of researchers, including Zeithaml has rejected the value of an expectations or gap-based model, finding that service was only influenced by perceptions (Buttle, 1996). Cronin & Taylor (1992) therefore suggested a performance-based tool termed SERVPERF, which explores casual order of the relationship between service quality, service user satisfaction and purchase intentions. However, this approach has also been criticised (Liusar & Zornoza, 2000) because it does not include expectations, and evaluates quality perception, solely based on the service user's perception of performance.

In addition, lack of direct service user input and involvement in the information collection process has led to misleading or secondary data. The researcher believes that it is about time that this perspective was flipped to get down to the roots of the exact requirements of the service user.

SERVQUAL and SERVPERF are said to measure service user satisfaction whether on the basis of perceptions / expectation (P-E) gap or service performance. In fact, they both measure service user satisfaction according to the author's understanding and interpretation based on theoretical knowledge, rather than on the exact needs of the service users (Cina, 1989; Adebanjo, 2001).

If this research's output is to be accepted as a means of measuring service user experience, the new tool has to come from a different perspective by measuring service user experience rather than service user satisfaction. This is achieved by providing service users with the opportunity to define issues which directly matter most to them as they experience their service.

- **Methodological contribution**

An examination of previous work carried out on behalf of the Health Commission Reviews (formerly CHI) and Service user Environment Action Team (PEAT) has shown that the basis on which service user experience was interpreted cannot be traced back to their roots. From a research perspective, an understanding of the basis is important to ensure the reliability and validity of the outcomes. Many questions currently remain unanswered which impact on the reliability of current measures.

As stated in chapter four the Picker institute service user surveys (2005) distinguished eight dimensions of user-centred care:

- Access (including time spent waiting for admission or time between admission and allocation to a bed in a ward);
- Respect for service user' values, preferences, and expressed needs (including impact of illness and treatment on quality of life, involvement in decision making, dignity, needs and autonomy);
- Coordination and integration of care (including clinical care, ancillary and support services, and 'front-line' care);
- Information, communication, and education (including clinical status, progress and prognosis, processes of care, facilitation of autonomy, self-care and health promotion);
- Physical comfort (including pain management, help with activities of daily living, surroundings and hospital environment);
- Emotional support and alleviation of fear and anxiety (including clinical status, treatment and prognosis, impact of illness on self and family, financial impact of illness);

- Involvement of family and friends (including social and emotional support, involvement in decision making, support for care giving, impact on family dynamics and functioning);
- Transition and continuity (including information about medication and danger signals to look out for after leaving hospital, coordination and discharge planning, clinical, social, physical and financial support).

Their definition of service user experience is based on the following:

- Preliminary discussion with stakeholders in the NHS and Department of Health (DoH) about issues to address in the surveys;
- Review of the existing literature and surveys;
- Focus groups with Acute Trusts' users to identify what matters to them; and
- Drafting, testing and piloting the questionnaire for 2003/2004 carried out with service users who recently experienced Acute Trust services.

Further investigations indicated that the development of the questionnaire used by (formerly CHI) to assess user experience within PCTs has followed the same developmental process as for other NHS Trusts. This process is regarded by the researchers as highly alarming, because it has not addressed issues that directly matter to the service users in PCTs.

The use of multiple sources of evidence in case studies allows an investigator to address a broader range of historical, attitudinal, and behavioural issues. Thus any finding or conclusion in a case study is

likely to be more convincing and accurate if it is based on different sources of information (Yin, 1994).

The researcher has therefore concluded that, after reviewing a number of the abovementioned service user experience measurement techniques, that semi-structured interviews along with focus groups, and questionnaire survey would be most appropriate for this study.

Elements noted by the researcher were classified into two categories in order to analyse their relevance to the service user experience concept. However, the two categories are presented as follows:

- **Service related elements including:**
  - Attitudes of receptionist
  - Quality of care
  - Quantity of care
  - Access
  - Disabled facilities
  - Waiting time
  - Variety of service & choice
  - Privacy
  - Respect & dignity
  - Communication
  - Information

In the service related elements category, there are eleven elements that make up this category, and should contribute to the development of the service user experience in PCTs. Clearly, the results of the study emphasise these particular elements of service user experience, and confirm that they are instrumental in the successful implementation of the service user experience in PCTs. Through this discussion it is

believed that service user related elements are important factors for contributing to the achievement of a positive service user concept.

While the general pattern from the respondents about the service related elements classified above were fairly positive to some extent, some elements in particular were likely to be rated negatively by some respondents, e.g. waiting time, where the majority (88%) had to wait before being seen for medical treatment, while (12%) mentioned being seen immediately.

Furthermore, looking specifically at respondent's impressions of the service users of the service related elements, the general pattern is that PCTs have not yet reached a stage where service users are completely impressed by the healthcare service. On the other hand, in relation to the same issues raised above a smaller proportion rated them as either poor or very poor. These critical responses are minor and prove that the gaps can be bridged if service users are taken on board at early enough stage

- **Environment related elements including:**
- Signage
- Comfort
- Children play area
- Cleanliness
- Entertainment facilities
- Pleasantness of decoration
- Waiting area
- Car parking
- Security

The various interpretations and discussions with service users provide evidence of service user's attitudes and reactions to their impressions of

the PCT outlets healing environment in which services are delivered and social interactions take place

As for the environment related elements category, the researcher identified that the facilities that were more likely to be rated fairly positively are essential to prepare Salford PCT to embrace a successful implementation of a service user experience concept. A review of the relevant impressions of the service user experience shows that the environment related elements are also of great importance, and should remain one of the main primary concerns of service user experience concept implementation. The environment related elements should cover many aspects, like signage, comfort, children play area, cleanliness, entertainment facilities, pleasantness of decoration, waiting area, car parking, and security.

- **Proposal for a new tool called ServExcel**

The research proposed a new tool called ServExcel to be employed for measuring service excellence, which represents an opportunity for further research to examine the various constructs of the proposed tool.

The research also identified that the new tool is made up of five constructs namely: Service user Experience (SUE) Staff Engagement (SE) Continuous Improvement (CI) Organisational Culture (OC) and Operational Effectiveness (OE).

Unlike existing service quality measurement tools, the new service excellence tool is demand - based. It should do the following:

- Measure service user experience rather than service user satisfaction
- Evaluate the effect of service characteristics rather than the

service characteristics

- Focus on service excellence rather than service quality
- Deal with out come of impressions of excellence rather than the process of service delivery.
- Be 'demand push' rather than 'supply pull'
- Identify major service user issues rather than assess 'P-E gap' or service performance.
- Multi dimensional rather than singular.

9.5.1 Contribution and recommendations to Research

The contribution of this thesis to the research community lies in its exploration of its philosophical and methodological stances. It reveals a new approach to assessing service user experience in primary healthcare setting, based on elements identified by the service users themselves. This approach enables the researcher to explore and learn from both the findings of the research and the process of the research. The thesis found that this was useful particularly useful when undertaking an exploratory case study research. This was in line with the adopted philosophy of viewing the individual elements of the research and bringing them together as a whole.

The thesis used several research methods and tools adopting them to the purpose of the thesis. Data collection and analysis tools were used in novel ways in this study to better understand the phenomenon under investigation.

Last, but not least, this thesis identified new areas of research, and created the opportunity for other researchers to take their PhD in the development of service excellence tool.

Recommendations to research include to:

- Take forward issues highlighted in this research
- Do not be afraid to think out of the "box" to criticise and explore new ways of exiting tools.
- Be objective when collecting, analysing and interpreting data and findings
- Ensure reliability of research

9.5.2 Contribution and recommendations to Practice

This thesis has shown that service user experience as a component of service excellence is not as slippery as many may think. There are growing examples in practice in this field now emerging.

The thesis has helped to identify that service user experience is an important element of the service user experience. It has also identified how the new tool can be applied to develop and generate improvement in service excellence.

Recommendations to practice include to:

- Invest more in research towards the development of a tool to measure service excellence.
- Share knowledge and experience to learn from one another

9.5.3 Contribution and recommendations to the case study organisation

Understanding and interpreting the impressions of the service users were the contribution of this study to the case study organisation. The research contributed to a better understanding of the service user experience as a component of service excellence, undertaking diagnosis of where they currently stood, and where they wanted to be. The discussion brought to the forefront underlying issues that had been wrongly implemented. These issues had serious consequences, not just for the facilities management, but also for the delivery of healthcare services.

This research highlighted the contribution that involved the methodologies adopted by Commission for Health Improvement (formerly CHI) and Patient Environment Action Team (PEAT) and others that not addressed and captured the exact and impressions of the service users. A close examination has shown that the basis on which user experience was interpreted cannot be traced back to their roots. From a research perspective, an understanding of the basis is important to ensure the reliability and validity of the outcomes. Many questions currently remain unanswered which impact on the reliability of current measures

It has also highlighted that the development of the questionnaire used by CHI to assess user experience within PCTs has followed the same developmental process as for other NHS Trusts. This process is regarded by the researchers as highly alarming, because it has not addressed issues that directly matter to the service users in PCTs.

Recommendations to the case study organisation include to:

- Bear in mind that PCTs have different role to other NHS Trusts
- Design healthcare services around the exact need of service users and vice versa.
- View initiatives not as just one-off exercise
- Aim for service excellence rather than service quality
- Create service user experience rather than service user satisfaction.

9.5.4 Summary of Contribution

In the past two decades, FM has evolved from asset of heuristic ideas to a portfolio of somewhat developed concepts and principles. This has followed the typical path of knowledge development. By focusing on particular desired service excellence outcomes and working back to discover the relative importance of service excellence variables in FM as determinants, an insight into the subject was provided. Moreover, by integrating different service excellence constructs into one theoretical tool, a comprehensive tool was suggested which should help to understand the service excellence assessment in service organisation its impact and value.

Whilst the thesis does not make a direct contribution, it addresses existing theory through its explanation of the background of service user experience as a component of service excellence in other industries and the transferability of lessons learnt to FM.

It has also contributed to documenting evidence of service excellence in FM. Its approach has been singular, i.e. simply looking at service user experience, but taking a system approach to addressing service excellence constructs. It has contributed to an understanding of what

issues service organisations are concerned with in service excellence in FM. In addition, it has contributed a guide to ` excellence practice` in FM service excellence through its exploration and clarification of the applicability of the SERVEXCEL tool.

Through the application of service user experience, which references accepted service excellence convictions and procedures, NHS Primary Care Trusts will have had the opportunity to examine itself objectively and hopefully make necessary adjustments to ensure that healthcare delivery is up the highest standards within the PCT out lets.

The new process of assessing service user experience within PCTs will enable the Trust to know where deficiencies lie and where improvements can be made. Evidential evaluation will also support or disapprove view points of healthcare providers which may be very valid or just be based upon accepted ways of delivering healthcare services and historical rhetoric.

Without formal assessment of service user experience within PCT`s outlets there is no way any service user change can be properly identified to improve healthcare delivery. Progressing this philosophy involves assessing service user experience based on issues identified by the service users themselves against the rest of constructs that make up the overall loop of service excellence.

Specifically, the research contributed to a better understanding of the service excellence within the Trust, undertaking a diagnosis of where they stood, and where they wanted to be. The discussion brought to the forefront underlying issues which had been ignored. These issues had serious consequences not just for the healthcare delivery, but in some cases for the individuals involved in the event of failure.

The researcher has explored and developed within this thesis, for the first time innovative service user experience indicators which directly reference the core business of PCTs. Only through taking on board all parties involved and more importantly service users. The assessment of service user experience through the use of such method should enable an assessment of organisational efficiency to take place at facilities/ service user interface. Indicators identified as performing poor can then analysed more closely to determine whether specific and even simple improvements can be made to enhance service user experience. Conversely, indicators identified as performing well at the facilities/ user interface could reveal certain methodologies that could be applied to other organisations to create service user experience.

This thesis has demonstrated that service excellence is not a fad. It shows that there growing examples of good practice in this field now emerging. It also identified that although service user experience should create a 'win-win' scenario, it should not be addressed on its own, but in the context of the overall loop of service excellence.

The new tool can be a good representation of excellence practice in demonstrating added value to service organisations from undertaking FM initiatives. The thesis has helped to identify the relationships between the different dimensions of service excellence. It has brought to the forefront issues related to creating not just service user experience, but also service excellence as a whole. As service user experience becomes increasingly an integral part of service excellence loop, service users reside within and across FM which needs to be captured and managed to improve efficiencies and effectiveness, as demonstrated by this thesis.

9.6 Reflection

This research thesis has the responsibility for accountability to different stakeholders, namely the case study organisation, the wider research community and the University of Salford to which it is to be submitted.

9.6.1 Reflection on the content

This Thesis reflects state of the art thinking in Fm service excellence research. It demonstrates through literature review that the significance of service quality is undisputed, and that the theory and practice of service quality has not reached a consensus. This primarily because of service intangibility, the problems associated with simultaneous production and consumption of services, and the difference between mechanical delivery of the service and the human component of quality. There is an instinctive connection between the concepts of service quality as distinct from product quality and service user satisfaction. However, the two constructs have followed distinctively different research streams.

The background studies into facilities management highlighted that the service excellence concept has evolved without corresponding evolution in the measurement tools. This in essence means that the service concept has reacted to the call for change, however the measuring tools have not done so. Most of the tools used to evaluate and improve service quality seem to neglect the role of the service user construct as well as other constructs that can contribute to a positive service user experience. These constructs include: staff delight, operational effectiveness, organisational culture, and continuous improvement.

This study indicated that the development of the questionnaire used by CHI to assess user experience within PCTs has followed the same

developmental process as for other NHS Trusts. This process is regarded by the researchers as highly alarming, because it does not address issues that directly matter to the service users in PCTs.

The key issue identified in this research is that, new approach has to come from a different perspective. It seeks to flip the perspective by attempting to measure service user experience rather than service user satisfaction. This is achieved by providing service users with the opportunity to define issues directly matter most to them as they experience their service delivery.

This thesis further identified that just as important as making a step change required, is defining the true service user needs and desires to create the right experience. In order to take on such a change, organisations are increasingly required to flip the perspective to justify their added value to the service users instead of service providers. The main challenges in the future however lie with organisations in managing all stakeholders in an ever evolving task that should help them move away from service quality stage to service excellence stage where service user experience is created.

9.6.2 Reflection on the research process

The most appropriate approach that could have been used to test and validate the service user experience concept for the primary healthcare sector would have been provided through its implementation in a primary healthcare setting in order to gather further tangible evidence to support its variables (Yin, 1994). Therefore, a case study strategy aiming at such implementation was explored during the field investigations.

This thesis demonstrated some of the benefits and difficulties with undertaken case study research. However, Amarattunga`s (1998) assertions that case study research usually only reports on positive aspects, and generally do not seek to analyse issues were disapproved. Case study evidence shows that they all reported on both positive and negative aspects of the relevant subject matter. Evidence also reveals that analysis was a very important aspect of the case studies and the thesis as a whole.

In judging the validity and reliability of the this case study Yin (1994) discussed that for any research study to be valid it should conform to and pass certain design tests with regard to different levels of research validity.

The question of validity in this case study dealt with establishing correct operational measures for the concept being studied (construct validity), truth value for findings (internal validity, credibility) and the domain to which findings can be generalised (external validity)

The validity of this research design was under threat due to the use of only selected quotes and examples and limited sample and repeatability of the same study. Some corrections of responses and various measures were taken to improve validity in this research design during the research process including:

- The phenomenon studied was derived from theory while the content of this phenomenon was formulated only through data.
- The researcher described in detail the Trust context and the sample used for studying the phenomenon. The field of application was therefore, made visible to the readers.

- Prior experience and skills of the researcher in language and data collection techniques strongly supported validity.
- Multiple sources of evidence were used as a form of data triangulation (see Yin, 1994 and Stake, 1995).

On the other hand, according to Yin (1994) reliability is demonstrating that the operations of the study such as the data collection procedures can be repeated with the same results. Reliability in this study was under threat by a number of factors such as the researcher's biases and methodology. Some of the reliability issues are illustrated in table (5.5).

Techniques such as use of one interviewer across the study ensured that recording took place consistently. All notes were properly stored for improving the reliability adjustments of expressions occurred during the interviews, focus groups and questionnaire surveys. Also, some verification was requested for some of the responses, in order to obtain a more robust picture of the subject area and increase reliability.

Emphasising the anonymity of respondents was another means of improving reliability of interviews, focus groups, and questionnaire surveys. The spirit of the respondents seemed open, frank, warm and lively and no sign of falseness or secrecy was experienced.

Further, the researcher however looked at other initiatives, which could be relevant and necessary to the validation of the concept. This approach to validation consisted of introducing the concept at specific service user experience related primary healthcare sector events in order to establish richer and more effective critiques necessary to its assessment and adjustment.

Based on this approach, the concept of the service user experience assessment was achieved through a number of presentations made at international conferences as well as at Salford PCT.

9.7 Limitations to the Study

As is the case with other research studies, this has a number of limitations that need to be discussed. These limitations are mainly related to the broadness of the topic under investigation, representative ness, and generalisability issues, as well as a lack of homogeneous service user experiences, and time constraints.

Service user experience is an area of research where theory is still inadequate. This is a particularly the case as the research seeks to develop a holistic and integrative understanding of service user experience. This feature demands broadening the scope of the study in reviewing a large body of relevant literature, and collecting a huge set of appropriate data.

However, while the researcher has attempted to meet such a requirement by reviewing various bodies of literature and seeking different types of data from interviews, focus groups and questioners sources. It is not possible to claim that the empirical investigation of this study has come across all issues related to this perspective, at least those issues presented in the literature.

The time frame for a complete investigation of the phenomenon under consideration, especially with the case study, could not be undertaken. Though all possible efforts were made to get the views of as many service users as possible within Salford City, lack of time was seen as the main inhibitor to this. With more time given for investigation, more

rich data could be obtained. Even with the use of questionnaires survey. Furthermore, the nature of service user experience practices suggests that measuring impact of service user experience implementation and exploitation might be difficult to quantify over a short period of time.

The practice of service user experience has inherited the confusion that surrounds the concept. It is therefore no surprise that respondents have different perspectives and knowledge of service user experience, and thus different practices. The lack of a common language regarding service user experience may cause bias in the data collection process, as data of various quality levels given. Though this diversity enriches the data collected, it inhibits generalisation and further comparisons.

9.8 Future research

The service user experience concept has the potential to guide empirical research in the development of service user experience concept in both PCTs and other organisations. It provides an integrated and holistic view of how the impressions of service users could be turned into a mechanism by which these impressions are assessed. This requires that further studies should be made in order to validate this statement.

The scope of this study was restricted to a single case study site at Salford PCT, further research is needed to expand the finding from this study and to provide more conclusive answers. Despite the attempts of the service user experience to be exhaustive and represent one of the main pillars of service excellence within PCTs, further research should therefore focus on developing a broad tool that could support any given organisation. Therefore the researcher would suggest that a number of recommendations should be considered in future research as follows:

- Through the review of the literature, and from the data collection process, it has been found that there is a lack of common and standardised terms and definitions for service user experience. This has been reflected in healthcare provider's impressions of service user experience concepts and practices. Even the concept of service user experience is not fully developed, embedded and comprehended by healthcare providers. Therefore, there is great need for more research. This would solicit the opinions and impressions of both academics and the practitioners of service user experience definitions and terms, and develop a clearer and common use of the service user experience terms. This study can be considered as a good starting point in this area of research, since it embraces a holistic perspective that unifies different focuses and definitions.

- The service user experience concept proposed by this study provides ample opportunities for further refinement and testing of the traditional service user experience. As for the researchers involved in similar research, it would be worth for them to explore how the concepts and practices of service user experience are being integrated with other service excellence constructs, like staff engagement, operational effectiveness, continuous improvement and culture.

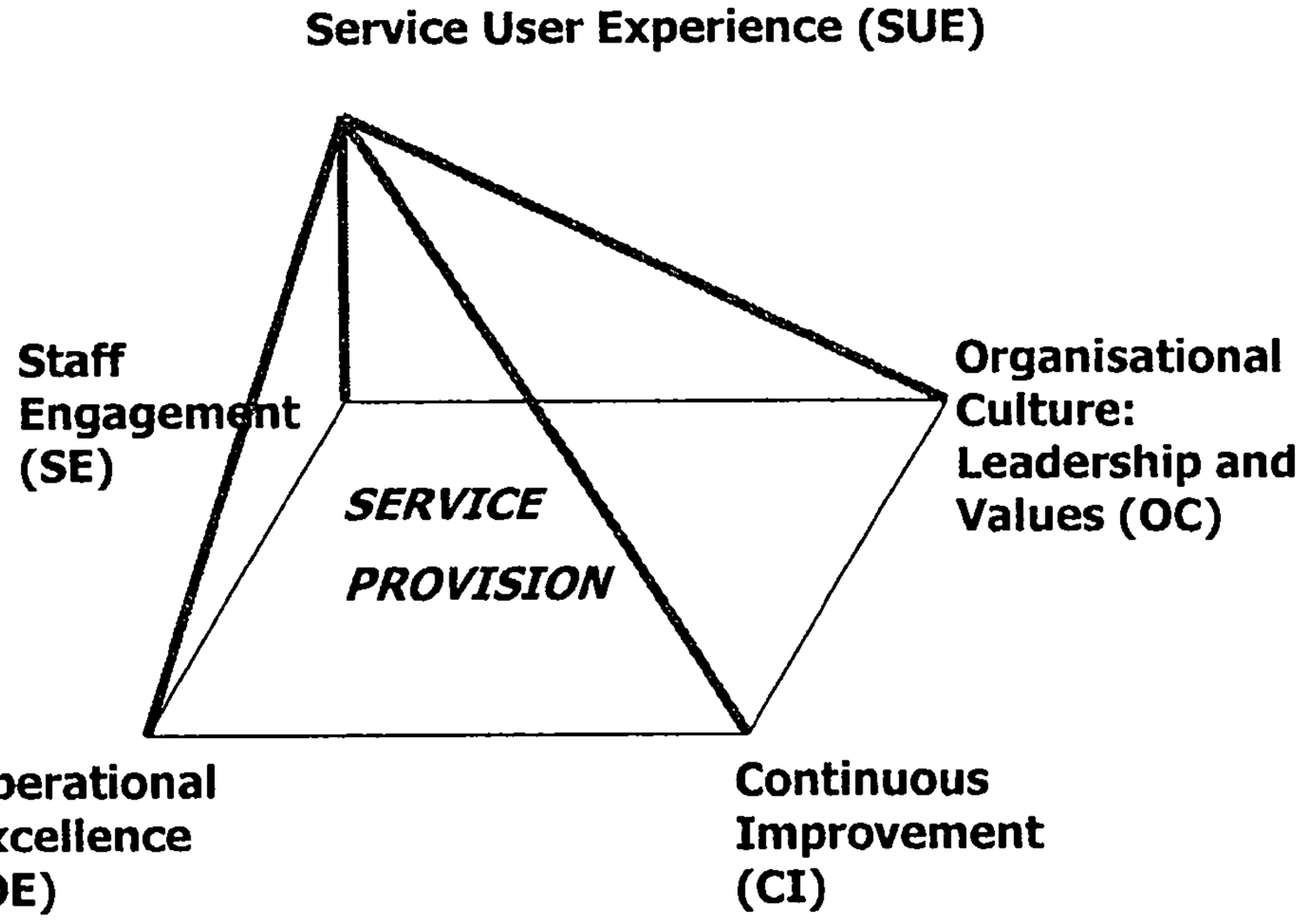
The evidence and elements emerging from these experiences have provided useful insights into the importance of different elements and variables that form the building blocks of the service user experience tool. Again, these variables can be further 'tuned' in future research to provide more analytical tools that could better serve the healthcare sector as a whole rather than being focused on one single organisation.

Future research should address the following domains:

- This study should be considered as the developing pilot work
- The future study should involve all stake holders as driving the resultant nature of the healthcare at PCTs
- The future study should further develop and test the service user experience elements
- The future study should take on board a wider diversity of groups and residents.
- The future study should further investigate how service users formulate their impressions about the services and the environment in which the services are delivered.

This study has also provided contextual and situational insights into understanding how Salford City service users experienced the concept of service user experience. The future study should build up a tool to assess service excellence in a holistic manner. The new tool is expected to provide an excellent foundation upon which can be laid the future framework for complementary research.

Therefore, to measure service excellence, a new tool is proposed here called SERVEXCELL. See figure (8-1)



9-1 Service User Experience

Unlike existing service quality measurement tools, the new Service Excellence Tool is demand based. It should do the following:

- Measure service user experience rather than service user satisfaction
- Evaluate the effect of service characteristics rather than the service characteristics
- Focus on service excellence rather than service quality
- Deal with out come of impressions of excellence rather than the process of service delivery.
- Be demand push rather than supply pull
- Identify major service user issues rather than assess P-E gap or service performance.
- Multi dimensional rather than singular

9.8.1 The five dimensions of service excellence

- Service User Experience
- Staff Engagement
- Continuous Improvement
- Operational Excellence
- Organisational Culture

Where as SERVQUAL measures

- Tangibles
- Reliability
- Assurance
- Responsiveness
- Empathy

SERVEXCELL is to measure relations

- R1=SUE : OC+CI
- R2=SUE : CI+OE
- R3=SUE : OE+SE
- R4=SUE : OC+SE
- R5=SUE : CI+SE
- R6=SUE : OC+OE

9.8.2 Scales of Measurement

Having identified the five constructs/dimensions for ServExcel, each construct/dimension is individually assessed as follows:

- **Service User Experience**

- Capture user's impressions
- Involve users

Methods

- Interview users
- Facilitate focus groups
- Distribute questionnaire
- Disseminate results

- **Operational Excellence**

- Customising the service
- Exceeding the requirements

Indicators should include

1. Overall number of complaints
2. Help desk logs

- **Staff Engagement**

- Engaging staff
- Training and encouraging
- Rewarding and caring

Indicators should include

1. Reduced staff turnover
2. Staff training figures
3. Absenteeism and sickness reduced
4. Benefits, incentives and fair deal

- **Organisational Culture: Leadership & Organisational Values**

  - Service culture
  - Vision, values, leadership
  - Respect and concern for the staff
  - Good communication
  - Professionalism and good image

Indicators should include

1. Cultural match in service provision:
   a. Main characteristics of service culture
   b. Leadership and governance
   c. Decision making
   d. Organisational structure and motivation
2. Vision statements

- **Continuous Improvement and Processes**

  - Having processes for service innovation and corrective actions are planned
  - Building the competencies for change
  - Constant change for improving the service delivery
  - Compliances

Indicators should include

1. Innovation logs
2. Compliance
    a. More services are managed and comply with SLA's and corporate standards
    b. Delivery on time, to budget and quality
    c. Less workplace related incidents and sicknesses

9.9 Conclusion

The empirical evidence emphasises that service users have varied impressions of the services provided by Salford PCT. As described in chapter six the study identified eleven common elements representing the impressions of the service users of the services provided by Salford PCT. The considered responses generated by different data collection methods suggest that the impressions of the service users towards the services delivered within Salford PCT related to whether PCT out lets provided homely feeling for the service users.

The service user's journey includes the first point of contact to the car park, waiting area, trips or movements during treatment and during the journey from PCT outlet to home. The study found that service user's journey and resulting experience were influenced by the nature of the healing environment that they move through.

The general trend was that for the environment related elements to be rated as either average or satisfactory rather than very satisfactory. Although respondents expressed that they are impressed to some

extent by the present state of the waiting area, others still feel that a lot needs to be done in many cases such as play area and so forth. This statement (in line with the previous ones) still confirms that Salford PCT has a long way to go, if the intent is to deliver a healthcare service designed around the true needs of the service users.

However, the empirical investigations revealed that the successful service user experience implementation requires a full and deliberate engagement of the service users. The researcher considers this as the core of service user experience implementation as per the results gathered from the literature review, interviews, focus groups and questionnaire surveys.

This cross analysis obtained from the results of the literature in chapters two, three and four, along with those obtained from the field investigations in chapter six, is a clear confirmation of the theoretical validity of the service user experience concept.

The concept of service excellence is still in its infancy. It has only got as far as service quality, and the promise of superior service delivery is far from being recognised. Therefore, there is a need for more awareness of the value-creating elements within the concept of service excellence and the supporting processes that would help develop those elements. Further, service excellence requires a total approach and does not need to be expensive.

It is often said that rational argument is not the most effective way to move agendas on. It is time for service providers to grasp a new narrative of service that is braver and altogether more ambitious. The battle to regain trust and legitimacy, alongside the need to create a sustainable and viable service infrastructure for tomorrow's challenges as well as today's, will not be won through speeding up and intensifying

current approaches to reform that, ultimately, continue to treat services as commodities.

Finally

Trust grows out of relationships, which in turn rely on believing service providers are acting in the best interests of service users and telling them the truth. What is needed now is a new tale about services that is rooted in relationships and experiences, in service users and in built environments. The current narrative and its focus on narrowly defined versions of effectiveness, personalisation and decentralization, is too limited. Service excellence has both the philosophy and the methods that could refocus the discussion, and provide service providers with the elements of a more vital, vivid and practical agenda for transformation.

References

Airey, C, Bruster, S, Calderwood, L, Erens, B, Piston, L, Prior, G and Richards, N 2001, *National survey of NHS patients: Coronary heart disease 1999*, National Report Summary of Findings, London. NHS Executive.

Aldlaigan, HA, Buttle, AF 2002, "SYSTRA-SQ: a new measure of bank service quality", *International Journal of Service Industry Management*, **13**(4), pp.362-381.

Alexander, K 1996, *Facilities management theory and practice*, E&FN Spon, London, UK.

Amaratunga, D, Baldry, D, and Sarshar, M 2000, Assessment of facilities management performance – What next?, *Facilities,* **18**(1/2), pp. 66-75.

Amaratunga, D, Haigh R, Sarshar, M and Baldry, D 2002, Assessment of facilities management process capability: a NHS facilities case study, *International Journal of Healthcare Quality Assurance*, **15**(6), pp. 227-288.

Amaratunga, D, Haigh, R, Sarshar, M and Baldry, D 2002, Application of the balanced score card concept to develop a conceptual framework to measure facilities management performance within NHS facilities, *International journal of Healthcare Quality Assurance*, **15**(4), pp. 141-151.

Antonacopoulou, E and Kandampully, J 2000, "Alchemy: the transformation to service excellence", *The Learning Organisation*, **7**(1), pp. 13-22.

Appleby, J 1994, *Financing the NHS* (1994-1995 NHS Hand Book), 9th Edition, JMH Publishing, Kent, pp. 55-64.

Ashbury, J 1999, *Overview of focus group research*, Qualitative Health Research.

Aukket, JW 1994, The development of clinical audit: Use of a "Quality Web" constructed for a community dental service, *International Journal of Health Care Quality Assurance*, **7**(1), pp. 32–36.

Babakus, E, and Boller, GW 1992, An empirical assessment of the SERVQUAL scale, *Journal of Business Research*, 24, pp. 253-268.

Baker, JA, and Lamb, CW 1993, Measuring architectural design service quality, *Journal of Professional Services Marketing*, **10**(1).

Barnes, J 2001, *Secrets of customer relationship management*, McGraw Hill.

Beer, AR 1991, Environmental planning for site development, E&FN. Spon, London, UK.

Beer, AR and Higgins, C 2000, Environmental planning for site development, 2nd ed, E&FN. Spon, London, UK.

Berry, LL, Parasuraman, A, and Zeithaml, VA 1985, *Quality counts in services too*, Business Horizons.

Birchall, J and Simmons R 2004, *User power: the participation of users in public services*, London: National Consumer Council, accessed on 20/06/06 <www.ncc.org.uk>.

Bitner, MJ 1992, "Service scapes: the impact of physical surroundings on customers and employees", *Journal of Marketing*, **56**(2), pp. 57-71.

Blanchard, RF and Galloway, RL 1994, Quality in retail banking, *International Journal of Service Industry Management*, **5**(4), pp. 5-23.

Bolton, RN and Drew, JH 1991, A longitudinal analysis of the impact service changes on customer attitudes, *Journal of Consumer Research*, 17, pp. 375-348.

Boulding, W, Kalra, A, Staelin, R and Zithamel, VA 1993, A dynamic process model of service quality from expectations to behavioural intentions, *Journal of Marketing Research*, 30, pp. 7-27.

Bowen, JT 1997, A market-driven approach to business development and service improvement in the hospitality industry, *International Journal of Contemporary Hospitality Management*, **9**(7).

Brady, MK 1997, Re-conceptualizing perceived service quality: Hierarchical model, Unpublished Ph.D., The Florida State University

Brown, RB and Bell, L 1998, Patient-centred audit: a user's quality model, Managing Service Quality, **8**(2), pp. 88-96.

Brown, SW and Swartz E 1989, A gap analysis of professional service quality, *Journal of Marketing*, 53, pp. 92-98.

Brown, TJ, Churchill, GA and Peter, JP 1993, Improving the measurement of service quality, *Journal of Retailing*, **69**(1), pp. 127-139.

Bruster, S, Jarman, B, Bosanquet, N, Weston, D, Erens, B and Delbanco, TL 1994, National survey of hospital patients, *British Medical Journal*, 309, pp. 1542-1549.

Bull, A 1994, Specifying quality in healthcare, *Journal of Management in Medicine*, **8**(2), pp. 5–8.

Buttle, F 1996, SERVQUAL: review, critique, research agenda, *European Journal of Marketing*, **30**(1), pp. 8-32.

CABE [Commission for Architecture and the Built Environment] 2002, The value of good design, London: CABE, accessed on 08/01/07 <www.cabe.org.uk>.

Campbell, C 1989, *The romantic ethic and spirit of modern consumerism*, Basil Blackwell Ltd.

Carman, JM 1990, "Customer perceptions of service quality: an assessment of servqual dimensions", *Journal of Retailing*, **66**(1), pp. 33-55.

Carman, JM 2000, Patient perceptions of service quality: combining the dimensions, *Journal of Services Marketing*, **140**(4), pp. 337-352.

Caruana, A, Pitt, L and Morris, M 1995, "Service firms and the service construct: implications for performance", *Service Industry Journal*, **15**(3), pp. 243-256.

Cassel, C and Symon, G 1994, *Qualitative methods in organization research*, London: Sage.

CFM 2001, *"Shell Expro case study report"*, Internal Document, Centre for Facilities Management, University of Salford., Salford.

CFM 2004, *Review of estates and facilities management workforce in NHS acute and primary care trusts in England*, Commissioned report by the Centre for Facilities Management, University of Salford.

Cheung, C and Law, R 1998, "Research and concepts: hospitality service quality and the role of performance appraisal", *Managing Service Quality*, **8**(6), pp. 402-406.

Churchill, GA and Surprenant, C 1982, An investigation into the determinants of customer satisfaction, *Journal of Marketing Research*, 19, pp. 491-504.

Cina, C 1989, "Five steps to service excellence: marketing impact on performance", *American Marketing Association*, pp. 1-10.

City of Salford 1995, *Unitary development plan*, Swinton: Salford.

City of Salford 2001, *The community plan: Our vision for Salford 2001-2006*, Swinton, Salford.

Cronin, JJ and Taylor, SA 1992, Measuring service quality: A re-examination and extension, *Journal of Marketing*, **56**(3), pp. 55-68.

Cronin, JJ and Taylor, SA 1994, *Servperf versus Servqual: Reconciling performance-based and perception-minus-expectations measurement of service quality.*

Curry, A and Sinclair, E 2002, Assessing the quality of physiotherapy services using SERVQUAL, *International Journal of Healthcare Quality Assurance*, **15**(5), pp. 197-205.

Dabholkar, PA, Thorpe, DI, and Rentz JO 1996, A measure of service quality for retail stores: Scale development and validation, *Journal of the Academy of Marketing Science*, **24**(1), pp. 3-16.

Department of Health 1989, *Working for patients*, HMSO, UK.

Department of Health 1992, *The patient charter*, HMSO, UK.

Department of Health 1997, *The new NHS modern and dependable*, HMSO, UK.

Department of Health 1998, *Modernizing healthcare and social services: national priorities guidance 1990/2000 – 2001/2002,* DOH publications.

Department of Health 2002, *Chef's executive report to the NHS.*

Department of Health 2004, *Agenda for change*, Final Agreement, accessed on 20/12/06 <http://www.dh.gov.uk/assetRoot/04/09/94/23/04099423.pdf>.

Department of Health 2006, *Our health, our care, our say: a new direction for community services*, Presented to Parliament by the Secretary of State for Health by command of Her Majesty, Crown.

Devlin, AS, and Arneill, AB 2003, *Health care environments and patient outcomes: A* review of the Literature, Environment and Behavior, **35**(5),PP 665-694.

Disend, JE 1991, *How to provide excellent service in any organization: A blueprint for making all the theories work Radnor*, PA: Chilton.

Douglas, CH and Douglas, MR 2004, *Patient-friendly hospital environments: Exploring the patient's perspective,* Health Expectations, (7).

Douglas, CH, Steele, A, Todd, S and Douglas, M 2002, *Investigation and assessment of attitudes and perceptions of the Built Environment of NHS hospitals*, Leeds, University of Salford and NHS Estates.

Drucker, P.F 1972, *The Practice Of Management*, Pan Books Ltd

Duffin, D 1997", Celebrate and record winning customer ownership-the jaeger service excellence story", *Managing Service Quality*, **7**(2), pp. 80-86.

Easterby-Smith, M, Thorpe, R and Lowe, A 1991, *Management research: introduction*, Sage publication, thousand oaks, London.

Edvardsson, B, Gustavsson, BO and Riddle, DI 1989, An *expanded model of the service encounter with emphasis on cultural context*, Research Report 89/4, CTF Services Research Centre, University of Karlstad, Sweden.

Eisenhardt, KM 1989, Building theories from case study research, *Academy of Management Review*, 14(4), pp. 532-550.

Embree, L 1997, *What is phenomenology?* CARP Inc 2000, accessed on --------- ,<http:// Phenomenologycenter.org/phenom.htm>.

Emerson, R and Harvey, C 1996, "Visions of Excellence in Australian and Canadian Human Services Organizations", *International Journal of Public Sector Management*, **9**(5/6), pp. 109-124.

Erlandson,DA 1993, Doing naturalistic inquiry: a guide to methods,

Erstad, M 2001, "Commitment to excellence at the forte hotel group", *International Journal of Contemporary Hospitality Management*, pp. 347-351.

Evans, JR and Lindsay, WM 1996, *The management and control of quality*, New York, West.

Fitzgerald, L, Johnston, R, Brignal, S, Silvestro, R and Voss, C 1994, *Performance measurement in service businesses*, P2, Cima, London.

Fleeman N, 1997, *Health impact assessment of the Southport drug prevention initiative (Observatory Report Series No 39)*, Public Health Observatory, University of Liverpool, Liverpool.

Flynn, N 1993, *Public sector management*, Harvester Wheatsheaf London, UK.

Fowler, E, Macrae, S, and Stern, A 1999, *The Built Environment as a component of quality care: Understanding and including the patients' perspective*, Joint Commission Journal of Quality Improvement, (25).

Fowler, FJ 1988, *Survey Research Methods*, Sage Publications Ltd.

Fowler, FJ 1995, *Improving survey questions : design and evaluation*, Sage, Thousand Oaks, London.

Francis, S, 2002, The architecture of health buildings: providing care: can architects help? *The British Journal of General Practice*, pp. 254-255.

Fu ,C, Michail, K, and John, Z 2005, *The development of a space-centered cad tool to support the healthcare building design*, SCRI,

Gesler, W, Bell, M, Curtis, S, Hubbard, P and Francis, S 2004, Therapy by design: evaluating the UK hospital building program, *Health and Place*, 10, pp. 117-128.

Ghauri, P, Gronhaug K and Krit-Anslund, I 1995, *Research methods in business studies*, Prints Hall, New York.

Ghobadian, A 1994, "Service quality concepts and models", *International Journal of Quality and Reliability Management*, 11(9), pp. 43-66.

Gilmore, JH and Pine II BJ 2000, "Customisation that counts" (ED), *Markets of One*, Harvard Business School Press, Boston.

Gorz, A 1988, *Critique of economic reason*, Translated by Handy Side, G &Turner, C, Verso.

Gro¨nroos, C 1982, *"Strategic management and marketing in the service sector"*, Swedish School of Economics and Business Administration, Helsingfors.

Gronroos, C 1984, A service quality model and its marketing implication, *European Journal of Marketing*, **18**(4), pp. 40.

Gronroos, C 1990, *Service management and marketing: managing the moment of truth in service competition*, Lexington, MASS: Lexington Books.

Gronroos, C 1998, Marketing services: the case of a missing product, *Journal of Business& Industrial Marketing*, **13**(4/5), pp. 322-338.

Gummesson, E, and Gronroos, C 1987, *Quality of products and services: a tentative synthesis between two models*, Research Report 83, Services Research Centre, University of Karlstad, Sweden.

Guthrie, J, Mathews, MR 1985, "Corporate social accounting in Australia", *Research in Corporate Social Performance and Policy,* 7, pp. 251-77.

Hague, PN 1993, *Questionnaire design,* Kogan Page, London.

Hammersly, M and Gomm, R 2000, *Introduction, In Gomm, Roger, Hammersly, Martyn and Foster, Peter (Eds), case study method*, Sage Publications Ltd, Surry.

Hansson, J 2000, Quality in health care, *Journal of Management in Medicine*, 14(5), pp. 357 – 361.

Haselgrove, S 1995, *'The Student Experience'*, The Society for Research into Higher Education and Open University Press.

Health Act 1999, Chapter 8, Crown.

Hibbert, S and Horne, S 1996, "Giving to charity: questioning the donor decision process", *Journal of Consumer Marketing*, 13, pp. 4-13.

Higgins, LF, Ferguson, JM and Winston, JM 1991, Understanding and assessing service quality in health maintenance organizations, *Health Marketing Quarterly*, 9, pp. 5-20.

Hiscock, J, Legard, R and Snape, D 2001, *Listening to diabetes service users: qualitative findings for the diabetes national service frame work*, Prepared for DOH.

Hogarth-Scott, S and Wright, G 1997, Is the quality of healthcare changing? GPs' views, *Journal of Management in Medicine*, 11(5), pp. 302 – 311, accessed on 20/07/06, <http://www.pickereurope.org/about/approach.htm>.

Humphrey, C, Ehrich, K, Kelly, B, Sandall, J, Redfern, S, Morgan, M and Guest, D 2003, Human resources policies and continuity of care, *Journal of Health, Organisation and Management*, 17(2), pp. 102–121.

Hwang Li-Jen, J, Eves, A and Desombre, T 2003, Gap analysis of patient service perceptions, *International Journal of Healthcare Quality Assurance*, 16(3), pp. 143-153.

IFMA 2003, *Occupational definition of facility management*, accessed on February 2003, <http://www.ifma.org/whatsfm/occ_definition.cfm?actionbig=9&actionlil=1 73>.

Jackson, D 1999, *Five years, Five lessons getting to the roots of service excellence*, Novius Ltd.

Jick, TD 1979, Mixing qualitative and quantitative methods: Triangulation in action, *Administrative Science Quarterly*, **24**(4), pp. 602-611.

Jo Moller ,J and Sonntag, HG, 1998, Systematic analysis and controlling of health care organisations lead to numerical healthcare improvements, *Health Manpower Management* , **24**(4-5), pp. 178-82.ice Marketing, 7, pp. 59-68.

John, J, 1996, A dramaturgical view of the health care service encounter: Cultural value-based impression management guidelines for medical professional behaviour, *European Journal of Marketing*, 30(9), pp. 60–74.

Johnston, R 1995, The determinants of service quality: satisfiers and dissatisfies, *International Journal of Service Industry Management*, l.6, pp. 53-71.

Johnston, R 2001, "Service excellence=reputation=profit, developing and sustaining a reputation for service excellence", *Institute for Customer Service: Warwick Business School*, Warwick.

Johnston, R and Clark, G 2001, *Service Operation Management*, Pearson Education Ltd, Essex.

Kandampully, J & Suhartanto, D 2000, Customer Loyalty In The Hotel Industry: The Role Of Customer Satisfaction And Image, *International Journal Of Contemporary Of Hospitality Management*

Kelley, SW, Donnelly, JH, and Skinner, SJ 1990, "Customer participation in service production and delivery", *Journal of Retailing*, **66**(3), pp. 315-335.

Kim, S and Kleiner, BH 1996, "Celebrate and record service excellence in the banking industry", *Managing Service Quality*, **6**(1), pp. 22-27.

Kotler, P 1988, *Marketing management: analysis, planning, implementation and control*, Englewood Cliffs Prentice-Hall, London.

Krippendorff, K 1980, *Content analysis: an introduction to its methodology*, Sage, Beverly Hills, CA, The Sage Comm Text Series.

Lakhe, RR, and Mohanty, RP 1995, Understanding TQM in service system, *International Journal of Quality & Reliability Management*, **12**(9), pp. 139-153.

Lam, WMC 1977, *Perception and lighting as formgivers for architecture*, McGraw Hill Book Company, New York.

Lashley, C 1997, *Empowering service excellence: beyond the quick fix*, Cassell, USA.

Lashley, C 2001, *Empowerment: HR strategies for service excellence*, Butterworth-Heinemann, Oxford.

Lassar, WM, Manolis, C and Winsor, RD 2000, Quality perspectives and satisfaction in private banking, *Journal of Service Marketing*, **4**(3).

Lawson, B and Phiri, M 2003, *Architectural healthcare environment and its effects on patient health outcomes*, London: The Stationery Office.

Lehtinen, U, and Lehtinen, JR 1982, *Service quality: A study of quality dimensions, working paper*, Service Management Institute, Helsinki.

Lewis, RC and Booms, BH 1983, The marketing aspects of service quality, In L Berry, g, Showstacks and G Upah (Eds), *Emerging Perspectives on Services Marketing*, pp. 99-107, Chicago, American Marketing.

Life in Salford 2006, *The community plan: making the vision real Salford 2006-2016*, Salford.

Lindberg, E 2002, Managing complexity: acknowledge the attraction patterns by supporting sense making and allowing the quality system to serve as the panoptic system, *International Journal of Health Care Quality Assurance*, **15**(5) Page: 213 – 216.

Lipovatz, D 1998, "Leadership performance in Greek enterprises using the EQA framework", *The TQM Magazine*, 3, pp. 194-203.

LIusar, JC and Zornoza, CC 2000, Validity and reliability in perceived quality measurement models: an empirical investigation in spanish ceramic companies, *International Journal of Quality & Reliability Management*, **17**(8), pp. 899-918.

Lovelock, C 1983, Classifying services to gain strategic marketing insights, *Journal of Marketing*, 47, pp. 9-20.

Lovelock, CH 1981, Why marketing needs to be different for services, In, J Donelly and W George, (Eds), *Marketing of Services*, Hicago: American Marketing Association.

Lovelock, CH 1988, *Managing services: marketing, operations, and human resources*, Englewood Cliffs, NJ: Prentice-Hall.

Ltd

Macrae, SK and Michel, MJ 1998, Consumer perceptions of the healthcare environment: an investigation to determine what matters, *Journal of Healthcare Design* 10, pp. 7-10.

Mallak.A, Larry, Lyth. M, David, Olson. D, Suzan, Ulshafer.M, Suzan and Sardone. J, Frank (2003), Perspectives: culture, the built environment and healthcare organisational performance, *Managing Service Quality*, **13**(1), pp. 27-38.

Mariampolski, HY 2001, *Qualitative market research: a comprehensive guide*, Sage publication, Thousand oaks, London.

McDougall, GHG and Levesque, TJ 1994, A revised view of service quality dimensions: an empirical investigation, *Journal of Professional Services Marketing*, 11, pp. 189-209.

Mehrabian, A and Russell, JA 1974, *An approach to environmental psychology*, Cambridge, MA: MIT Press.

Merkens, BJ and Spencer, JS 1998, "A successful and necessary evolution to shared leadership: a hospital's story-incorporating leadership in health services", *International Journal of Healthcare Quality Assurance*, 11(1), pp. 1-4.

Merriam, SB 2002, *Introduction to qualitative research*, in Merriam, SB (Ed.), Qualitative research in practice–examples for discussion and analysis, San Francisco: Wiley, pp. 3-17.

Miles, MB and Huberman, AM 1994, *Qualitative data analysis*, Sage Publications, Thousand Oaks, California

Milne, M, Adler, R 1999, "Exploring the reliability of social and environmental disclosures content analysis", *Accounting, Auditing & Accountability Journal*, 12(2), pp. 237-56.

Mitchell, ES 1986, Multiple triangulation: A methodology for nursing science, *Advances in Nursing Science,* **8**(3), pp. 18-26.

Morgan, D 1997, *Focus groups as qualitative research*, 2nd edition, Thousand Oaks: Sage.

Mosley, T 2001, *Service excellence tour USA*, Customer Service Management, Kent.

Mudie, P and Cottam, A 1999, *The management and marketing of services*, Oxford: Butterworth-Heinemann.

Newman K and Tanya P 1996, Quality matters: junior doctors' perceptions, *Journal of Management in Medicine*, 10(4), pp. 12 – 23.

NHS survey of NHS Patients: *General practices 1998 NHS Executive*, London.

Openheim, AN 1966, *Questionnaire design and attitude measurement*, Heinemann, London.

Parasuraman, A, Berry, LL and Zeithaml, VA 1991a, Perceived service quality as a customer based performance measure: an empirical examination of organizational barriers using an extended service quality model, *Human Resource Management*, 30, pp. 335-364.

Parasuraman, A, Berry, LL and Zeithaml, VA 1993, Research note: more on improving service quality measurement, *Journal Of Retailing*, 69(1), pp. 140- 147.

Parasurarman, A, Zeithaml, VA and Berry, LL 1985, A conceptual model of service quality and its implications for future research, *Journal of Marketing*, **49**(4), pp. 41-50.

Parasurarman, A, Zeithaml, VA and Berry, LL 1988, SEVRVQUAL: A multiple-item scale for measuring consumer perceptions of service quality, *Journal of Retailing*, **64**(1), pp. 12-37.

Parker S and Heapy J 2006, *The journey to the interface: how public service design can connect users to reform*, Demos, UK.

Patton MQ 1987, *Qualitative research and evaluation method (3rd edition)*, Sage publication, thousand oaks, London.

Patton, MQ 1999, Enhancing the quality and credibility of qualitative analysis, *Health Services Research*, **34**(5), pp. 1189-1208.

Patton, MQ 2002, *Qualitative research & evaluation methods*, 3rd edition, Thousand Oaks: Sage.

Peters, TJ and Waterman, RH 1982, *In search of excellence*, Harper and Row Publications, New York, USA.

Picker institute service user surveys 2005, accessed on 01/04/06 <http://www.pickereurope.org/about/approach.htm>.

Pine II, BJ and Gilmore, JH 1999, *The experience economy: work is theatre and every business a stage*, Harvard Business School Press, Boston, Massachusetts.

Pizzam, A &Taylor, E 1999, Customer Satisfaction And Its Measurement In The Hospitality Enterprise, International Of Contemporary Hospitality Management, 11/7

Preece, RA 1994, *Starting research: an introduction to academic research and dissertation writing*, Pitner, First Edition, London.

Preiser, WFE and Vischer, JC 1991, *An introduction to design intervention: a manifesto for the future of environmental design*, In: Preiser, WFE, Vischer, JC and White, ET 1991, Design Intervention: Toward a More Humane Architecture, Van Nostrand Reinhold, New York.

Pugh, SD, Dietz, J, Wiley, JW and Brooks, SM 2002, Driving service effectiveness through employee-customer linkages, *Academy of Management Executive*, **16**(4), pp. 73-83.

Radnor, Zoe and Lovell, Bill 2003, Success factors for implementation of the balanced score card in a NHS multi-agency setting, *International Journal of Healthcare Quality Assurance*, **16**(2), pp. 99-108.

Ramaswamy, R 1996, *Design and management of service processes: keeping customers for life,* Reading, MA: Addison-Wesley Publishing Co.

Reeves, CA and Bednar, DA 1994, Defining quality: alternatives and implications, *Academy of Management Review*, 19, pp. 419-445.

Remenyi, D, Williams, B, Money, A and Swartz, E 1998, *Doing Research in Business and Management,* London, Sage Publications.

Richard, MD and Allaway, AW 1993, Service quality attributes and choice behavior, *Journal of Service Marketing*, 7, pp. 59-68.

Robson, C 1993, *Real world research: a research for social scientists and practitioner-researchers*, Blackwell, Oxford.

Rowley, J 1994, Customer experience of libraries, *Library Review*, **43**(6), pp. 7-17.

Rowley, J 1999, Measuring total customer experience in museums, *International Journal of Contemporary Hospitality Management*, **11**(6), pp. 303-308.

Rust, RT, and Oliver, RL (Eds) 1994, *Service quality: insights and managerial implications from the frontier*, Service Quality: New Directions in Theory and Practice, pp. 241-268.

Ryder, C and King, C 2002, *A white paper: commoditization, standards and the enterprise*, The Sageza Group Inc.

Sage Publications, California, USA.

Salford and Trafford Health Authority 1999, *Public health report*, Supporting Health Improvement.

Salford PCT 2003, *Annual report 2002/3*, Salford Primary Care Trust, Salford.

Sasser, E 1976, *Match supply and demand in service industries*, Harvard Business Review 54.

Sasser, WE, Olsen, RP and Wyckoff, DD 1987, *Understanding service operations in management of service operations: text and cases*, Boston MA: Allyn and Bacon.

Schneider, B, Bowen, D, Ehrhart, M and Holcombe, K 2000, *The climate for service*, In N Ashkanasy, C Wilderom & M Peterson (Eds.), Handbook of Organizational Culture and Climate (pp. 21-36), Thousand Oaks: Sage Publications.

Scott-Samuel, A, Briely, M and Arden A, 2001, *The merseyside guidelines for health impact assessment (2nd edn)*, Merseyside Steering Group, Public Health Observatory, University of Liverpool, Liverpool.

Sekeran, U 1992, *Research methods for business: a skill building approach*, Second Edition, John Wiley & Sons, Inc, USA.

Sekeran, U 2000, *Research methods for business: a skill building approach*, Third Edition, John Wiley & Sons, Inc, USA.

Shaw, C and Ivens, J 2002, *Building great customer experiences*, Palgrave Macmillan, Wales.

Singh, J 1993, Boundary role ambiguity: facts, determinants, and impacts, *Journal of Marketing*, 57, pp. 11-36.

Smith F 1998, Focus groups and observation studies, *International Journal of Pharmacy Practice*, 6, 229–242.

Sohail 2003, Service quality in hospitals: more favourable than you may think, *Managing Service Quality*, **13**(3), pp. 197-205.

Stahr, H 2001, Developing A Culture of Quality within The United Kingdom Healthcare System, *International Journal of Healthcare Quality Assurance*, **14**(4), pp. 174-180.

Stahr, H 2001, Developing a culture of quality within the United Kingdom healthcare system, *International Journal of Healthcare Quality Assurance*, **14**(4), pp. 174-180.

Stake, R 1995, *The art of case study design*, California: Sage Publications.

Stauss, B and Weinlich, B 1997, "Process oriented measurement of service quality: applying the sequential incident technique", *European Journal of Marketing*, 31(1), pp. 33-55.

Steinfild, E and Dunford, GS 1999, *Enabling environments: measuring the impact of environment on disability and rehabilitation*, Kluwer Academic/Plenum Publishers, New York.

Stevens, P, Knutson, B and Patton, M 1995, "Dineserv: a tool for measuring service quality in restaurant", *The Cornell Hotel and Restaurant Administration Quarterly*, 36(2), pp. 56-60.

Strauss, A and Corbin, J 1990, *Basics of qualitative research techniques and procedures for developing grounded theory (2nd edition)*, Sage publication, thousand oaks, London.

Tear, R 1998, "Interpreting and responding to customer needs", *Journal of Workplace Learning*, 10(2), pp. 76 –94.

Teas, RK 1993, "Expectations, performance evaluation and customers perceptions of quality", *Journal of Marketing*, 57(4), pp. 18-34.

The World Bank Annual Report 2004, Chapter 3 Thematic Perspectives, Volume 1Year in Review.

Then, DS 1996, *A study of organizational response to management of operational property assets and facilities support services as a bussiness resource–real estate asset management*, Unpublished Thesis, Heriot-Watt University, Edinburgh.

Thomas, D 1978, *Strategy is different in service business*, Harvard Business, Review, pp. 161-165.

Todd, S, Steele, A, Douglas, C and Douglas, M 2002, Investigation and assessment of attitudes to and perceptions of the built environments in NHS trust hospitals, *Structural Survey*, **20**(5).

Tombs, A and McColl-Kennedy, JR 2003, Social-servicescape conceptual model, *Marketing Theory*, 3(4), pp. 447-475.

Ulrich, RS, Symons, RF, Losito, BD, Fioroto, E, Miles, MA and Zelson, M 1991, Stress recovery during exposure to natural and urban environments, *Journal of Environmental Psychology*, 11.

UNISYS 2001, "Service Excellence Awards", *Management Today*, UNISYS Limited.

Vicher, CJ 2005, *Post-occupancy evaluation for healthcare facilities management*, SCRI, Salford,

Wehmeier, S 2000, *Oxford advanced learners*, Dictionary, Oxford University Press, Oxford.

Wiley, JW and Brooks, S 2000, *The high performance organizational climate*, In N Ashkanasy, C Wilderom & M Peterson (Eds.), Handbook of Organizational Culture and Climate, Thousand Oaks: Sage Publications.

Williams, C 1998, Is the servqual model an appropriate management tool for measuring service delivery quality in the UK leisure industry? *Managing Leisure*, 3, pp. 98-110.

Yin RK 1994, *Case study research: design and methods*, Second Edition, Sage Publications Ltd.

Yin, RK, Bateman P and Moor GB 1983, *Case studies and organisational innovation: strengthening the connection*, Cosmos Cooperation.

Zeithaml, VA and Bitner, MJ 1999, *Service marketing*, Second Edition, New York, McGraw-Hill Company.

Zeithaml, VA, Berry, LL and Parasurarman, A 1988, Communication and control in the delivery of service quality, *Journal of Marketing*, 52, pp. 35-48.

Zeithaml, VA, Berry, LL and Parasurarman, A 1993, The nature and dimensions of customer expectations of service, *Journal of the Academy of Marketing Science*, **21**(1), pp. 1-12.

Zeithaml, VA, Parasuraman, A and Berry, LL 1990, Delivering quality service: balancing customer perceptions and expectations, the Free Press, New York.

APPENDICIES

Appendix1 Interviews Template

Basis for Users impressions of PCT healthcare delivery

Healthcare Provider		Impressions of Service	Impressions of Environment
GP	Single-handed ( )		
	Group practice ( )		
Practice Nurse	Single handed ( )		
	Group practice ( )		
Dentist's Practice	NHS ( )		
	Private ( )		
Chemist's Shop	Incorporated ( )		
	Not incorporated ( )		
Opticians	NHS ( )		
	Private ( )		
PCT: physiotherapy, paediatric, district nurse, out of hour, health visitor, minor surgeries, speech & language therapy, contraceptives			

Appendix 2 Questionnnaire Survey

Dear Salford service user

Salford Primary Care Trust (PCT) receives money from the Government to plan and provide local health services. It guides the work of 61 doctors' surgeries and other local health services such as dentists, chemists and opticians. The PCT also works with the hospitals to ensure that care is available when you need it including specialist treatment such as cancer and diabetes.

This is a joint study between Salford University and Salford PCT. The main aim of this study is to explore your impressions of the environment and service of healthcare delivery provided by your local PCT. This is important, as it takes into account your views and priorities in order to bring about improvements in the delivery of healthcare services.

Please answer the following questions based on your last experience of the healthcare delivery by selecting the answer on the scale which most closely coincides with your opinion.

All data will be maintained in strict confidence. A copy of the overall survey results will be available once the research has been finished

Once you completed the questionnaire and placed it in the envelope provided. Please do not forget to seal the envelope and hand back to the receptionist.

For further details, please do not hesitate to contact:

Bashir Abusaid through:b.a.a.abusaid@pgr.salford.ac.uk

Thank you for your participation

The first section of this questionnaire contains a series of questions about your age and income etc. The reason for asking these questions is to determine if various groups have different impressions and attitudes about healthcare. **Please** answer these personal questions. **No** one will ever associate these responses with your name.

1. I am from.....in Salford,
and I have lived in this community for.....years

2. I am .... (Please **circle** that which applies)

- Male
- Female,

and my age is.....Years

3. I am .... (Please **circle** that which applies)

- Single
- Married
- Divorced
- Separated
- Co habiting

4. My ethnic minority group is.... (Please **circle** that which applies)

- White
- Pakistani
- Indian
- Bangladeshi
- Chinese
- Black Caribbean
- Black other
- other, please specify.....

5. My average household income is £.....per year,
and my current occupation is.....

6. My highest level of formal education I have completed is....
(Please **circle** that which applies)

- Secondary school
- College
- university
- other, please specify.....

7. I last visited my local healthcare practice.....months ago

8. Please **circle** which of the long term illness/ condition you suffer from

- Sight impairment
- Hearing impairment
- Physical disability
- Learning disability
- None
- Other, please specify.....

The second section of this questionnaire deals with your last experience of healthcare. **Please** take a few minutes to express your impressions of the e

9. On your last visit to your local healthcare practice, how did you contact the health practice to arrange the appointment? (Please **circle** that which applies)

- By telephone
- In person at the reception desk

10. From your last healthcare experience, to what extent do you agree that....

	Disagree strongly	Disagree	Nether agree nor disagree	Agree	Agree strongly
•There was enough parking space					
•There were good directional signs					
• Parking facilities were secure					
• Healthcare practice was easily accessible					

11. On your last visit to your local practice, about how long (in minutes) did you have to queue before being spoken to by the reception staff?.. (Please **circle** that which applies)

- I did not have to queue at all
- I had to queue for .....minutes on arriving.

12. On your last visit to the healthcare practice, to what extent do you agree that the reception staff were....

	Disagree strongly	Disagree	Nether agree nor disagree	Agree	Agree strongly
• Approachable					
• Polite					
• Friendly and helpful					
• Knowledgeable about their services					
• Understanding of your health needs					

13. On your last visit to your local practice, who did you go to see? (Please **circle** that which applies)

• GP • Dentist • Optician • Practice nurse • Health visitor

14. Please indicate how long (in minutes) did you have to wait before being seen.. (Please **circle** that which applies)

• I was seen immediately

15. Please describe your last waiting experience in terms of:

	Very poor	Poor	average	satisfact ory	Very satisfactory
• The typical length of time you had to wait					
• The effort made by the staff to reduce waiting time					
•Staff apologising about the wait					
• Entertaining facilities such as news papers and magazines					
•The way the staff kept you informed					

16. From your last experience, please describe your impressions of the waiting area in terms of:

	Very poor	Poor	Average	Satisfactory	Very satisfactory
• Location of waiting area					
• Size of waiting area					
• Layout of waiting area					
• Directional signs					
• Ease of access through doors					
• Fresh air and ventilation					
• Pleasantness of decoration					
• Access to telephone					
• Smell of waiting area					
• Cleanliness of waiting area					
• Lighting of waiting area					
• Comfort of waiting area					
• Facilities for people with special needs					
• Privacy levels					
• Toilets					
• Children s' play area					

17. From your last experience, could you please describe your medical treatment in terms of:

	Very poor	Poor	Average	Satisfactory	Very satisfactory
• Sufficient time					
• Respect and dignity					
• The variety of service and choice					
• The quality of healthcare					
• The promptness displayed by your GP					
• The promptness of your Practice nurse					
• The promptness of your health visitor					
• The promptness of your dentist					
• The promptness of your optician					

18. Before departing the health practice, how would you describe your leaving experience?

	Very poor	Poor	Average	satisfactory	Very satisfactory
• Reception staff were responsive to your needs					
• Reception staff gave you 100% of their attention					
• Reception staff did mean it when they said (have a nice day)					
• Reception staff treated you as an individual					

19. Finally, taking every thing into an account, please show your overall impressions of the last healthcare experience you have been through?

- Extremely Impressed
- Very Impressed
- Impressed
- Unimpressed
- Very unimpressed

20. Please write down any further comments you wish to make on improving your visit to the health practice

.....
.....
.....
.....
.....
.....
.....

If you wish to receive a copy of the results of this survey, please contact me on
b.a.a.abusaid@pgr.salford.ac.uk

Appendix 3Health Centre/Practice

SALFORD PRIMARY CARE TRUST

GP Practice List - Salford North

Bradley SMA	*Female*		✉	*Lower Kersal and Charlestown Primary Care Centre, Pendleton House,*
Smithson P	*Female*			*Broughton Road, Salford M6 6LS*
(Central Locality)			☎	*0161 - 737 - 9729* ***FAX*** *0161 - 925 - 0327*
Buch KH	*Male*	*C*	✉	*Lower Broughton Health Centre, Great Clowes Street,Salford M7 1RD*
(Central Locality)			☎	*0161 - 832 - 4915* ***FAX*** *0161 - 832 - 1210*
Chowdhury HR	*Male*	*CR*	✉	*Lower Broughton Health Centre, Great Clowes Sreet,Salford M7 1RD*
(Central Locality)			☎	*0161 - 839 - 2725* ***FAX*** *0161 - 832 - 1210*
Dass BK	*Male*	*C*	✉	*Higher Broughton Health Centre, Bevendon Square, Salford M7 4TP*
Warburton CB	*Male*	*C*	☎	*0161 - 792 - 5111* ***FAX*** *0161 - 708 - 8944*
(Central Locality)				
Davis WS	*Male*	*CR*	✉	*53 Leicester Road, Salford M7 4AS*
(Central Locality)			☎	*0161 - 708 - 9992* ***FAX*** *0161 - 792 - 9800*
De Silva AKL	*Male*	*C*	✉	*29 Littleton Road, Salford M6 6ED*
(Central Locality)			☎	*0161 - 736 - 7333* ***FAX*** *0161 - 736 - 1856*
			✉	*417 Chorley Road, Swinton, Manchester M27 9UQ*
(North Locality)			☎	*0161 - 281 - 4111* ***FAX*** *0161 - 281 - 4115*
Finegan NA	*Male*	*C*	✉	*Sorrel Group Practice, 23 Bolton Road, Salford M6 7HL*
Picardo L	*Male*	*C*	☎	*0161 - 736 - 1616/1021* ***FAX*** *0161 - 736 - 1878*
Kallis P	*Male*		✉	*9 Victoria Road, Salford M6 8FZ*
			☎	*0161 - 789 - 3722* ***FAX*** *0161 - 707 - 7450*

SALFORD PRIMARY CARE TRUST

GP Practice List - Salford North

Ghosh PR	*Male*	*CR*	✉	*Higher Broughton Health Centre, Bevendon Square, Salford M7 4TP*
(Central Locality)			☎	*0161 - 792 - 6888* ***FAX*** *0161 - 708 - 8510*
Jeet I	*Male*	*C*	✉	*Lower Broughton Health Centre, Great Clowes Street,Salford M7 1RD*
			☎	*0161 - 839 - 2723* ***FAX*** *0161 - 832 - 1210*
			✉	*169 Gerald Road, Salford M6 6BL*
(Central Locality)			☎	*0161 - 792 - 0476* ***FAX*** *0161 - 708 8812*
Kassam NN	*Male*	*C*	✉	*4-5 Mocha Parade, Salford M7 1QE*
Pira A	*Female*	*C*	☎	*0161 - 839 - 2721* ***FAX*** *0161 - 819 - 1191*
			✉	*47 Gainsborough Street, Salford M7 0AL*
(Central Locality)			☎	*0161 - 792 - 6478* ***FAX*** *0161 -*
Larah DG	*Female*	*C*	✉	*Higher Broughton Health Centre, Bevendon Square, Salford M7 4TP*
Bacall L	*Male*	*CR*	☎	*0161 - 792 - 2142* ***FAX*** *0161 - 792 - 9203*
Joseph SG	*Male*			
(Central Locality)				
Levenson S	*Male*	*C*	✉	*6 - 8 Limefield Road, Salford M7 4LZ*
(Central Locality)			☎	*0161 - 721 - 4845* ***FAX*** *0161 - 720 - 6494*
Randall SC	*Female*	*C*	✉	*37 Orient Road, Salford M6 8LE*
Raj VB	*Male*	*C*	☎	*0161 - 789 - 3029* ***FAX*** *0161 - 281 - 0192*
(Central Locality)				
Sultan M	*Male*	*C*	✉	*Lower Broughton Health Centre, Great Clowes Sreet,Salford M7 1RD*
(Central Locality)			☎	*0161 - 839 - 2730* ***FAX*** *0161 - 832 - 1210*
Tankel JW	*Male*	*C*	✉	*Clarendon Surgery Lance Burn Health Centre*
Owen W	*Female*	*C*		*Churchill Way, Salford M6 5QX*
			☎	*0161 - 736 - 4529* ***FAX*** *0161 - 736 - 2724*
			✉	*Trinity Medical Centre*
				The Angel, St Philips Place, off Chapel Street, Salford. M3 2AA
(Central Locality)			☎	*0161 - 833 - 3862* ***FAX*** *0161 -*

*C - Contraceptive services **NOT** restricted to patients for whom other general medical services are provided.*
CR - Contraceptive services restricted to patients for whom the GP provides general medical services.

SALFORD PRIMARY CARE TRUST

GP Practice List - Salford South

Baishnab RM	*Male*	*C*	✉	*195 Langworthy Road, Salford M6 5PW*
(Central Locality)			☎	*0161 - 736 - 2338* **FAX** *0161 - 737 - 2415*
Bakhshi NA	*Male*	*CR*	✉	*Lance Burn Health Centre*
(Central Locality)				*Churchill Way, Salford M6 5QX*
			☎	*0161 - 745 - 9235/9* **FAX** *0161 - 736 - 2387*
Bedi S	*Female*		✉	*Salford Care Centres (Weaste)*
Malcomson CI	*Male*			*3 Derby Road, Salford M5 5NZ*
Bayes AN	*Male*		☎	*0161 - 736 - 4037* **FAX** *0161 - 743 - 9384*
(Central Locality)				
Collier PA	*Female*	*C*	✉	*91 Claremont Road, Salford M6 7GP*
Haque ME	*Male*	*C*	☎	*0161 - 743 - 0453* **FAX** *0161 - 743 - 9141*
Austin MA	*Male*	*C*	✉	*Pendleton Medical Centre*
(Central Locality)				*1 Paddington Close, Salford M6 5PL*
			☎	*0161 - 736 - 1028* **FAX** *0161 - 743 - 9985*
Haber S	*Male*	*C*	✉	*Langworthy Medical Centre*
Goodman KL	*Female*	*C*		*250 Langworthy Road, Salford M6 5WW*
Rosenberg SE	*Female*	*C*	☎	*0161 - 736 - 7422* **FAX** *0161 - 736 - 4816*
Addlestone LS	*Male*	*C*		
Leventhall PA	*Female*	*C*		
Mcphillips MS	*Female*			
(Central Locality)				
Rahman A	*Male*	*C*	✉	*Salford Medical Centre*
(Central Locality)				*194-198 Langworthy Road, Salford M6 5PP*
			☎	*0161 - 745 8341* **FAX** *0161 - 745 - 8955*
Robinson J	*Female*	*C*	✉	*Ordsall Health Centre*
Saxby K	*Female*	*C*		*Belfort Drive, Salford M5 3PP*
Coulson SM	*Female*		☎	*0161 - 872 - 2021* **FAX** *0161 - 877 - 3592*
(Central Locality)				

Continued

SALFORD PRIMARY CARE TRUST

GP Practice List - Salford South

Rodgers ME	*Male*	*C*	✉	*The Willows*
				Lords Avenue, Salford M5 2JR
(Central Locality)			☎	*0161 - 736 - 2356* ***FAX*** *0161 - 737 - 2265*
Salim A	*Male*	*C*	✉	*Salford Medical Centre*
(Central Locality)				*194-198 Langworthy Road, Salford M6 5PP*
			☎	*0161 - 736 - 2651* ***FAX*** *0161 - 745 - 8955*
Tankel JW	*Male*	*C*	✉	*Clarendon Surgery Lance Burn Health Centre*
Owen W	*Female*	*C*		*Churchill Way, Salford M6 5QX*
(Central Locality)			☎	*0161 - 736 - 4529* ***FAX*** *0161 - 736 - 2724*
			✉	*Trinity Medical Centre*
				The Angel, St Philips Place, off Chapel Street, Salford. M3 2AA
			☎	*0161 - 833 - 3862* ***FAX*** *0161 -*

*C - Contraceptive services **NOT** restricted to patients for whom other general medical services are provided.*
CR - Contraceptive services restricted to patients for whom the GP provides general medical services.

SALFORD PRIMARY CARE TRUST

GP Practice List - Eccles

Allweis B	Male	C	✉	St. Andrews Medical Centre
				30 Russell Street, Eccles Manchester M30 0NU
(South Locality)			☎	0161 - 707 - 5500 **FAX** 0161 - 787 - 9159
Borg-Costanzi JM	Male	C	✉	Monton Medical Centre
				Canal Side, Monton Green, Eccles, Manchester M30 8AR
(South Locality)			☎	0161 - 789 - 5966 **FAX** 0161 - 707 - 7693
Broxton JS	Female	C	✉	St. Andrews Medical Centre
Budden P	Male	C		30 Russell Street, Eccles, Manchester M30 0NU
Sutherland H C	Female	C	☎	0161 - 707 - 5500 **FAX** 0161 - 787 - 9159
(South Locality)				
The Ganvir Practice			✉	169 Church Street
Ellis MB	Female			Eccles Manchester M30 0LU
Harniess D	Male		☎	0161 - 787 - 8880 **FAX** 0161 - 787 - 8864
Pramanik K	Female			
(South Locality)				
Jacobs E	Female	C	✉	St. Andrews Medical Centre
Yates MS	Female	C		30 Russell Street, Eccles, Manchester M30 0NU
(South Locality)			☎	0161 - 707 - 5500 **FAX** 0161 - 787 - 9159
Khanna M	Female	C	✉	Monton Medical Centre
				Canal Side, Monton Green, Eccles, Manchester M30 8AR
(South Locality)			☎	0161 - 789 - 5966 **FAX** 0161 - 707 - 7693
Leach G	Male	C	✉	Monton Medical Centre
				Canal Side, Monton Green, Eccles, Manchester M30 8AR
(South Locality)			☎	0161 - 789 - 5966 **FAX** 0161 - 707 - 7693
Lindsay SD	Male	C	✉	St. Andrews Medical Centre
Behardien JY	Male	C		30 Russell Street, Eccles, Manchester M30 0NU
(South Locality)			☎	0161 - 707 - 5500 **FAX** 0161 - 787 - 9159

SALFORD PRIMARY CARE TRUST

GP Practice List - Eccles

Purser JH	*Male*	*C*		*Springfield House*
Whittaker NA	*Female*	*CR*		*New Lane, Patricroft, Eccles, Manchester M30 7JE*
(South Locality)			☎	*0161 - 789 - 5858* ***FAX*** *0161 - 707 - 7747*
Singh H	*Male*	*C*		*Eccles Health Centre*
				Corporation Road,Eccles,Manchester, M30 0EL
(South Locality)			☎	*0161 - 788 - 7337* ***FAX*** *0161 - 212 5501*
Tamkin EJ	*Female*	*C*		*Springfield House*
Garner MR	*Female*	*C*		*New Lane, Patricroft, Eccles, Manchester M30 7JE*
(South Locality)			☎	*0161 - 789 - 5858* ***FAX*** *0161 - 707 - 7747*
Tasker IT	*Male*	*C*		*Springfield House*
				New Lane, Patricroft, Eccles, Manchester M30 7JE
(South Locality)			☎	*0161 - 789 - 5858* ***FAX*** *0161 - 707 - 7747*
Tyrrell NM	*Female*	*C*	✉	*St. Andrews Medical Centre*
				30 Russell Street, Eccles, Manchester M30 0NU
(South Locality)			☎	*0161 - 707 - 5500* ***FAX*** *0161 - 787 - 9159*

SALFORD PRIMARY CARE TRUST

GP Practice List - Irlam

Hope B	Male	C	✉	Irlam Medical Centre
Bates N	Male	C		MacDonald Road, Irlam, Manchester M44 5LH
Craigie HC	Female		☎	0161 - 776 - 0737 **FAX** 0161 - 775 - 2568
Logan AJM	Female		✉	Longfield Lodge Surgery
				276 Liverpool Road, Cadishead, Manchester, M44 5UJ
(South Locality)			☎	0161 775 2023
Joshi V	Female	C	✉	Chapel Medical Centre
				220 Liverpool Road, Irlam, Manchester M44 6FE
(South Locality)			☎	0161 - 775 - 7373 **FAX** 0161 - 775 - 5603
Koria K	Male	C	✉	Irlam Medical Centre
White JS	Female	C		MacDonald Road, Irlam, Manchester M44 5LH
(South Locality)			☎	0161 - 775 - 2760 **FAX** 0161 - 775 - 5829
Malcomson CI	Male	C	✉	Salford Care Centres (Irlam)
Bedi S	Female			125 Liverpool Road, Irlam, Manchester M44 6DP
Bayes AN	Male		☎	0161 - 775 - 0000 **FAX** 0161 - 775 - 2575
(South Locality)				
Rolfe JN	Male	C	✉	523 Liverpool Road, Irlam, Manchester M44 6ZS
Malloy NP	Male	C	☎	0161 - 776 - 1000 **FAX** 0161 - 776 - 0477
Shahbaz M	Male	C		
(South Locality)				

SALFORD PRIMARY CARE TRUST

GP Practice List - Swinton

De Silva AKL (Central Locality)	*Male*	*C*	✉	*29 Littleton Road, Salford M6 6ED*
			☎	*0161 - 736 - 7333* **FAX** *0161 - 736 - 1856*
(North Locality)			✉	*417 Chorley Road, Swinton, Manchester M27 9UQ*
			☎	*0161 - 281 - 4111* **FAX** *0161 - 281 - 4115*
Forman WM	*Male*	*C*	✉	*The Poplars Medical Centre 202 Partington Lane Swinton M27 0NA*
Stewart AR	*Female*	*C*	☎	*0845 - 070 - 6237* **FAX** *0845 - 070 - 5159*
Harris J	*Female*	*C*		
Brunt CV	*Male*	*CR*		
Williams B J	*Male*	*CR*		
Short A D (North Locality)	*Male*	*C*		
Kyaw T (North Locality)	*Male*	*C*	✉	*155 Manchester Road, Swinton, Manchester M27 4FH*
			☎	*0161 - 794 - 6901* **FAX** *0161 - 728 - 4977*
Moore M A	*Male*	*C*	✉	*The Sides Medical Centre, Moorside Road,*
Singh KV	*Male*	*C*		*Swinton, Manchester M27 0EW*
Marginson JE	*Male*	*C*	☎	*0161 - 794 - 1604* **FAX** *0161 - 727 - 3615*
Russell PM	*Female*	*C*		
Jolly GK	*Female*	*C*		
Patel G	*Male*	*C*		
Cribbin LJ (North Locality)	*Male*	*C*		

Continued

SALFORD PRIMARY CARE TRUST

GP Practice List - Swinton

Sharma MM	*Male*	*C*	✉	*Pendlebury Health Centre*
Nicholson S (North Locality)	*Male*	*C*		*659 Bolton Road, Pendlebury, Manchester M27 8HP*
			☎	*0161 - 950 - 4545* ***FAX*** *0161 - 950 - 4546*
Singh HS	*Male*	*C*	✉	*Pendlebury Health Centre*
Wilcock DJ	*Male*	*C*		*659 Bolton Road, Pendlebury, Manchester M27 8HP*
Wilcock J	*Female*	*CR*	☎	*0161 - 793 - 8686* ***FAX*** *0161 - 727 - 8011*
Ballin IA	*Male*	*C*		
Choudhury NN (North Locality)	*Female*	*C*		
Stedman HGB	*Male*	*CR*	✉	*63 Manchester Road, Swinton, Manchester M27 5FX (Surgery closes 12/12/04)*
Hayes MJ	*Male*	*C*	☎	*0161 - 794 - 4343* ***FAX*** *0161 - 736 - 0669*
	wef 13/12/04			*The Lakes Medical Practice The Lakes Medical Centre*
(North Locality)				*21 Chorley Road Swinton Manchester M27 4AF*
			☎	*0161 - 794 - 4343* ***FAX*** *0161 - 736 - 0669*

SALFORD PRIMARY CARE TRUST

GP Practice List - Worsley

Ahuja A	*Female*	*C*	✉	*1A Dearden Avenue, Little Hulton, Manchester M38 9GH*
(West Locality)			☎	*0161 - 799 - 2784* ***FAX*** *0161 - 799 - 1889*
Boyce C T	*Male*	*C*	✉	*Walkden Medical Centre*
Sutherland B	*Male*	*C*		*2 Hodge Road, Walkden, Worsley, Manchester M28 3AT*
Wright SA	*Male*	*C*	☎	*0161 - 790 - 3615* ***FAX*** *0161 - 703 - 7638*
Hyams NA	*Male*	*C*		
(West Locality)				
Cleator P J	*Female*	*C*	✉	*The Gill Medical Centre*
				5 Harriet Street, Walkden, Worsley, Manchester M28 3DR
(West Locality)			☎	*0161 - 790 - 3033* ***FAX*** *0161 - 702 - 9544*
Cleggs Lane Medical Practice			✉	*Cleggs Lane Medical Practice 81-85 Cleggs Lane, Little Hulton,*
Wong GT	*Male*			*Manchester M38 9WU*
Umeadi UIN	*Male*		☎	*0161 - 799 - 4988* ***FAX*** *0161 - 799 - 5271*
(West Locality)				
Element P	*Male*	*C*	✉	*The Limes Medical Centre*
McCarthy DK	*Male*	*C*		*10-12 Hodge Road, Walkden, Worsley, Manchester M28 3AT*
Tran MNL	*Male*	*C*	☎	*0161 - 790 - 8621* ***FAX*** *0161 - 703 - 8670*
Gregory G	*Female*	*C*		
(West Locality)				
Garg T L	*Male*	*C*	✉	*7 Manchester Road, Walkden, Worsley, Manchester M28 3NS*
(West Locality)			☎	*0161 - 790 - 3132* ***FAX*** *0161 - 703 - 7463*
Gore H	*Female*	*C*	✉	*129-131 Cleggs Lane, Little Hulton, Manchester M38 9RS*
(West Locality)			☎	*0161 - 799 - 4001* ***FAX*** *0161 - 703 - 8276*
Hulton General Practice	*Male*	*C*	☎	*Hulton General Practice Hulton District Health Centre*

Continued

SALFORD PRIMARY CARE TRUST

GP Practice List - Worsley

Waldman SJ				*Haysbrook Avenue, Little Hulton, Manchester M28 0AY*
(West Locality)			✉	*0161 - 790 - 3276* ***FAX*** *0161 - 703 - 7948*
Khan M T	*Male*	*CR*	✉	*152A Manchester Road East, Little Hulton, Manchester. M38 9LQ*
(West Locality)			☎	*0161 - 799 - 3233* ***FAX*** *0161 - 975 2861*
McCorkindale S	*Female*	*CR*	✉	*Ellenbrook Medical Centre, Ellenbrook Village Centre,*
McCorkindale JW	*Male*	*C*		*14 Morston Close, Worsley. Manchester.M28 1PB*
Milligan H S	*Male*	*C*	☎	*0161 - 703 - 9091* ***FAX*** *0161 - 703 - 9111*
Levison M	*Female*	*C*		
(West Locality)				
Reddy P	*Female*	*C*	✉	*10 Leigh Road, Boothstown, Manchester M28 1LZ*
(West Locality)			☎	*0161 - 702 - 8579* ***FAX*** *0161 - 703 - 8922*
Sinha R P	*Male*	*CR*	✉	*90 Worsley Road North, Walkden, Worsley, Manchester M28 3QW*
(West Locality)			☎	*01204 - 791409* ***FAX*** *01204 - 862096*
Tauk T	*Male*	*C*	✉	*Cherry Medical Centre, 478 - 482 Manchester Road East,*
				Little Hulton, Manchester M38 9NS
(West Locality)			☎	*0161 - 799 - 7478* ***FAX*** *0161 - 799 - 3489*